



MEDICAL PEACE WORK

MPW Course 7: Prevention of interpersonal and self-directed violence



General objectives

This course will analyse the origin and extent of different types of violence at the micro level, including community violence, domestic violence and suicide. It will help you describe risk factors and prevention strategies for each type of violence.



Education and Culture

Leonardo da Vinci

THE MEDICAL PEACE WORK TEXTBOOK, 2ND EDITION

Course 7: Prevention of interpersonal & self-directed violence

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⇒ COURSE 1

⇒ COURSE 2

⇒ COURSE 3

⇒ COURSE 4

⇒ COURSE 5

⇒ COURSE 6



Contents

Chapter 1: Preventing interpersonal violence	5
Lesson 1.1: Definition and nature of interpersonal violence	6
Introduction	6
Definition and types of violence	7
Interpersonal violence as a human rights problem	8
Lesson 1.2: Interpersonal violence as a health problem	10
The epidemiology of interpersonal violence	10
The economic costs of interpersonal violence	13
Lesson 1.3: At-risk groups and the public health approach	15
At-risk groups	15
A public health approach to violence	16
Lesson 1.4: Primary prevention of interpersonal violence	18
Introduction	18
A public health approach to violence prevention	18
An ecological model	21
Individual level	22
Relationship level	22
Community level	23
Societal level	23
Addressing poverty and inequality to prevent interpersonal violence	24
Violence prevention – the evidence	24
Chapter 2: Preventing self-directed violence	26
Lesson 2.1: The epidemiology of self-directed violence	27
Introduction	27
Defining important concepts	27
Deliberate self-harm – a statistical picture	28
Suicide – a statistical picture	28
Other variations in suicide rates	30
Conclusion	31

Lesson 2.2: Vulnerability to suicidal behaviour	32
Introduction	32
Family structure	33
Family history	33
Economic factors	34
Health status	34
Life stress	35
The interaction of genetic and environmental factors	35
Conclusion	36
Lesson 2.3: Treating suicidal people and people who self-harm	37
Introduction	37
Problem-solving therapy	37
Intensive psychological therapy	38
Community outreach and increased intensity of care	38
Pharmacological treatment	38
Conclusion	39
Lesson 2.4: Preventing suicide	40
Introduction	40
Education and awareness campaigns	40
Screening at-risk populations	41
Treatment interventions	42
Restricting access to lethal means	42
Media reporting guidelines	42
Levels of prevention	43
Conclusion	43
Glossary Course 7	45



GO TO CONTENTS



GO TO GLOSSARY



GO TO PREVIOUS VIEW

Chapter 1: Preventing interpersonal violence



This chapter introduces you to the public health challenges of dealing with violence from intimate partners or strangers at the interpersonal level.

Intermediate objectives

By the end of this chapter you will be able to:

- outline the magnitude of interpersonal violence
- describe the ecological model for understanding and preventing violence
- describe the roles that health professionals can play in preventing interpersonal violence.

Lesson 1.1: Definition and nature of interpersonal violence

*Authors: Leo van Bergen and Marianne Begemann;
updated by Ole Kristian Hjemdal*

Introduction

Interpersonal violence – especially violence within the family – is no longer considered a private matter. It violates the rights to safety, protection and health enshrined in the Universal Declaration of Human Rights (UN 1948), the Convention on the Elimination of All Forms of Discrimination against Women (UN 1980), and the Declaration of the Rights of the Child (UN 1959). As a result, the problem of interpersonal violence is now considered a human rights problem and a direct responsibility of the state.

In 1985, the UN General Assembly adopted the Declaration on the Basic Principles of Justice for Victims of Crime and Abuse of Power (UN 1985). It says that victims should receive the necessary material, medical, psychological and social assistance through governmental, voluntary, community-based and indigenous means.

Violence is a major and growing public health problem across the world, the Forty-Ninth World Health Assembly declared (WHO 1996). It drew attention to the serious short-term and long-term consequences for individuals, families, communities and countries, and the damaging effects on health services. Interpersonal violence has also been defined as a public health problem because these types of violence can be prevented by addressing their underlying causes, using tools like epidemiology, primary prevention and evaluation that are also applied to tuberculosis, malaria and HIV/AIDS.

Other health disciplines and functions may also be involved, including:

- health policy and planning
- health information systems
- mental health and substance abuse
- family and community health
- emergency medical services
- medico-legal services.

Learning objectives

By the end of this lesson you will be able to:

- define interpersonal violence and outline the different forms it takes
- explain why interpersonal violence is a human rights problem.

Definition and types of violence

WHO has defined violence as ‘the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation’ (WHO 2002:5). It further divides violence into three sub-categories according to the context in which it is committed:

Collective violence is violence ‘committed by larger groups of individuals’. It can be subdivided into social, political and economic violence. (Collective violence is the main theme of MPW **Courses 2, 3 and 5.**)

Self-directed violence is violence in which the perpetrator and the victim are the same. This category is subdivided into self-harm and suicide. You will learn more about it in **Chapter 2.**

Interpersonal violence refers to violence between individuals. This is further subdivided into family and intimate partner violence and community violence.

- Family and intimate partner violence includes child maltreatment, intimate partner violence and elder abuse.
- Community violence can be acquaintance or stranger violence, categories which encompass youth violence, assault by strangers, violence related to property and violence in workplaces and other institutions, among other forms of aggression.

All these kinds of violence can take four forms (see Figure 1):

- physical attack
- sexual attack
- psychological attack
- deprivation and neglect.

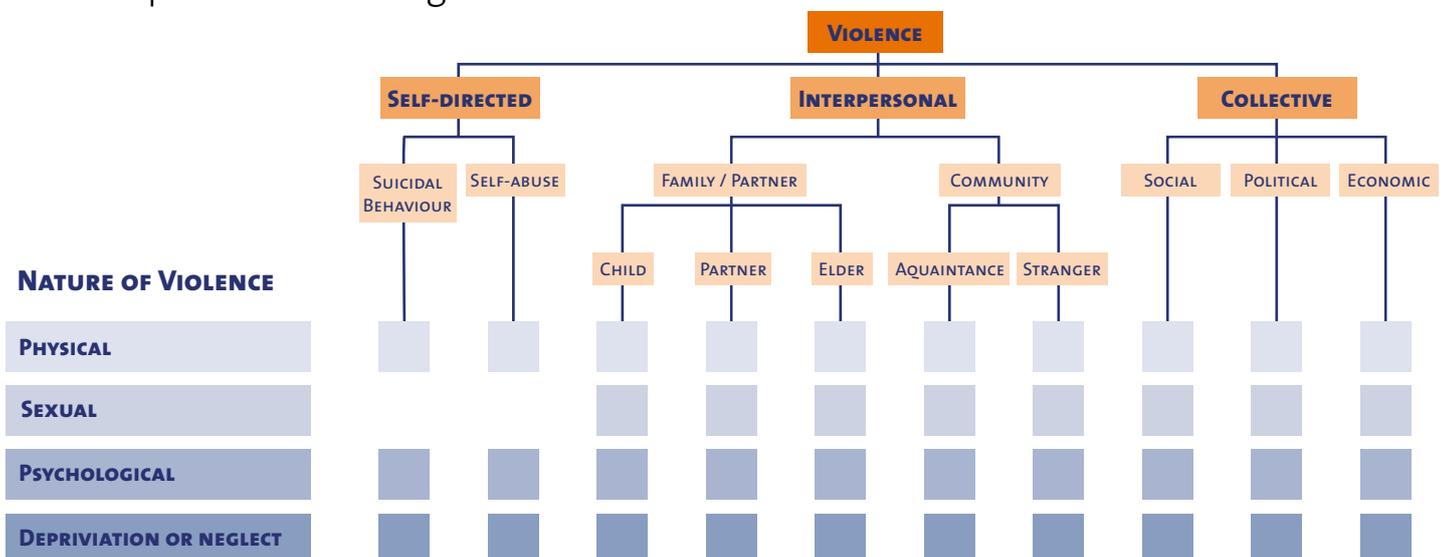


Figure 1: A typology of violence (WHO 2002:7)

Interpersonal violence as a human rights problem

Various forms of interpersonal violence, such as violence against women, child abuse and elder abuse, are recognised as human rights violations. Violence against women, for instance, perpetuates the unequal status of women, making gender equality difficult or even impossible to achieve. The Beijing Declaration and the Platform for Action (UN 1995) argued that gender equality could not be achieved without addressing violence. WHO says the connection goes further (WHO 2004:50):

‘The degree to which human rights are protected and fulfilled directly influences the conditions that give rise to such violence. States that have ratified the international instruments enshrining these rights are obligated to **respect** them (meaning that governments should refrain from their direct violation); to **protect** them (meaning that governments are expected to implement reasonable measures to prevent rights violations and to allow for redress if this occurs); and to **fulfill** them (by taking steps to ensure that they are realised, not merely protected). Specifically in the case of violence, states must ensure that they are not committing acts of violence against individuals; that victims of violence have access to services and redress for violations that do occur (whether by public-sector or private actors); and that individuals, communities and society enjoy peace and safety.’

