# Chapter 4
# Self-Inflicted Violence

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## Introduction

Contemporary views of suicide see it as self-inflicted violence. It constitutes 1 of the 3 unnatural (or violent) causes of death, the other 2 being homicide and accidents. However, the relation between suicide and violence is unidirectional, inwards directed, in which the individual causes and receives the violence. Along the path of suicidal processes, different forms of external violence can be identified that contribute to the development of that process.

Concepts and social perceptions behind suicide have changed greatly over the ages. In some of the most aged manuscripts that reached us – usually mythical, theogonic or religious texts, such as Gilgamesh, the Upanishads, the Bhagavad Gita, the Theogony, the Torah (or Pentateuch) – suicide is presented as an heroic act, whose outcome not only redeems the hero of some previous misdeed but also brings some good to his people (Minois 1995).

Those books describe, among many other things, the creation of the World and of Man, and, with the exception of the Torah, gave origin to different polytheistic religions. However, as religions moved towards monotheism, being (or wishing to be) like God became anathema in many parts of the world, more particularly in Christian, Muslim and Jewish societies, this evolved into a theological credo according to which suicide became a major sin, a serious offense to God, and dealt with accordingly. In parallel, many philosophical schools also kept alive a

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J. Lindert and I. Levav (eds.), *Violence and Mental Health*,
DOI 10.1007/978-94-017-8999-8_4, 

great interest in suicide, along their interest both in issues related to live and death, and on the topic of free will.

From the eighteenth century on, however, suicide became to be perceived increasingly as a pathological event to such an extent that during the nineteenth century, eminent psychiatrists such as Philippe Pinel, Jean-Étienne Esquirol and Sigmund Freud stated that suicide was the consequence of some form of mental disorder, anchoring it clearly in the field of psychopathology.

Nevertheless, at the end of the nineteenth century, Emile Durkheim, one of the fathers of sociology, advanced the thesis that suicide was a predominantly sociological phenomenon. Around the same time there was a renewed interest in it from several important philosophers (e.g., Kierkegaard, Nietzsche) that continued into the twentieth century, when, particularly Sartre and Camus wrote extensively on it. Camus, who was awarded a Nobel Prize in Literature in 1957, stated that suicide was *the one truly serious philosophical problem* (Camus 1942).

At any rate, suicide remained also a matter of interest for medicine, and, in view of its impact on mortality, gradually it caught the attention of public health, along with other forms of violent deaths (i.e., homicide and accidents) (World Health Organization 1998). In 2002, the publication of the WHO World Report on Violence and Health made it worldwide clear that suicide represented a form of violence – self-inflicted – with a great relevance for Public Health (De Leo et al. 2002).

## Definition

Given the multifaceted characteristics of suicide, it has received several definitions, some of them of an operational nature. In the World Report on Violence and Health there is a detailed discussion on different proposed definitions, highlighting advantages and limitations of each. It also discusses proposed synonyms or alternatives, such as the one employed in the International Classification of Diseases (self-inflicted injury).

De Leo and collaborators (2006) have proposed a much-used definition that takes into account limitations of previous ones. They stated: *Suicide is an act with a fatal outcome, which the deceased, knowing or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes.*

## Suicide Attempts

In addition to suicide – as an extreme form of self-injury – there are other non-fatal forms of self-injury that deserves mention, where the outcome in not death, varying from suicide attempts (or parasuicide) to different degrees of self-mutilation. However, the information on suicide attempts and these other forms of self-harm does not match the quantity and quality of that on mortality due to suicide. While

information about suicide is based on periodic reports submitted by countries to the World Health Organization, and carefully checked for its accuracy, no records exist equivalent to suicide attempts. What is known about it comes from specific and circumstantial clinical/pathological studies, most of which cover relatively circumscribed geographic areas, generally a city or catchment area of a given hospital or emergency room.

## Potential Causes of Suicide

Suicide is a multifactorial phenomenon for which no single cause can be identified. Generally speaking, suicide is a process affecting different domains of the life of an individual, i.e. physical, psychological, social and cultural.