And:

‘Social and gender policy can be mechanisms for meeting human rights obligations, and conversely, human rights obligations in accordance with international law provide a rationale for improvements in these policy areas. Basic human rights include the right to an adequate standard of living, the right to the highest attainable standard of health, the right to social security, the right to education, and the right to equality and non-discrimination. These economic, social and cultural rights have a direct bearing on poverty, economic and gender equality, unemployment, substance abuse, and weak social safety nets – the same underlying and cross-cutting risk factors for interpersonal violence [...]. Where human rights are respected, protected and fulfilled, levels of interpersonal violence are likely to decrease.’

Furthermore, the economic and social consequences of violence are obstacles to development, so violence is a threat to the right of health for all. The UN Millennium Development Goals, that provide a framework for development, include targets for reducing poverty and promoting health. Research shows that interpersonal violence will have direct and indirect negative effects on our ability to reach the goals (WHO undated:10).

References

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Lesson 1.2: Interpersonal violence as a health problem

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The epidemiology of interpersonal violence

Around 520 000 of the 1.6 million people who died in 2000 as a result of direct violence died as a result of interpersonal violence (Table 1). This means 1400 deaths worldwide every day – the same number that would result from three long-haul commercial aircraft crashing every single day, week in and week out, year after year (WHO 2002:10).

Learning objectives

By the end of this lesson you will be able to:

- outline the scale of the problem of interpersonal violence
- describe its economic cost.

Table 1: Estimated global violence-related deaths, 2000 (WHO 2002:10)

TYPE OF VIOLENCE	NUMBER ^A	RATE PER 100,000 POPULATION ^B	PROPORTION OF TOTAL (%)
HOMICIDE	520 000	8.8	31.3
SUICIDE	815 000	14.5	49.1
WAR-RELATED	310 000	5.2	18.6
TOTAL^C	1 659 000	28.8	100.0
LOW- TO MIDDLE-INCOME COUNTRIES	1 510 000	32.1	91.1
HIGH-INCOME COUNTRIES	149 000	14.4	8.9

A | ROUNDED TO THE NEAREST 1000

B | AGE-STANDARDIZED

C | INCLUDES 14 000 INTENTIONAL INJURY DEATHS RESULTING FROM LEGAL INTERVENTION

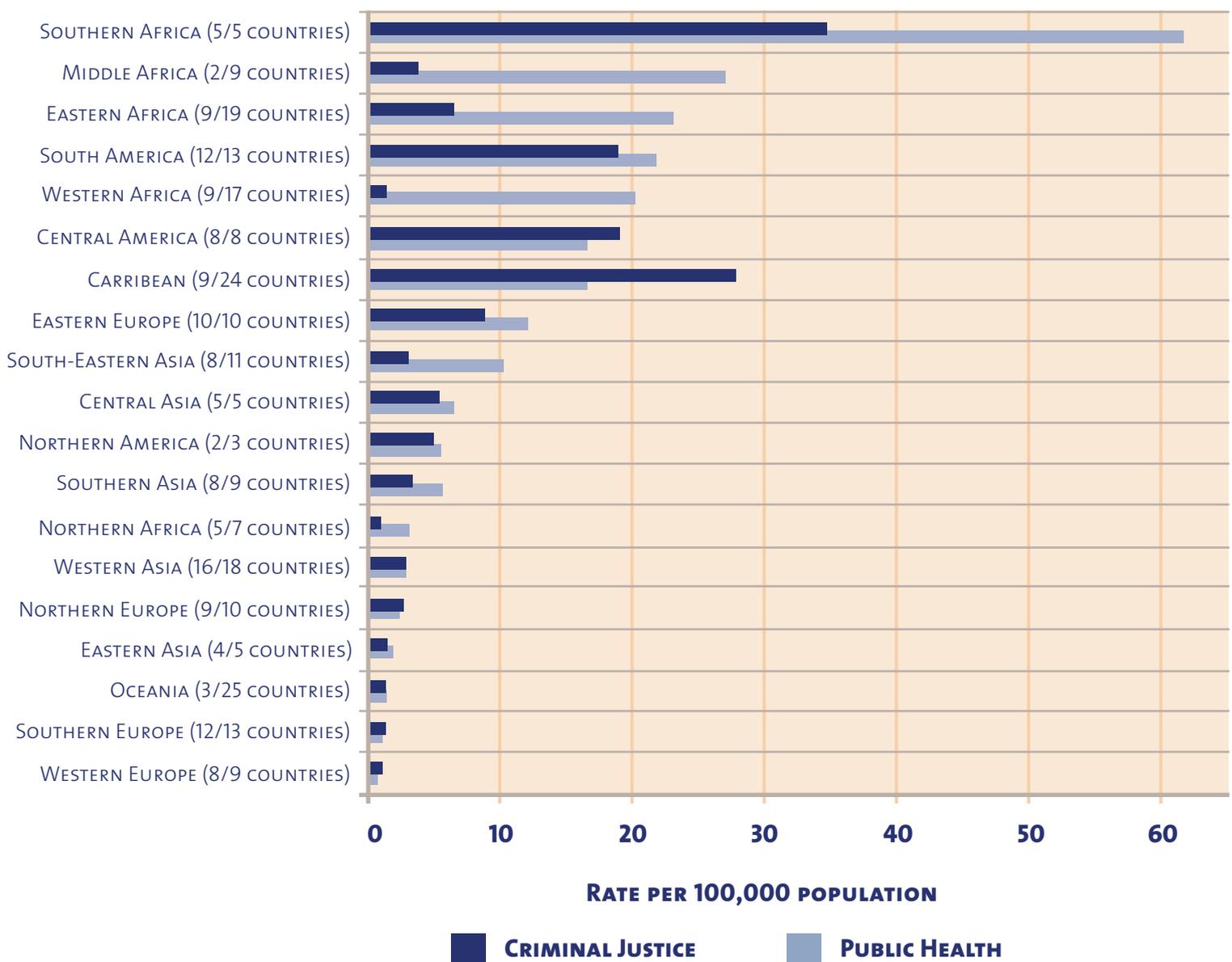


Most victims and perpetrators of interpersonal violence are aged 15–44. High rates of interpersonal violence can therefore nullify gains made by child health programmes.

The occurrence of fatal interpersonal violence differs greatly between different parts of the world and between men, women and children.

- Male homicide rates (the number of males killed) are considerably higher than female homicide rates in all parts of the world.
- Homicide rates are higher in countries with higher income inequality, and among the residents of poorer households.
- Homicide rates are highest for men aged between 15 and 44.
- Most deaths occur in low- and middle-income countries.

Table 2: Average intentional homicide rate by sub-region, latest available year, criminal justice and public health data (UNDOC 2010)



Violence is both a cause and a consequence of poverty, inequality and social inequity, political instability and scarcity of resources (WHO undated:9–10). Such conditions are known to contribute to high levels of both interpersonal and collective violence. Interpersonal violence may also be viewed as a potentially valuable warning sign of impending collective violence resulting from a volatile social, political or economic situation.

WHO also says poverty results from violence in many ways (WHO undated:9–10). For example, at the individual and family levels, the catastrophic costs of health and long-term care to treat violent injuries push families into insurmountable debt. Disability from violent injuries, as with all disabilities, can marginalize victims and push a formerly productive person out of the labour force, plunging them and the family into poverty. At the societal level, high levels of interpersonal violence result in large-scale disinvestment in communities and countries.

For every occurrence of interpersonal violence resulting in death, there are hundreds of occurrences in which the victim survives. Fatal violence is therefore just the tip of the iceberg, the more so because most violence does not result in injuries severe enough to require medical attention or even visible injuries. Most violent acts are not reported to the police, mainly because the victim does not think the police can or will do anything about it, does not think it is grave enough to report, or fears retaliation from the perpetrator. Psychological abuse often goes completely unnoticed.

Rape does not always leave physical traces, and admitting to having been raped is psychologically, and in some countries even physically, difficult and risky. Similarly, in cases of domestic violence, people who have been hurt are sometimes ordered to stay indoors and not allowed to receive visitors – so the magnitude of the problem stays hidden.

The levels of non-fatal violence are shocking:

- Tens of millions of children are abused and neglected each year worldwide.
- Up to 10% of males and 20% of females report having been sexually abused as children.
- For every case of homicide among young people there are 20–40 non-fatal cases that require hospital care.
- Rape and domestic violence account for 5–16% of healthy years of life lost among women of reproductive age.
- 10–50% of women experience physical violence at the hands of an intimate partner during their lifetime (WHO 2002:9–11).

The economic costs of interpersonal violence

Because it is difficult to define the exact magnitude of the problem, it is also difficult to calculate the exact costs of interpersonal violence. Some estimates have been made, however, for different types of violence in different parts of the world.

- In the USA the cost of interpersonal violence has been estimated at 3.3% of its gross domestic product. A 1992 study estimated the costs of gunshot wounds alone at US\$ 126 billion (€89 bn).
- In Australia the annual cost of assault was reported in 2002 to be US\$ 159 million, based mainly on the cost of imprisonment. Similarly the cost of homicide in Australia was calculated at US\$ 194 m per year, and in New Zealand at US\$ 67.9 m.
- The costs of health care expenditures arising from violence were 1.9% of national income in Brazil and 5% in Colombia, according to a 1997 study.

At the global level it is estimated that crime and violence together cost the equivalent of 5% of the gross national product of industrialized countries, and as much as 14% of the gross national product of low-income countries.