It is believed that constitutional and genetic factors might play a role, but so far no specific mechanism has been pinpointed. There is room to believe that a chain of reactions mediated by noradrenergic and serotonergic systems end up by creating a given physiological tonus (more or less reactive, more or less impulsive) that will help in shaping terminal behaviours. Mann and collaborators have demonstrated the presence of the same genetic markers for violent behaviours in both people who died from suicide employing very violent methods and extremely violent homicides (Mann et al. 2009).

On the other hand, it is well known that hopelessness, helplessness and despair were present in most cases of suicide studied in this respect. Those feeling can arise from a variety of reasons, but are almost always present in some forms of mental disorders, among them, depression, alcoholism and schizophrenia. Indeed, psychological autopsy studies have shown that those 3 forms of mental disorders were present in about 80.0 % of all those who died from suicide. Sadly, the majority of them did not receive appropriate treatment and care – which is another form of violence.

The social domain provides numerous situations of violence that constitute risk factors for suicidal behaviours. From child, physical and sexual abuse to negative interpersonal experiences (e.g., rejection, affective breakdowns, social and professional ruptures) there is host of events that can combine with the previous one to facilitate specific forms of suicidal behaviour.

Finally, there are cultural factors that more than presenting a risk can act as protective factors. Some cultural factors, such as religiosity or spirituality, and social connectedness, can act as potent protective factors against suicidal behaviors, thus offsetting even the presence of strong risk factors active in one of the other domains (Bertolote and Fleischmann 2002).

Thus, in suicidology, instead of analyzing “causes” solely, it is preferable to consider that suicidal behaviors result from a balance between risk (predisposing and precipitating) factors and protective factors. Table 4.1 shows a non-exhaustive list of factors often found in people who engage in self-injurious behaviours, whereas some factors found to be protective against suicidal behaviours are presented in Table 4.2. Importantly, with the current level of knowledge there is

**Table 4.1** Factors usually found in people at risk of suicidal behaviours

| Predisposing (distal) factors | Precipitating (proximal) factors | |
|---|---|---|
| Socio-demographic and individual factors | Environmental factors | Recent stressors |
| Previous attempt(s) | Easy access to methods of suicide (e.g. firearms, poisons, high places) | Marital separation |
| Psychiatric disorders (mainly depression, alcoholism, schizophrenia and some types of personality disorders) | | Bereavement |
| Medical diseases (terminal, painful, debilitating, disabling, socially rejected (e.g., AIDS)) | | Family conflict |
| Family history of suicide, alcoholism or other psychiatric disorders | | Change in employment or financial situation |
| Being divorced, widow or single | | Rejection from a significant other |
| Social isolation | | |
| Being unemployed or retired | | |
| Child/sexual abuse | | Shame and fear of being found guilty |
| Recent discharge from a psychiatric hospital | | |

**Table 4.2** Some factors considered to be protective against suicidal behaviours

| Cognitive style and personality | Family standards | Cultural and social factors | Environmental factors |
|---|---|---|---|
| Self esteem | Good family relationships | Adherence to positive values, norms and traditions | Good nutrition |
| Self-assurance | Support from family members | Good relationships with friends, workmates and neighbors | Good sleeping habits |
| Help-seeking when needed | Good parenting in childhood | Support from relevant others | Sunlight |
| Openness to get advice | | Friends who do not use drugs | Physical activities |
| Openness to others' experiences | | Social integration at work, church and sports activities, clubs etc. | Tobacco and drug-free environments |
| Openness to acquire new knowledge | | Clear goals in life | |
| Good communication skills | | | |

no way of ascertaining the relative weights of each of them. Only in post-mortem analysis of individual cases one can make sense of the interplay of several factors, none of which in isolation could have produced that outcome.

## Magnitude

The International Classification of Diseases – 10th Version (ICD-10) classifies deaths primarily into those due to natural causes (i.e., diseases, communicable or otherwise, and malformations) and those due to unnatural causes. The latter can be subdivided further into: Unintentional injuries (i. e., accidents not involving motor vehicles), road traffic accidents, intentional (interpersonal) injuries (i.e., homicides), self-inflicted injuries (i.e., suicide) and violence (i.e., collective violence such as wars, terrorism).

Currently, only slightly over 100 countries provided updated information on mortality to WHO (out of its 194 membership). According to the most recent data provided by those Member States, in 2011 there were nearly 850,000 deaths due to suicide. Table 4.3 lists suicide mortality rates (per 100,000) for males and females in those countries.

It can be seen that there are huge differences across countries but, although some variation in the quality and reliability of the data are to be expected, those figures represent a clear and informative picture of the world situation. In general, rates for males are 2–4 times higher than those for females and while the highest rates for males are usually observed in members of the former Soviet Union, the highest female rates are found in Asia. Yet, what is not visible in this table is the huge variation according to age, a serious inequity problem that will be discussed later on.

By comparison with other causes of death (Table 4.4), suicide ranked 14th in 2002, and WHO projections indicate that in 2030 it will raise to 12th, when it will reach more than a million deaths (Mathers and Loncar 2006), which is more than those due to homicides, terrorism and wars combined. It is noticeable that of all other unnatural causes of death, only road injury will kill more persons than suicide.

## Inequity: A Special Form of Violence

In addition to the overall violence associated with suicide, there are other, more subtle forms of violence related to it: the disproportioned share affecting the elderly.

Age-adjusted suicide mortality rates were extracted from the WHO mortality data bank (2004 onwards) concerning people aged 65 years and above. In view of the disproportionate weight of individual cases of relatively rare events (such as suicide mortality) in small populations, countries with less than 100,000 inhabitants, those with very low overall suicide rates (less than 5 per 100,000) or less than 50 cases of suicide per year for both males and females aged 65 and plus years were not included in the analyses. The final sample, shown in Table 4.5, comprised of 65 countries, of which 22 were located in the American Region, 37 in the European

**Table 4.3** Suicide rates per 100,000 by country, year and sex. Most recent year available; as of 2011

| Country | Year | Males | Females |
|---|---|---|---|
| Albania | 2003 | 4.7 | 3.3 |
| Antigua and Barbuda | 1995 | 0.0 | 0.0 |
| Argentina | 2008 | 12.6 | 3.0 |
| Armenia | 2008 | 2.8 | 1.1 |
| Australia | 2006 | 12.8 | 3.6 |
| Austria | 2009 | 23.8 | 7.1 |
| Azerbaijan | 2007 | 1.0 | 0.3 |
| Bahamas | 2005 | 1.9 | 0.6 |
| Bahrain | 2006 | 4.0 | 3.5 |
| Barbados | 2006 | 7.3 | 0.0 |
| Belarus | 2007 | 48.7 | 8.8 |
| Belgium | 2005 | 28.8 | 10.3 |
| Belize | 2008 | 6.6 | 0.7 |
| Bosnia and Herzegovina | 1991 | 20.3 | 3.3 |
| Brazil | 2008 | 7.7 | 2.0 |
| Bulgaria | 2008 | 18.8 | 6.2 |
| Canada | 2004 | 17.3 | 5.4 |
| Chile | 2007 | 18.2 | 4.2 |
| China (selected rural and urban areas) | 1999 | 13.0 | 14.8 |
| China (Hong Kong SAR) | 2009 | 19.0 | 10.7 |
| Colombia | 2007 | 7.9 | 2.0 |
| Costa Rica | 2009 | 10.2 | 1.9 |
| Croatia | 2009 | 28.9 | 7.5 |
| Cuba | 2008 | 19.0 | 5.5 |
| Cyprus | 2008 | 7.4 | 1.7 |
| Czech Republic | 2009 | 23.9 | 4.4 |
| Denmark | 2006 | 17.5 | 6.4 |
| Dominican Republic | 2005 | 3.9 | 0.7 |
| Ecuador | 2009 | 10.5 | 3.6 |
| Egypt | 2009 | 0.1 | 0.0 |
| El Salvador | 2008 | 12.9 | 3.6 |
| Estonia | 2008 | 30.6 | 7.3 |
| Finland | 2009 | 29.0 | 10.0 |
| France | 2007 | 24.7 | 8.5 |
| Georgia | 2009 | 7.1 | 1.7 |
| Germany | 2006 | 17.9 | 6.0 |
| Greece | 2009 | 6.0 | 1.0 |
| Grenada | 2008 | 0.0 | 0.0 |
| Guatemala | 2008 | 5.6 | 1.7 |
| Guyana | 2006 | 39.0 | 13.4 |
| Haiti | 2003 | 0.0 | 0.0 |
| Honduras | 1978 | 0.0 | 0.0 |
| Hungary | 2009 | 40.0 | 10.6 |
| Iceland | 2008 | 16.5 | 7.0 |
| India | 2009 | 13.0 | 7.8 |