The costs of the indirect consequences of interpersonal violence tend to be omitted from these calculations. For instance, victims of domestic and sexual violence and of childhood abuse and neglect have more health problems, higher associated health care costs, and are less economically productive throughout their lives. When these costs are included, the annual cost of interpersonal violence raises considerably.

- In England and Wales, the total cost of direct violence – including homicide, wounding and sexual assault – is an estimated US\$ 40.2 bn (€29 bn) annually. This includes direct costs such as police and judicial system costs, and indirect costs that include foregone output and physical and emotional costs.
- In 1997 the percentage of gross domestic product lost due to direct violence was estimated to be 10.5% in Brazil, 24.7 % in Colombia and 24.9 % in El Salvador. The estimates included
 - A | lost earnings,
 - B | the opportunity cost of time,
 - C | policing, incarceration and judicial costs,
 - D | foregone investments in human capital and
 - E | effects on investment.

The public sector, and society in general through payment of taxes or out-of-pocket fees for treatment, pay the price of interpersonal violence. In the US 56–80% of the costs of care for gunshot and stabbing injuries ‘are either directly paid by public financing or are not paid at all’. In developing countries too, society absorbs the costs of violence, either through direct public expenditures or by ‘negative effects on investment and economic growth’ (WHO 2004:2, WHO 2002:12, WHO undated 8–9, WHO 2004:13–14).

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Lesson 1.3: At-risk groups and the public health approach

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At-risk groups

Interpersonal violence occurs in all social groups and classes across the world. It results from the interaction of all kinds of factors – biological, social, cultural, economic, political, sexual or religious. Some risk factors, however, such as inequality and poverty, are more prevalent in some groups, which means they are more likely to become victims or perpetrators of interpersonal violence. This applies especially to low-income groups.

Both absolute poverty and income inequality are related to levels of violence. Homicide is more prevalent in low-income communities and countries. The economic and social burden of the consequences of interpersonal violence are often most devastating for low-income groups. Furthermore, countries with a larger gap between rich and poor experience more violence than countries in which there is more income equality, regardless of the country's absolute income level (WHO undated:10).

Absolute poverty and income inequality foment violence through many mechanisms. For instance, a lack of educational and economic opportunities may compel young people who have few prospects for gainful employment to deal in drugs, often a trigger of violence. Women and girls in rural and economically depressed areas often face greater risk of sexual violence when they carry out everyday tasks such as collecting water and working in the fields, and poverty is also a leading factor that pushes women into prostitution. Poorer people have less leisure time as they work long hours or far from home, leaving children unsupervised and more vulnerable (WHO undated:10).

Learning objectives

By the end of this lesson you will be able to:

- recognize what groups are more or less vulnerable to the risk of interpersonal violence
- understand why risk and protective factors help us to identify where prevention efforts should be focused
- understand what factors protect people or put them at risk of experiencing or perpetrating interpersonal violence.

A public health approach to violence

It is very hard to explain why one person uses violence and another does not. It is also hard to explain why some communities use violence earlier than others. Some say war is the normal state of humankind, and that humans are innately violent – but just as there always has been war, there have always been states of peace, and in more places. This is also true of interpersonal violence. There has always been violence, but there have always been religious, philosophical, legal and communal systems that attempt to prevent or contain it.

The field of public health has also been involved in responding to violence, since the early 1980s. A wide range of public health practitioners, researchers and systems work to understand the roots of violence and prevent it. As WHO says, violence can be prevented and its impact reduced, 'in the same way that public health efforts have prevented and reduced pregnancy-related complications, workplace injuries, infectious diseases, and illness resulting from contaminated food and water in many parts of the world' (WHO 2002:3).

As always in a public health approach, the main concern is to prevent health problems and to improve the care and safety of populations. Public health practitioners should not simply accept or react to violent acts, but try to prevent them. They can do this in four steps:

- By expanding the knowledge base about all aspects of violence – through systematically collecting data on the scale, scope, characteristics and consequences of violence at local, national and international levels.
- By investigating why violence occurs – that is, conducting research to determine:
 - A | the causes and correlates of violence
 - B | the factors that affect the risk of violence
 - C | the factors that might be modifiable through interventions.
- By exploring how to prevent violence, using information gathered during investigation, by designing, implementing, monitoring and evaluating interventions.
- By implementing, in a wide range of settings, interventions that appear promising, through ongoing monitoring of their effects on the risk factors and the target problem; widely disseminating information; evaluating their impact; and determining the cost-effectiveness of programmes (WHO 2002:4; WHO 2004:5).

The public health approach requires the involvement of many sectors and disciplines. Because of the overlap between the risk factors for different types of violence, partnerships should be established between groups with a major interest in prevention. These groups include:

- health and social care professionals
- child protection workers
- local government and community officials
- social housing planners
- the police
- women's and human rights groups
- family counsellors
- researchers and expert groups.

Effective partnerships improve the effectiveness of interventions; avoid duplication of effort; increase the resources available through pooling funds and personnel in joint actions; and allow research and prevention activities to be conducted in a more collective and coordinated way.

Too often agencies and services act alone, without seeking partnership with other agencies in other sectors. As a result the victim is left to seek assistance from different services, if she has the strength to do it. If this fragmentation could be overcome, future interventions could be more successful (WHO 2002:244). However important these partnerships may be, however, WHO says the health sector is 'the natural leader' as it is explicitly designed to define, understand, and address population-wide health challenges (WHO 2004:5). It is the health worker who sees the patient, and their unique relationship is the first link in the chain of public health.

References

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Lesson 1.4: Primary prevention of interpersonal violence

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Introduction

The public health approach to interpersonal violence goes far beyond the people directly involved in violent acts, as we saw in the previous lesson (see also **Course 1, Lesson 2.2**). Prevention can revive whole communities and improve people's circumstances throughout their lives. In this lesson we consider: How can violence be prevented, and what if complete prevention fails? What should be done to minimize the violence that has already occurred and the damage done to the victim and to the community? What is the role of health professionals?

Learning objectives

By the end of this lesson you will be able to:

- outline best practice in primary interventions to prevent interpersonal violence
- describe the cultural, social and economic factors that contribute to violence.

A public health approach to violence prevention

A key goal of public health is to collect and use epidemiological and other data on the factors that influence the health of populations. Public health interventions work on three levels, and together form an integrated approach to prevention.

- **Primary prevention** encompasses approaches that aim to prevent violence before it occurs.
- **Secondary prevention** includes approaches focusing on more immediate responses to violence, such as pre-hospital care, emergency services and treatment for sexually transmitted diseases following rape.
- **Tertiary prevention** covers approaches that focus on long-term care after violence, such as rehabilitation and reintegration, and attempts to lessen trauma and reduce long-term disability associated with violence (WHO 2002, Dahlberg and Butchart 2005).

The distinction between these categories lies in the temporal aspect. Does the prevention – focused more on target groups than individuals – take place before violence occurs (primary), immediately afterwards (secondary) or in the longer run (tertiary)? For secondary and tertiary prevention health professionals should be trained to spot the characteristics of abuse, and not be afraid to ask questions, and to seek help and information. Studies have shown that patients appreciate being asked about violence as part of their medical examination or health assessment.

Another way of distinguishing between interventions is on the lines of the ecological model (see also **Course 1, Lesson 2.2**). Does the preventive activity aim to change individual behaviour directly, or to modify the factors, conditions and systems that influence behaviour (Dahlberg and Butchart 2005)?

Most prevention activities worldwide have focused on secondary and tertiary interventions, and understandably focus mainly on dealing with the immediate consequences of violence, which includes helping the victims and punishing the perpetrators. These interventions should, however, be accompanied by primary prevention activities. 'A comprehensive response to violence is one that not only protects and supports victims of violence, but which also promotes non-violence, reduces the perpetration of violence, and changes the circumstances and conditions that give rise to violence in the first place' (WHO 2002:15–16).

Prevention programmes will vary in emphasis depending on the type of violence being dealt with. In relation to youth violence, for instance, most preventive activities are of a primary nature, including (WHO 2002):

- prenatal and perinatal health care for mothers
- preschool enrichment and social development programmes for children and young people
- training in good parenting and improved family functioning
- improvements to urban infrastructure (physical and socioeconomic)
- measures to reduce firearm injuries and improve firearm-related safety
- media campaigns to change attitudes, behaviour and social norms.

Most efforts against violence in the home – partner violence, sexual violence, child maltreatment and elderly abuse – are of a secondary or tertiary nature (identifying victims, providing care and preventing re-victimisation), although there have been some primary prevention efforts involving schools, parents and caregivers. Dahlberg and Butchart (2005) ask why this is still so, 'given the relatively long history of public-health-oriented work on these types of violence'. They suspect that it is partly because the effects of investment in primary prevention take a long while to appear, whereas arrest and imprisonment are visible and popular methods of dealing with the problem.

This leads them to conclude that ‘shifting the balance toward more primary prevention efforts requires a stronger body of research about the effectiveness of these types of effort, including their cost-effectiveness, to show that positive benefits are possible even in the short term and that such efforts are more cost-effective than other alternatives’ (Dahlberg and Butchart 2005:94).