(continued)

**Table 4.3** (continued)

| Country | Year | Males | Females |
|---|---|---|---|
| Iran | 1091 | 0.3 | 0.1 |
| Ireland | 2009 | 19.0 | 4.7 |
| Israel | 2007 | 7.0 | 1.5 |
| Italy | 2007 | 10.0 | 2.8 |
| Jamaica | 1990 | 0.3 | 0.0 |
| Japan | 2009 | 36.2 | 13.2 |
| Jordan | 2008 | 0.2 | 0.0 |
| Kazakhstan | 2008 | 43.0 | 9.4 |
| Kuwait | 2009 | 1.9 | 1.7 |
| Kyrgyzstan | 2009 | 14.1 | 3.6 |
| Latvia | 2009 | 40.0 | 8.2 |
| Lithuania | 2009 | 61.3 | 10.4 |
| Luxembourg | 2008 | 16.1 | 3.2 |
| Maldives | 2005 | 0.7 | 0.0 |
| Malta | 2008 | 5.9 | 1.0 |
| Mauritius | 2008 | 11.8 | 1.9 |
| Mexico | 2008 | 7.0 | 1.5 |
| Netherlands | 2009 | 13.1 | 5.5 |
| New Zealand | 2007 | 18.1 | 5.5 |
| Nicaragua | 2006 | 9.0 | 2.6 |
| Norway | 2009 | 17.3 | 6.5 |
| Panama | 2008 | 9.0 | 1.9 |
| Paraguay | 2008 | 5.1 | 2.0 |
| Peru | 2007 | 1.9 | 1.0 |
| Philippines | 1993 | 2.5 | 1.7 |
| Poland | 2008 | 26.4 | 4.1 |
| Portugal | 2009 | 15.6 | 4.0 |
| Puerto Rico | 2005 | 13.2 | 2.0 |
| Republic of Korea | 2009 | 39.9 | 22.1 |
| Republic of Moldova | 2008 | 30.1 | 5.6 |
| Romania | 2009 | 21.0 | 3.5 |
| Russian Federation | 2006 | 53.9 | 9.5 |
| Saint Kitts and Nevis | 1995 | 0.0 | 0.0 |
| Saint Lucia | 2005 | 4.9 | 0.0 |
| Saint Vincent and the Grenadines | 2008 | 5.4 | 1.9 |
| Sao Tome and Principe | 1987 | 0.0 | 1.8 |
| Serbia | 2009 | 28.1 | 10.0 |
| Seychelles | 2008 | 8.9 | 0.0 |
| Singapore | 2006 | 12.9 | 7.7 |
| Slovakia | 2005 | 22.3 | 3.4 |
| Slovenia | 2009 | 34.6 | 9.4 |
| South Africa | 2007 | 1.4 | 0.4 |
| Spain | 2008 | 11.9 | 3.4 |
| Sri Lanka | 1991 | 44.6 | 16.8 |
| Suriname | 2005 | 23.9 | 4.8 |
| Sweden | 2008 | 18.7 | 6.8 |

(continued)

**Table 4.3** (continued)

| Country | Year | Males | Females |
|---|---|---|---|
| Switzerland | 2007 | 24.8 | 11.4 |
| Syrian Arab Republic | 1985 | 0.2 | 0.0 |
| Tajikistan | 2001 | 2.9 | 2.3 |
| Thailand | 2002 | 12.0 | 3.8 |
| TFYR Macedonia | 2003 | 9.5 | 4.0 |
| Trinidad and Tobago | 2006 | 17.9 | 3.8 |
| Turkmenistan | 1998 | 13.8 | 3.5 |
| Ukraine | 2009 | 37.8 | 7.0 |
| United Kingdom | 2009 | 10.9 | 3.0 |
| USA | 2005 | 17.7 | 4.5 |
| Uruguay | 2004 | 26.0 | 6.3 |
| Uzbekistan | 2005 | 7.0 | 2.3 |
| Venezuela | 2007 | 5.3 | 1.2 |
| Zimbabwe | 1990 | 10.6 | 5.2 |

Source: WHO Mortality Data Bank

**Table 4.4** Expected changes in rankings for 15 leading causes of death, 2002 and 2030

| Disease or injury | 2002 Rank | 2030 Rank |
|---|---|---|
| Ischaemic heart disease | 1 | 1 |
| Cerebrovascular disease | 2 | 2 |
| Lower respiratory infections | 3 | 5 |
| HIV/AIDS | 4 | 3 |
| COPD | 5 | 4 |
| Perinatal conditions | 6 | 9 |
| Diarrhoeal diseases | 7 | 16 |
| Tuberculosis | 8 | 23 |
| Trachea, bronchus, lung cancers | 9 | 6 |
| Road traffic accidents | 10 | 8 |
| Diabetes mellitus | 11 | 7 |
| Malaria | 12 | 22 |
| Hypertensive heart disease | 13 | 11 |
| Self-inflicted injuries | **14** | 12 |
| Stomach cancer | 15 | 10 |

Source: Mathers and Loncar (2006)

Region and 6 in Australasia. No countries from other parts of the world (i.e. Africa, East Mediterranean and South-East Regions) met the inclusion criteria.

Those rates were then compared with the overall national average suicide mortality rate by sex. Those rates at least 50.0 % above the overall national average for the same sex were considered as 'disproportionally' high; similarly, those rates 50.0 % or less below the overall national average for the same sex were considered as 'disproportionally' low. Tables 4.6 and 4.7 show the results of this comparison, for males and females, respectively.

It can be see that for males, with the exception of the Dominican Republic, suicide rates are disproportionately high among those aged 65 and plus. For

**Table 4.5** Frequency and rate (per 100,000) of suicide mortality in selected countries among people aged 65 years and over, by sex. Most recent year available