Similarly, in relation to sexual violence, WHO notes that services for survivors take priority over prevention, and says emphasis should also be given to a range of primary preventive activities, including (WHO 2002:173):

- programmes in communities, schools and refugee settings
- support for culturally sensitive and participatory approaches to changing attitudes and behaviour
- support for programmes addressing the prevention of sexual violence in the broader context of promoting gender equality
- programmes that address some of the underlying socioeconomic causes of violence, including poverty and lack of education, for example by providing job opportunities for young people
- programmes to improve child rearing, reduce the vulnerability of women and promote more gender-equitable notions of masculinity.

Research suggests that primary prevention is most effective when carried out early, and among people and groups known to be at greater risk than the general population – though even efforts directed at the general population can have beneficial effects (Box 1) (WHO 2002:110).

Box 1: Promoting non-violence: some examples of primary prevention programmes

The following are a few of the many examples from around the world of innovative programmes to prevent violence between intimate partners.

In Calabar, Nigeria, the Girl’s Power Initiative is aimed at young girls. They meet weekly over a period of three years to discuss frankly a range of issues related to sexuality, women’s health and rights, relationships and domestic violence. Specific topics in the programme, designed to build self-esteem and teach skills for self-protection, include societal attitudes that put women at risk of rape, and distinguishing between love and infatuation.

In Trinidad and Tobago, the nongovernmental organization SERVOL (Service Volunteered for All) conducts workshops over 14-weeks for adolescents to assist them in developing healthy relationships and learning parenting skills. The project helps these young people understand how their own parenting contributed towards shaping what they are and teaches them how not to repeat the mistakes their parents and other relatives may have made in *(cont.)*

Box 1 (continued): Promoting non-violence: some examples of primary prevention programmes

bringing up their families. As a result, the students discover how to recognize and handle their emotions, and become more sensitive to how early physical and psychological traumas can lead to destructive behaviour later in life.

Education Wife Assault in Toronto, Canada, works with immigrant and refugee women, helping them develop violence prevention campaigns that are culturally appropriate for their communities by means of special 'skill shops'. Education Wife Assault provides technical assistance, enabling women to conduct their own campaigns. At the same time, it also offers emotional support to the women organisers, to help them overcome the discrimination often directed at women campaigning against domestic violence because they are seen as threatening their community's cohesiveness.

In Mexico, the nongovernmental organization Instituto Mexicano de Investigacion de Familia y Poblacion has created a workshop for adolescents to help prevent violence in dating and within relationships between friends. Entitled "Faces and Masks of Violence", the project uses participatory techniques to help young people explore expectations and feelings about love, desire and sex, and to understand how traditional gender roles can inhibit behaviour, both in men and women.

An ecological model

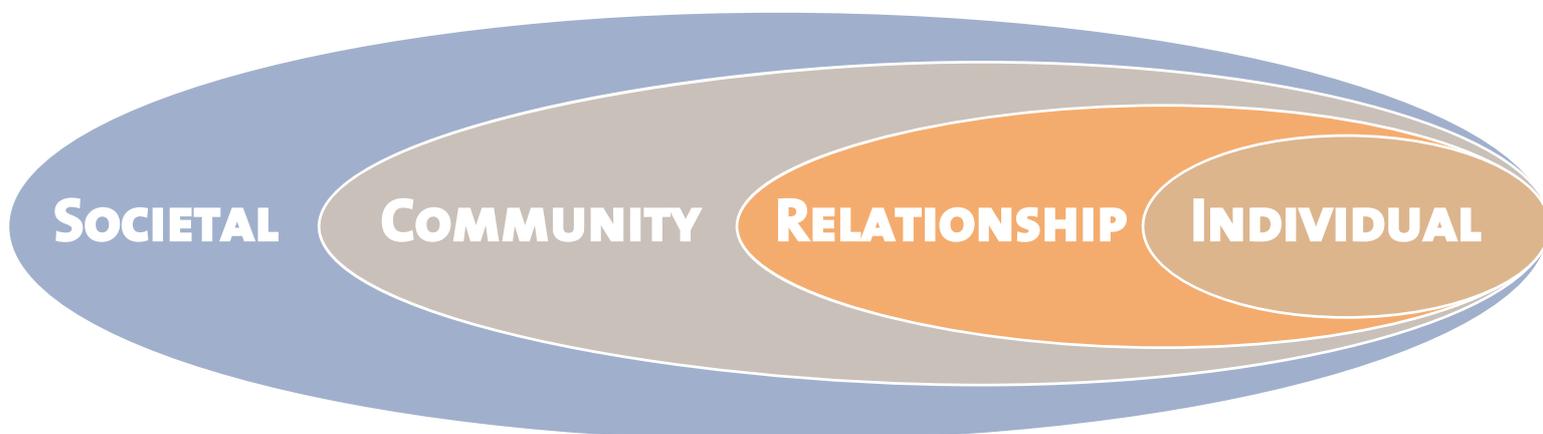


Figure 1: An ecological model for understanding and preventing violence (Dahlberg and Butchart 2005:99)

WHO has adopted this ecological model for understanding and preventing violence in Figure 1 to understand the causes, consequences and prevention of violence. It is based on evidence that 'no single factor can explain why some people or groups are at higher risk of interpersonal violence while others are more protected from it' (WHO 2004:4). It therefore views interpersonal violence as the result of an interaction between different factors at four levels of influence. Each level is also a key point for intervention. Moving from the inside to the outside of Figure 1, the levels are as follows.

Individual level

At this level, individual behaviour and the likelihood of becoming a victim or a perpetrator are influenced by personal history and biological factors. These include:

- being a victim of child maltreatment or abuse
- having a psychological or personality disorder
- suffering from an alcohol/substance addiction
- a history of violent behaviour.

Suffering one type of violence or abuse greatly increases the risk of other types of violence. These 'multiple victimizations' can be in the form of repeated violence, i.e. the same form of violence repeated over time, or polyvictimization, i.e. different forms of victimization, both violence and other threatening life experiences. Being a victim of both child maltreatment and interpersonal violence as an adult can be seen as a form of multiple victimization, but can also occur during adolescence or in adulthood.

Relationship level

The state of the relationships with those closest to you also influence your chances of becoming violent or becoming a victim of violent behaviour. Risk factors include experiencing:

- poor parenting practices
- violent parental conflict
- troubled relationships with intimate partners
- poverty
- friendships with people who engage in violence.

Community level

The way a person feels in their community (school, neighbourhood, workplace etc) and its broader socioeconomic characteristics is also influential. Risk factors operating at community level include:

- poverty
- high crime levels
- high residential mobility
- high unemployment
- local illicit drug or gun trade
- weak institutional policies
- inadequate victim care services.

Societal level

Societal factors are important because they determine whether violence is encouraged or inhibited. Is violence prohibited, or is it – explicitly or implicitly – accepted as a way to resolve conflict? Social risk factors for interpersonal violence include the following (WHO 2002:12–13; WHO 2004:4–5; Dahlberg et al. 2005:97–100):

- rapid social change
- economic inequality
- gender inequality
- poverty
- weak economic safety nets
- poor rule of law and poor health care system
- cultural norms that support or tolerate violence
- high availability of firearms
- recent or current armed conflict
- availability and cost of alcohol and other drugs.

The interaction between factors at different levels is as important as the influence of factors within a level. For example, longitudinal studies suggest that complications associated with pregnancy and delivery (that is, individual risk factors that may lead to neurological damage and psychological or personality disorder) seem to predict violence during youth and young adulthood, mainly when they occur in combination with family problems (a close relationship factor) such as poor parenting practices (WHO 2004:4).

Addressing poverty and inequality to prevent interpersonal violence

Factors such as poverty and economic inequality are important determinants of interpersonal violence at community and societal levels. Economic growth or decline predicts the fall or rise of homicide rates. High levels of poverty and inequality create conditions that lead to higher rates of violence. High levels of absolute poverty and low levels of economic development may also be associated with high homicide rates. Economic inequality is a strong predictor of interpersonal violence (see **Course 4, Chapter 2** for more discussion on these issues).

Measures to alleviate poverty and reduce economic inequality are therefore an absolute necessity for wide-scale prevention of interpersonal violence. The greatest gains in violence prevention will be made 'when poverty reduction and economic development are accompanied by policies that promote an equitable distribution of the benefits of economic growth and minimise the negative effects of rapid social and economic change' (WHO 2004:51).

Violence prevention – the evidence

TABLE 1 – KEY:

- WELL SUPPORTED BY EVIDENCE (MULTIPLE RANDOMIZED CONTROLLED TRIALS WITH DIFFERENT POPULATIONS)
- EMERGING EVIDENCE

CM CHILD MALTREATMENT;

IPV INTIMATE PARTNER VIOLENCE;

SV SEXUAL VIOLENCE;

YV YOUTH VIOLENCE;

EA ELDER ABUSE;

S SUICIDE AND OTHER FORMS OF SELF-DIRECTED VIOLENCE

(TABLE 1 see following page)

INTERVENTION	TYPE OF VIOLENCE					
	CM	IPV	SV	YV	EA	S
1 DEVELOPING SAFE, STABLE AND NURTURING RELATIONSHIPS BETWEEN CHILDREN AND THEIR PARENTS AND CAREGIVERS						
PARENT TRAINING, INCLUDING NURSE HOME VISITATION	●			○		
PARENT-CHILD PROGRAMMES	○			○		
2 DEVELOPING LIFE SKILLS IN CHILDREN AND ADOLESCENTS						
PRESCHOOL ENRICHMENT PROGRAMMES				○		
SOCIAL DEVELOPMENT PROGRAMMES				●		
3 REDUCING THE AVAILABILITY AND HARMFUL USE OF ALCOHOL						
REGULATING SALES OF ALCOHOL				○		
RAISING ALCOHOL PRICES				○		
INTERVENTIONS FOR PROBLEM DRINKERS		●				
IMPROVING DRINKING ENVIRONMENTS				○		
4 REDUCING ACCESS TO GUNS, KNIVES AND PESTICIDES						
RESTRICTIVE FIREARM LICENSING AND PURCHASE POLICIES				○		○
ENFORCED BANS ON CARRYING FIREARMS IN PUBLIC				○		
POLICIES TO RESTRICT OR BAN TOXIC SUBSTANCES						○
5 PROMOTING GENDER EQUALITY TO PREVENT VIOLENCE AGAINST WOMEN						
SCHOOL-BASED PROGRAMMES TO ADDRESS GENDER NORMS AND ATTITUDES		●	○			
MICROFINANCE COMBINED WITH GENDER EQUITY TRAINING		○				
LIFE-SKILLS INTERVENTIONS		○				
6 CHANGING CULTURAL AND SOCIAL NORMS THAT SUPPORT VIOLENCE						
SOCIAL MARKETING TO MODIFY SOCIAL NORMS		○	○			
7 VICTIM IDENTIFICATION, CARE AND SUPPORT PROGRAMMES						
SCREENING AND REFERRAL		○				
ADVOCACY SUPPORT PROGRAMMES		●				
PSYCHOSOCIAL INTERVENTIONS				○		
PROTECTION ORDERS		○				

Table 1: Overview of violence prevention interventions with evidence of effectiveness by type of violence prevented (WHO 2009:2)

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Chapter 2: Preventing self-directed violence



This chapter focuses on self-directed violence, and in particular on suicide attempts and the health professional's role in preventing them.

Intermediate Objectives

By the end of this chapter you will be able to:

- outline the extent of suicide around the world and variations in its incidence
- describe what makes people vulnerable to suicidal behaviour
- evaluate interventions to tackle suicide.

Lesson 2.1: The epidemiology of self-directed violence

Author: Barbara Bernik; updated by Marianne Larssen

This lesson gives a general introduction to different forms of self-directed violence and to patterns of suicide rates in different parts of the world. The variations in rates suggest that a range of causal factors is involved in suicide.

Introduction

Violence is an important global health problem, as we saw in **Chapter 1**. At least 1.6 million people lose their lives to acts of violence each year (Krug et al. 2002). Nearly half are suicides, a third are homicides and about a fifth are war-related.

Suicide or deliberate self-harm is the most personal self-destructive act one person can perform, and has long-term consequences for many other people.

Suicidal behaviour and other forms of self-directed violence are understood differently and given different meanings depending on many factors including society, culture and time in history. This chapter is based on a Western understanding of suicide and on research done in the Western part of the world (Wasserman and Wasserman 2009). Historically, suicidal behaviour has often met with denial, avoidance and punishment. Fortunately these attitudes are changing and today it is often met with recognition, openness, respect, understanding and prevention.

Defining important concepts

Three different concepts are central to understanding these lessons. They are suicide, deliberate self-harm, and attempted suicide.

Learning objectives

By the end of this lesson you will be able to:

- describe different categories of self-directed violence
- outline global suicide rates and trends
- highlight different factors in suicide rates in different regions
- describe variations in suicide rates in relation to sex, age and culture.

One definition of suicide is often used by WHO. 'For the act of killing oneself to class as suicide, it must be deliberately initiated and performed by the person concerned in the full knowledge, or expectation of its fatal outcome' (Wasserman and Wasserman 2009).

A suicide attempt can be defined as an action where the person intentionally hurts him- or herself, in a variety of ways, with a non-fatal outcome, and the intention was to die.

Deliberate self-harm can be defined as an act where the person intentionally causes self-injury, in a variety of ways, and the act has a non-fatal outcome. The person's apparent motivation or intention for the act is not considered. The motivations or intentions might be an actual suicide attempt, a means of altering a distressing state of mind, a way of showing others how bad a person really feels, or an attempt to change the dynamics of an interpersonal relationship (Hawton et al. 2006).

Deliberate self-harm – a statistical picture

Deliberate self-harm is more than twice as common among females as males, according to a seven-country comparative community study of deliberate self-harm among young people (Madge et al. 2008). Ten per cent had taken actions classified as deliberate self-harm. The most common reasons given were 'to get relief from a terrible state of mind', 'to die' and 'to punish myself'. The researchers conclude that deliberate self-harm is a widespread international problem, but often hidden because many people harm themselves without telling anyone or showing help-seeking behaviour.

Suicide – a statistical picture

Few countries have a national system to record and report on suicide attempts, so it is impossible to compare national trends of suicide with national trends of suicide attempts, although accurate statistics are improving through register-based studies in an increasing number of countries. We can also make an educated guess about its extent based on the statistics of the past century, although there is great under-reporting of suicides (5–25 % uncertainty).

About one million people commit suicide each year, according to WHO estimates – about one death every 20 seconds. By the year 2020, on current trends, 1.53 million people will die as a result of suicide (Figure 1). These numbers can only hint at the depth of suffering that provokes people to kill themselves.

Figures 1 and 2 show patterns of suicide in different parts of the world.

They are divided by age and gender, as these factors play an important role in determining the prevalence of suicide. Suicide rates of men and women are consistently different in most places, as are rates in different age groups (Figure 2). Many factors contribute to suicidal behaviour, at personal, relational and societal levels.

The **highest suicide rates** for both men and women are found in Eastern Europe, a group of countries that share similar historical and sociocultural

characteristics including, in the past 60 years, war, totalitarian government and a difficult transition from planned to market economies.

Interestingly, there are some similarly high rates in countries with quite different characteristics. Island countries such as Cuba, Japan, Mauritius and Sri Lanka also have high suicide rates, but it would be wrong to group them together based on the fact that they are islands. Each has different reasons for the high suicide rates. In Sri Lanka these include the effects of decades of civil strife, the socioeconomic problems faced by peasants forced to abandon their land, and the overwhelming hopelessness felt by many.

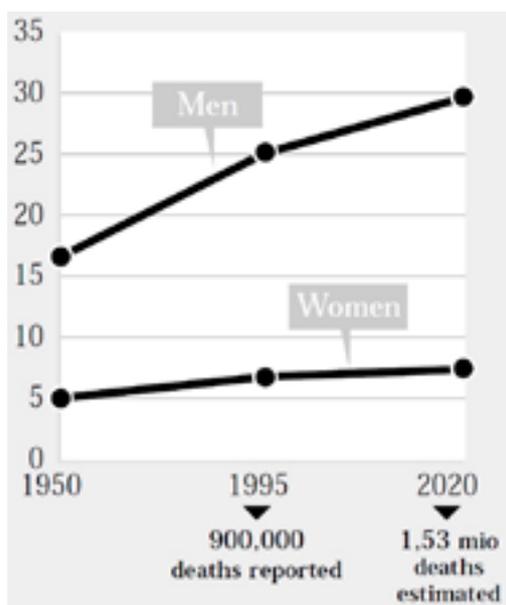


Figure 1: Global suicide rates per 100,000 population since 1950 and trends until 2020 (Bertolote and Fleischmann 2002)

Japan is a stable country but with recent experience of rapid economic development and a cultural emphasis on honour and shame, so the reasons behind the high rates might be quite different. A broad causal theme uniting the high rate countries may be related to ‘societal transition’, but this is a vague definition of a causal factor and may not be a helpful explanation.

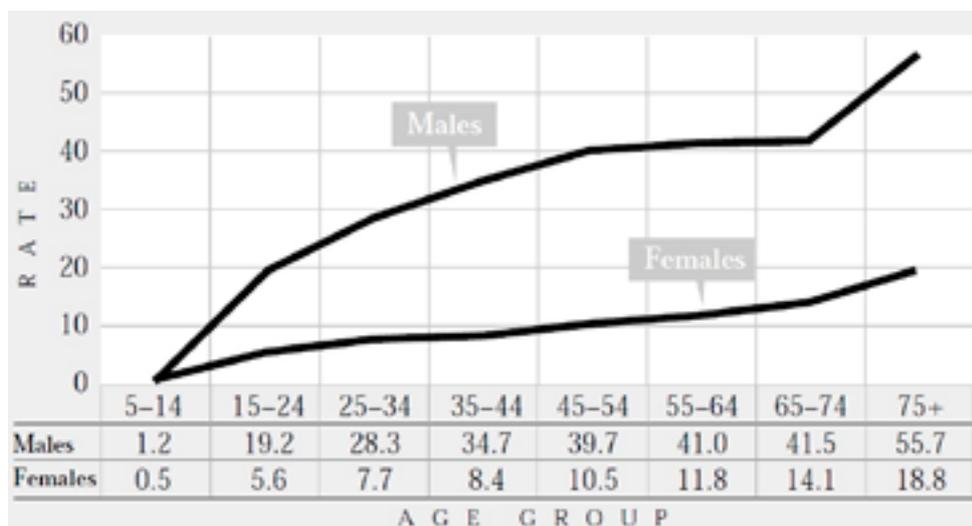


Figure 2: Distribution of suicide rates per 100,000 by gender and age, 1998 (Bertolote and Fleischmann 2002)

The **lowest suicide rates**, according to WHO, are found in East Mediterranean countries with a strong Islamic tradition, and in Central Asian republics that used to be part of the Soviet Union. The countries in this latter group have also been through rapid social change in the past 20 years, similar to some high-rate countries.

Other variations in suicide rates

Across the world as a whole:

- Men have an overall higher suicide rate than women: there were 3.2 male suicides to every female suicide in 1950, rising to 3.6 male suicides to every female suicide in 1995. Rural China is an exception: suicide rates among women are consistently higher than among men. More research needs to be done to determine the cause.
- The age group in which most suicides are committed is between 35 and 44 for both men and women.
- Suicide rates vary greatly around the world. There is a big difference between countries with large Muslim populations and virtually all countries where other religions are strong. In Muslim countries, where there is strong stigma related to suicides, the rate is very low (0.1 deaths per 100 000 people). In India (predominantly Hindu) and Italy (predominantly Christian) the total suicide rate is 10 per 100 000. In Japan (predominantly Shinto and Buddhist) it is much higher at 17.9 per 100 000. So-called 'atheist' countries like China, with a suicide rate at 25.6 per 100 000, and Albania, where religious observance was officially banned for long periods, also have among the highest suicide rates in the world (Figure 3) (Bertolote and Fleischman 2002).
- In relation to suicide indigenous people are a high-risk group, although some indigenous groups have very low rates. Young men are considered to be especially at risk. Explanations of underlying causes include the enormous social and cultural turmoil resulting from colonialism, difficulties with adjusting and integrating into modern societies, and social problems such as poverty and alcohol abuse (Leenaars 2006).

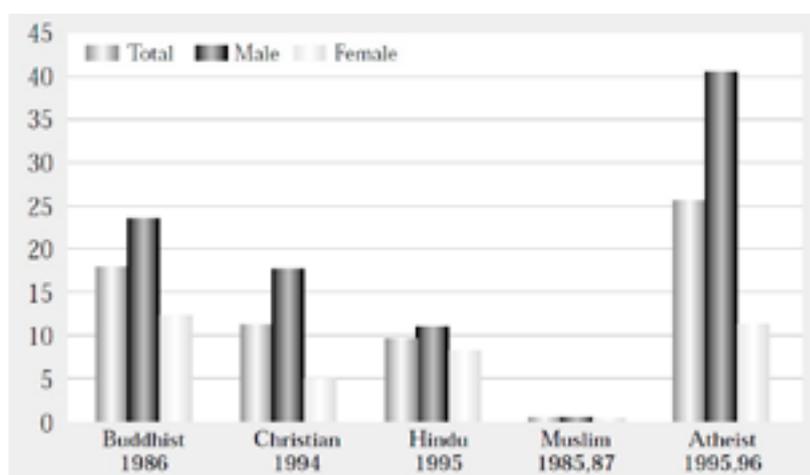


Figure 3: Suicide rates (per 100,000) according to religion (Bertolote and Fleischmann 2002)

Suicide statistics reveal other intriguing patterns. The incidence of suicide in England showed a downturn during the First and Second World Wars, as well as during armed conflicts in the 19th century, but rose in the late 1920s and 1930s when there was a deep economic recession. Periods of recession lead to increased unemployment, which is associated with increased suicide risk.

Conclusion

This lesson has given you a general introduction to different forms of self-directed violence and to patterns of suicide rates in different parts of the world. The variations in rates suggest that a range of causal factors is involved in suicide. We will look more closely at risk factors in the next lesson.

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Lesson 2.2: Vulnerability to suicidal behaviour

Author: Barbara Bernik; updated by Marianne Larssen

The suicidal process takes place both within the person and in their interaction with their surroundings. The reasons why someone commits suicide are never easy to understand, and are usually a combination of different factors. In this lesson we will consider these factors.

Introduction

The determinants of suicide have traditionally been divided into a number of categories including:

- biological factors such as serotonin deficiency
- biomedical causes such as clinical depression
- psychological causes such as hopelessness
- social factors such as social isolation
- cultural influences such as religion
- economic factors such as unemployment.

The problem with this system of classification is that the categories tend to overlap. For example, a mental disorder such as depression can lead to social isolation and economic problems like unemployment. So broadly speaking it might be best to see vulnerability to suicide as an interaction between genetic and environmental forces. Here we will try to break down these categories into a range of key factors that contribute to a person's propensity to become suicidal. These include family structure and history, economic factors, health factors, life stress, co-morbidity with other psychiatric disorders, and the interaction between a person's genes and their environment.

Learning objectives

By the end of this lesson you will be able to:

- identify the groups most at risk of suicidal behaviour
- describe how genetics and environment can interact to cause suicide.

Family structure

Family structure may contribute to a decision to commit suicide. Marriage, the resilience of one's partner and being a parent may act as protective factors. Some studies indicate that marriage serves as a protective factor against suicide (Qin et al. 2003), while others show a significantly increased risk in single people. For married people, the risk of suicide is associated with the state of their relationship, spousal mental (psychiatric) condition or spousal death.

There is a significantly higher risk among couples who cohabit rather than marry, despite this being similar to a certified marital relationship in some countries. Gay men and lesbians are also more likely to commit suicide.

It is uncertain what accounts for the protection from suicidal behaviour afforded by marriage: possibly it involves wanting to stay alive for one's children, or the availability of support from a partner. People living in a family structure may be less likely to practise negative health behaviours. Healthier people and those who lead happier lives are more likely to marry than those who have health problems (Waldron et al. 1996). A family structure appears to help prevent some negative health behaviours, such as substance abuse.

The protective effect of parenthood was also shown to reduce suicide. This, interestingly enough, exists independently of individual marital, socioeconomic and psychiatric status in mothers and fathers. Having a child of young age appeared to protect parents from suicide to a higher degree than having several children of an older age (Qin et al. 2003).

Furthermore, being married seems to have different effects on men and women. Some studies indicate that marriage is a protective factor for men in its own right. This implies that being a parent of a young child appears to explain the apparent protective effect of marriage for women (Qin et al. 2003). The loss of a child significantly increased the risk of suicide in a parent – particularly if the child was between one and six – and more specifically during the first month after losing the child.

Family history

Suicide risk is associated with family psychopathology and suicidal behaviours (Qin et al. 2003). Two factors are at play. Firstly, a family history of completed suicide as well as a family history of hospitalized psychiatric disorders increased the risk of suicide even after adjustment for other risk factors including a person's own psychiatric admission status. Secondly, a family history of completed suicides significantly increased suicide risk independently of a family history of psychiatric disorder.

A suicide is considered to be a sudden and traumatic death that often throws the survivors into a severe psychological crisis. Many survivors struggle with the questions of why the suicide happened and the associated stigma, exposing them to an increased likelihood of complicated and morbid grief outcomes (Dunne and Dunne-Maxim 2009).

Economic factors

The suicide rate is higher in people suffering from economic stress, such as the unemployed, those on low incomes, and those facing financial problems. Employment and financial security seem to provide some protection against depression and other psychiatric conditions that can lead to suicide. Unemployment among men raises the risk of suicide, but not among women. Perhaps the expectations placed on men in their breadwinner role in a traditional family structure (and in society in general) lead more easily to loss of self-esteem when they are unable to fulfil that role.

Health status

Psychiatric illnesses are the most significant risk factor for suicide and are found in up to 90% of cases (Suominen et al. 1996). Being hospitalized for psychiatric disorders was the single highest risk factor for suicide in men and women, and was particularly high for those discharged from hospital within seven days. Again, we see a gender difference with respect to the influence of previous psychiatric hospitalizations. A history of previous psychiatric hospitalizations significantly increased suicide risk in women compared to men, although female mortality rates are lower in the general population.

The most prevalent psychiatric disorders in patients who have committed suicide or suicide attempts are depression, anxiety (panic, agoraphobia and post-traumatic stress disorder), bipolar (manic depression) and personality disorders (such as borderline personality disorder), and substance abuse. Anxiety, bipolar personality disorder, chronic organic disease and poor general health were predictive of depressive episodes. Having a terminal illness correlates significantly with suicide.

Another characteristic of suicidal patients is the tendency to feel hopeless (anticipation of a lack of positive events). They also suffer from low self-esteem (i.e. the negative view a person holds of their self-worth, abilities and attractiveness to others). Repetition of self-harm is very common – 15–20% repeat the act within a year of an earlier episode (Ownes et al. 2002). The risk is greatest in the first few weeks after the attempt, and the more repetitions there are, the greater the risk of eventual suicide.

Life stress

The field of psychotraumatology addresses the intense influence of traumatic exposure on the person's perception of self and others, and on the ability to form and maintain stable and healthy interpersonal relationships. Stress responses, with their secondary ill effects, may be caused by brief or single overwhelming events, such as accidents, disasters and violent assault. If the trauma has been relatively short or of limited duration, enduring symptoms are usually seen only in those exposed to very intense trauma. Some examples of longer-lasting traumatic stress exposure or chronic traumatization are long-term violent relationships, prolonged childhood abuse and combat stress.

Under these conditions the person may adapt to their situation, so that more exposure to this stress is actually expected and there is little support or protection. This in turn tends to create more complex stress responses such as personality disturbance, dissociation and behavioural changes. These may involve self-destructive behaviours such as self-mutilation and completed suicide. Traumatic loss such as death and separation, childhood physical and sexual abuse, violent rape and torture, and war zone trauma are all traumatic stressors that can lead to suicidal behaviour.

Acute and chronic stress has the potential to increase the risk of suicidal behaviour, and multiple stressful events have a cumulative effect (Heikkinen et al. 1994). Some events produce greater psychological harm and create fear and an intense sense of threat, and it is important to consider the type and nature of the event, the intensity of fear and helplessness experienced, personal coping styles and any available support systems. Socially disadvantaged groups who have fewer resources to combat stressful situations may be particularly vulnerable.

The interaction of genetic and environmental factors

Evidence on the role of genetic risk factors in suicide comes from family, twin and adoption studies. A tendency to suicide is found more often in monozygotic than dizygotic twins. The evidence suggests an important role for the heritability of suicidal behaviour. However, the effect of genetic influences is more probable than deterministic and biological heritage is certainly shaped by environmental influences (Marusic and Farmer 2001).

If you consider the way suicidal processes often work, thoughts that trigger suicide are frequently associated with depressed moods that can occur in the context of a number of mental disorders, emotional lability and instability. Genetics or heritability are important in these traits, but so are environmental circumstances such as a severe or threatening life event. Some people may view an environment as threatening and hostile (more than the average person)

and may overact or exaggerate the actual impact of the event. This negative thinking can often lead to suicidal thoughts, followed by suicidal intent and a suicide plan.

At this point it is important to take into consideration two traits: impulsivity and aggression. Both have genetic components (for instance, hypofunction of the serotonergic system) and are equally influenced by environmental circumstances. They are crucial in distinguishing between a suicide attempt and actual completed suicide. The environmental aspect of impulsivity could be a social network in which the likelihood of taking drugs such as alcohol and cocaine is higher (Mann et al. 1999).

Aggressiveness has a genetic component related to innate hostility and states of anger. It also has an environmental aspect, for example where the risk of self-harm is raised if there is access to firearms. If the person is aggressive, any associated suicide attempt is more likely to be fatal.

Conclusion

Our past determines how we see the future, and this determines to a large extent whether we will develop hopelessness when confronted with adverse events. Our genetic makeup also determines our future reactions. The suicidal process can be defined as the development and progression of suicidality: it takes place both within the person and in their interaction with their surroundings. The reasons why someone commits suicide are never easy to understand, and are usually a combination of different factors.

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Lesson 2.3: Treating suicidal people and people who self-harm

Author: Barbara Bernik; updated by Marianne Larssen

Planning treatment and care for people who are deliberately self-harming and those who are suicidal must be thorough and detailed. It must be tailored to individual needs, which vary greatly as the reasons for deliberate self-harm and suicidal behaviour are highly individual, although certain factors are common to many people. This lesson looks at the main forms of medical treatment available, and their effectiveness.

Learning objectives

By the end of this lesson you will be able to:

- describe four forms of treatment of deliberate self-harm patients and suicidal patients
- assess the extent to which these treatments can influence the suicidal process.

Introduction

We will begin by looking at the four main forms of treatment for people who are deliberately self-harming and those who are suicidal. These are:

- problem-solving therapy
- intensive psychological therapy
- community outreach and increased intensity of care
- pharmacological treatment.

Problem-solving therapy

People who are deliberately self-harming and those who are suicidal often have difficulty with solving problems, particularly interpersonal ones (Williams and Pollock 2000). They also tend to adopt a passive approach, such as letting problems resolve themselves or letting someone else solve their problems for them. An increase in their problem-solving capacity may reduce the burden of unsolved problems and reduce suicidal feelings (Beskow et al. 2009).

Problem-solving and cognitive therapy focuses on looking carefully at the person's problems, deciding together which problems can be tackled, agreeing the goals and working out what steps need to be taken to achieve them. It can involve individuals, couples and families. There is a major focus on 'homework', especially practical steps, and a focus not only on current problems, but on teaching problem-solving skills for the future. Cognitive therapy of this kind addresses motivational issues and the pros and cons of different solutions are examined. The approach is generally fairly brief (up to ten sessions).

Effective therapeutic response depends a lot on psychological makeup and circumstances. Poor motivation and low expectations of success are barriers to treatment, due to overall low self-esteem and hopelessness that makes the person pessimistic about getting better. Problem-solving has been a major focus of therapeutic intervention for people who deliberately self-harm, but evaluation has not unambiguously concluded that problem-solving therapy is more effective than other treatments in reducing deliberate self-harm and suicidal behaviour. Thus the relationship between problem-solving deficits and suicidality appears complex.

Intensive psychological therapy

As mentioned above, personality disorders are very common in people who deliberately self-harm. Dialectical behaviour therapy may reduce deliberate self-harm in those with borderline personality disorders. It addresses a range of problems but particularly impulsivity, motivation and emotional reactivity. It also focuses on behavioural skills, especially in relation to interpersonal difficulties. Studies have shown that it reduces deliberate self-harm behaviour (Linehan et al. 2006).

Community outreach and increased intensity of care

Relatively intensive intervention was followed up with outreach in a few studies (Hawton et al. 2001). Outreach usually consists of home visits or telephone contact, and may be provided for all clients or those who fail to attend the initial session. A visit by a nurse to people who did not attend their initial outpatient appointment resulted in an increased rate of attendance, compared with those who did not get a visit if they had not attended the first session.

Continuous therapy and group therapy may prove successful by countering a sense of abandonment, and can help to improve interpersonal relationships.

Pharmacological treatment

There has been little evaluation of treatment with pharmacological agents of people who deliberately self-harm (Hawton et al. 2009). Pharmacological treatment is often aimed at actual prevention of suicide – mostly through

sedative-anxiolytic or sleep-inducing approaches, or specific treatment of psychiatric disorders that are the underlying cause of the suicidal behaviour.

Antidepressants, particularly selective serotonin re-uptake inhibitors (SSRIs), are mainly used to reduce suicidality in association with the reduction of depressive symptoms. There has been little research on the use of anti-depressants for suicidal people (independent of impact on depression) (Hawton et al. 2009). Antidepressants are most often given as an addition to psychotherapy and these two interventions often work best in conjunction.

Lithium has been proved effective in reducing suicidality in people with unipolar or bipolar mood disorders. Some studies report that clozapine more effectively reduces suicidal behaviour in people with schizophrenia through neuroleptics.

Conclusion

This lesson was a general introduction to four forms of treatment of people who deliberately self-harm and those who are suicidal. Treatment needs to be tailored to individual needs. It is also important to note that treatment and other interventions from health professionals are just one aspect of helping suicidal people. The care and support of family, friends, social networks and social care professionals are also invaluable. Health professionals play an important role in accessing these resources.

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Lesson 2.4: Preventing suicide

Author: Barbara Bernik; updated by Marianne Larssen

This lesson looks at the three main elements of effective suicide prevention. As the earlier lessons in this chapter demonstrate, it is necessary to understand suicidal behaviour in order to create appropriate preventive interventions.

Learning objectives

By the end of this lesson you will be able to:

- identify different strategies that can be used to prevent suicide
- classify these strategies as primary or secondary prevention.

Introduction

Psychiatric illness is a major contributing factor to suicidal behaviour, as mood disorders such as depression and bipolar disorder are associated with up to 60% of suicides (Bertolote et al. 2003). Other factors that contribute are alcohol or drug misuse, availability of lethal means, help-seeking behaviour, marital status, age and sex. Multifaceted prevention strategies are needed to address these issues. Strategies that simultaneously target many of the factors mentioned above may be more effective owing to synergy between the different interventions. The prevention of suicide requires access to and use of knowledge from many sources. The media, schools, health services, social services, employment services and many others should be involved in the prevention of suicide (Hegerl et al. 2009).

Five major prevention strategies have been identified: **education and awareness programmes** for the public and professionals; **screening programmes** for those at high risk; **treatment of psychiatric disorders**; **restrictions on access to lethal means** (such as guns); and **media reporting guidelines** for suicide (Mann et al. 2005). These in turn can be divided into primary prevention strategies involving population-wide interventions, and secondary prevention strategies that focus on high-risk groups.

Education and awareness campaigns

Educating the public through campaigns is an important factor in suicide prevention. It seeks to improve recognition of suicide risk, and promotes the idea that it is necessary and possible to get help if a person has suicide thoughts, through promoting a better understanding of the causes and risk factors in suicidal behaviour.

Education should cover awareness of risk factors; promote policy changes to encourage help-seeking; stimulate campaigns for more resources; and reduce the stigma associated with seeking help. The role of public education is also to reduce the stigmatization of mental illness in general and to question the acceptance of suicide as inevitable, as an appropriate solution to life's problems, or as a national trait. Specific education strategies can be aimed at young people, including school and community-based programmes.

One example of a multilevel approach to suicide prevention was implemented in Nuremberg, Germany in 2001–2002. The intervention was implemented at four levels: cooperation with primary care doctors, a public relations campaign, intervention with community facilitators, and intervention with high-risk groups. You can learn more about it in the e-learning case.

Screening at-risk populations

Depression and other psychiatric illnesses are under-recognized and under-treated in primary care (Goldman et al. 1999). Primary care physicians' lack of knowledge and/or failure to screen people for depression may be a large contributing factor in the failure to prevent suicide – 83% of people who commit suicide had contact with their primary care physician within a year of their death and up to 66% within a month (Anderson et al. 2000). Programmes aimed at educating primary care physicians have been shown to improve the detection and treatment of depression. In addition mental health nurses and mental health social workers often play an important role in discovering patient's suicidal thoughts and deliberate self-harm.

A range of community-level interventions can be promoted, including organized gatekeepers whose contact with potentially vulnerable populations provides opportunities to identify high-risk groups or individuals and direct them to appropriate assessment, treatment and care. These gatekeepers might include emergency services (first responders), pharmacists, social workers, priests, people in schools, the armed forces and prisons. The goal of screening is to identify people at risk and direct them to proper treatment and care. The focus can be on suicidal behaviour or on predisposing factors such as depression, bipolar disorder and alcohol and drug abuse.

Applied Suicide Intervention Skills Training (ASIST) (<http://www.livingworks.net>), developed in Canada and used around the world, is an example of a programme aimed at both primary health care workers and gatekeepers. It aims to help caregivers feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. They include people who are professionally trained and expected to have skills to help someone at risk of suicide, and those who are accessible and often selected by people at risk but not specifically expected to be suicide intervention helpers.

Treatment interventions

Treating mood and other psychiatric disorders is a central component of suicide prevention (Goldsmith et al. 2002). Antidepressant medication is commonly used to alleviate depression and other mood disorders, but it is difficult to say whether it has any effect on reducing suicide or suicide attempts.

Psychotherapy, including cognitive therapy, problem-solving, outreach therapy, and interpersonal psychotherapy have shown promising results in suicidal people (Hawton 2002). Follow-up after suicide attempts and of people who self-harm has proven beneficial, particularly when interventions by primary care professionals are followed up by case workers.

People who are bereaved by suicide often experience difficulties in recovering. Health and social care professionals who work with survivors need specialized knowledge and skills. Survivors may also want peer support. Many countries have self-help groups and other organizations for people bereaved by suicide, where they can find support and share experiences.

Restricting access to lethal means

There is probably a relationship between access to a specific method of suicide and suicidal behaviour (Beautrais and Gibb 2009). Asking and talking openly about methods with suicidal people is recommended. Restricting access to a specific method will result in reduced mortality by that method. For example, restricting access to firearms in the US and pesticides in rural China and India has led to a decrease in suicide rates. Restrictions on pesticides have been implemented, domestic gas has been detoxified, there are restrictions on prescribing barbiturates, and the packaging of analgesics has been changed. Many countries also require the use of catalytic converters in motor vehicles, the construction of barriers at jumping sites, and the use of lower toxicity antidepressants (Mann 2005).

Media reporting guidelines

The media can be a very powerful tool in helping or impeding suicide. They may be a channel for prevention by public education, or increase risk by glamorizing suicide. Preventing suicide. A resource for media professionals, a summary of what the media should and should not include in reporting on suicide, has been circulated worldwide (WHO 2000).

The Internet provides much useful information, help and guidance for people in crisis. Around 40% of web sites relating to suicide represent a preventive view (Westerlund and Wasserman 2009). However, there are also many suicide chat rooms and sites that provide instructions on suicide methods, and restricting them is extremely difficult.

Levels of prevention

Some of these strategies are examples of **primary prevention** – preventive activities aimed at many people who are at low risk, often the population in general. A growing number of countries have national suicide prevention strategies that focus on these issues, including Canada, Germany, the UK and the USA. The strategies often focus on promoting awareness of suicide as an important, preventable public health problem, and on developing strategies to reduce the stigma of seeking help.

A primary prevention model can also include training and availability of health professionals and community gatekeepers to recognize and respond appropriately to people at risk. This kind of approach would encourage people seeking treatment for sexual abuse, alcohol abuse and assault, trauma and depression to be referred to mental health services as well. Other examples of primary prevention are reducing public access to lethal means, and using the media to promote suicide prevention.

A **secondary prevention** strategy focuses on a small number of people at high risk. Examples include early detection of suicidal ideation and planning, and appropriate referral and treatment for suicide risk.

Effective prevention programmes using the different strategies mentioned in this lesson must be based on culturally sensitive ideas and local resources. A prevention strategy that is successful in one country might not be successful elsewhere.

Every year on World Suicide Prevention Day, September 10, activities all over the world promote understanding of suicide and focus public attention on the burden and costs of suicidal behaviours.

Conclusion

Effective suicide prevention has three main elements (Wasserman and Wasserman 2009):

- suicide prevention in the community, provided by the community as a whole, making it well-integrated and locally active;
- a close-knit health and social care network providing continuous assessment of risk and ongoing prevention;
- optimal social care and occupational (or educational) provision, ensuring all are supported and kept outside dangerous levels of suicide risk.

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⇒ COURSE 1

⇒ COURSE 2

⇒ COURSE 3

⇒ COURSE 4

⇒ COURSE 5

⇒ COURSE 6

Glossary Course 7

Armed conflict:

Similar to violent conflict, but denoting conflicts where parties on both sides resort to the use of physical violence and weapons.

Collective violence:

Violence committed by larger groups of individuals or by states.

Community violence:

Violence between individuals who are unrelated, and who may or may not know each other, generally taking place outside the home.

Conflict:

Perception of incompatible goals in a goal-seeking system. Conflict is not necessarily violent. In fact, parties who have incompatible goals may deal with them in productive and non-violent ways.

Convention on the Elimination of All Forms of Discrimination:

The Convention on the Elimination of All Forms of Discrimination Against Women was adopted in 1979 by the UN General Assembly and entered into force in 1981. Established an international bill of rights for women, and an agenda for action to promote enjoyment of those rights.

Development:

Alan Thomas says that the term development is commonly used in three ways: as a vision of how we would like the world to be; to describe a process of historical change; and to mean the actual interventions of governments, international agencies and others make to bring development about.

Direct violence:

A deliberate act or omission, acute or chronic, causing a reduction in the physical, mental or social potential of beings (J. Galtung).

Family and intimate partner violence:

Violence largely between family members and intimate partners, usually, though not exclusively, taking place in the home.

Gender:

Gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women (World Health Organisation).

Health:

The World Health Organisation defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.

Inequality:

Inequalities represent disparities in income, health, education, ownership of land, access to power and so on. Some inequalities are unavoidable: not all of us have the genetic make-up that will help us run the 100 metres as fast as Olympic sprinters. But many inequalities, such as those listed above, can be avoided. These avoidable inequalities are sometimes called inequities.

Inequity:

Inequities are inequalities that can be avoided through directed human action, most notably the application of government policy.

Millennium Development Goals:

The eight Millennium Development Goals (MDGs) were agreed at the United Nations Millennium Summit in September 2000 and nearly 190 countries have subsequently signed up to them. They set targets related to poverty, health, education, hunger and other key development issues that countries – assisted by international aid agencies – should achieve by 2015.

Morbidity:

Morbidity means illness or disease. Measures of morbidity such as the prevalence of chronic diseases can be used, among other measures, to help understand the health of a population.

Mortality:

Mortality means death. Measures of rates of mortality such as life expectancy and infant mortality can be used, among other measures, to help understand the health of a population.

Peace:

Not merely the absence of violence, but a state of mutual beneficial relationships, fair structures, and a culture of peace. Peace is also a capacity to handle conflicts with empathy, creativity and by non-violent means (J. Galtung).

Poverty:

Poverty has many dimensions. It can include lack of income and material goods, as well as lack of the things that we all have reason to value, such as the ability to lead a healthy life, be educated, to have political or spiritual liberty. The World Bank has set an international poverty line at about US\$1 per day. The 1.2 billion people who live below this line are said to be in a state of “absolute poverty”, in other words “a condition of life so characterised by malnutrition, illiteracy and disease as to be beneath any reasonable definition of human decency” (World Bank). But poverty is also a relative concept: all societies – at different levels of economic and social development – have different standards for what constitutes living in poverty.

Protection:

In the context of humanitarian aid this refers to the protection efforts of humanitarian agencies in conflict areas (but not including physical armed protection).

For humanitarian agencies, protection refers to ‘all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law (i.e. human rights law, international humanitarian law and refugee law)’ (Inter-agency Standing Committee 1999).

Psychosocial:

A programme or way of thinking that puts the psychological development of individuals in the context of their social environment.

Refugee:

A person who, owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.

Self-directed violence:

Self-directed violence includes acts of self-abuse (such as self-mutilation) and suicidal behaviour (thoughts and attempts).

Sex:

Sex refers to the biological and physiological characteristics that define men and women. (World Health Organisation).

Violence:

Unnecessary insult of basic human needs (J. Galtung).

War:

Extreme form of violence. Used as a means to solve conflicts between nation states, or between groups within a nation state (civil war).