| | | 65–74 years of age | | | | 75+ years of age | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Males | | Females | | Males | | Females | |
| Country | Year | N | Rate | N | Rate | N | Rate | N | Rate |
| Argentina | 2008 | 203 | 19.9 | 36 | 2.7 | 208 | 32.7 | 36 | 3.0 |
| Australia | 2006 | 92 | 13.6 | 31 | 4.4 | 90 | 17.8 | 34 | 4.6 |
| Austria | 2009 | 134 | 36.3 | 59 | 13.8 | 186 | 78.7 | 68 | 15.8 |
| Belarus | 2007 | 213 | 71.0 | 81 | 15.3 | 122 | 77.4 | 70 | 16.5 |
| Belgium | 2005 | 161 | 36.5 | 75 | 14.5 | 170 | 55.1 | 69 | 12.8 |
| Brazil | 2008 | 442 | 12.7 | 110 | 2.6 | 318 | 15.6 | 52 | 1.8 |
| Bulgaria | 2008 | 103 | 32.0 | 66 | 11.4 | 132 | 60.4 | 66 | 18.7 |
| Canada | 2004 | 165 | 15.7 | 64 | 5.5 | 154 | 20.7 | 44 | 3.7 |
| Chile | 2007 | 111 | 29.5 | 14 | 3.1 | 63 | 28.3 | 9 | 2.5 |
| China (Hong Kong) | 2009 | 77 | 33.2 | 40 | 17.9 | 85 | 46.6 | 74 | 28.9 |
| Colombia | 2007 | 120 | 18.6 | 4 | 0.5 | 67 | 18.1 | 3 | 0.6 |
| Costa Rica | 2009 | 12 | 14.7 | 2 | 2.3 | 6 | 11.3 | 0 | 0.0 |
| Croatia | 2009 | 87 | 46.1 | 34 | 13.5 | 107 | 97.2 | 53 | 24.5 |
| Cuba | 2008 | 136 | 36.4 | 67 | 16.8 | 199 | 82.8 | 37 | 13.1 |
| Czech Rep. | 2009 | 94 | 24.1 | 27 | 5.4 | 135 | 56.2 | 42 | 9.3 |
| Denmark | 2006 | 75 | 35.2 | 25 | 14.1 | 79 | 54.5 | 25 | 10.6 |
| Dominican Rep. | 2005 | 12 | 7.3 | 1 | 0.6 | 2 | 2.0 | 1 | 1.0 |
| Ecuador | 2009 | 44 | 17.5 | 5 | 1.8 | 20 | 12.4 | 9 | 4.5 |
| El Salvador | 2008 | 9 | 7.9 | 1 | 0.7 | 19 | 24.9 | 1 | 1.0 |
| Estonia | 2008 | 15 | 31.0 | 4 | 4.9 | 18 | 65.4 | 12 | 16.5 |
| Finland | 2009 | 74 | 33.5 | 20 | 7.8 | 57 | 38.2 | 20 | 7.3 |
| France | 2007 | 755 | 33.3 | 317 | 11.8 | 1,315 | 68.0 | 461 | 13.7 |
| Georgia | 2009 | 22 | 15.0 | 8 | 3.7 | 18 | 19.9 | 10 | 5.8 |
| Germany | 2006 | 1,215 | 27.9 | 448 | 9.1 | 1,160 | 49.8 | 611 | 13.7 |
| Greece | 2009 | 28 | 5.6 | 9 | 1.5 | 49 | 11.3 | 9 | 1.6 |
| Guatemala | 2008 | 11 | 6.2 | 1 | 0.5 | 9 | 8.6 | 1 | 0.0 |
| Guyana | 2006 | 9 | 65.3 | 0 | 0.0 | 3 | 43.5 | 0 | 0.0 |
| Hungary | 2009 | 240 | 65.3 | 93 | 16.8 | 214 | 90.5 | 91 | 18.4 |
| Ireland | 2009 | 26 | 19.2 | 10 | 7.0 | 5 | 5.8 | 1 | 0.8 |
| Israel | 2007 | 19 | 11.2 | 8 | 3.9 | 27 | 20.4 | 6 | 3.0 |
| Italy | 2007 | 450 | 15.7 | 143 | 4.3 | 596 | 28.3 | 171 | 4.8 |
| Japan | 2009 | 2,993 | 41.8 | 1,431 | 17.8 | 2,216 | 42.8 | 1,648 | 19.4 |
| Kazakhstan | 2008 | 143 | 47.7 | 41 | 8.3 | 86 | 73.6 | 47 | 16.8 |
| Korea (South) | 2009 | 1,498 | 99.5 | 647 | 34.2 | 1,006 | 173.9 | 920 | 77.2 |
| Kyrgyzstan | 2009 | 7 | 9.8 | 5 | 5.1 | 4 | 10.3 | 3 | 4.3 |
| Latvia | 2009 | 42 | 50.5 | 7 | 4.9 | 30 | 67.8 | 26 | 21.4 |
| Lithuania | 2009 | 91 | 80.6 | 21 | 11.1 | 57 | 83.5 | 40 | 24.1 |
| Mexico | 2008 | 187 | 9.8 | 12 | 0.6 | 139 | 12.2 | 13 | 0.8 |
| Netherlands | 2009 | 85 | 13.3 | 52 | 7.5 | 96 | 32.2 | 48 | 6.9 |
| New Zealand | 2007 | 19 | 13.8 | 0 | 0.0 | 23 | 23.2 | 7 | 4.9 |
| Nicaragua | 2006 | 8 | 11.5 | 1 | 1.3 | 5 | 12.9 | 1 | 2.0 |
| Norway | 2009 | 35 | 20.2 | 12 | 6.4 | 36 | 26.4 | 7 | 3.2 |

(continued)

**Table 4.5** (continued)

| | | 65–74 years of age | | | | 75+ years of age | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Males | | Females | | Males | | Females | |
| Country | Year | N | Rate | N | Rate | N | Rate | N | Rate |
| Panama | 2008 | 11 | 16.8 | 2 | 2.9 | 3 | 7.8 | 2 | 4.5 |
| Paraguay | 2008 | 8 | 8.4 | 1 | 1.0 | 7 | 13.5 | 1 | 1.5 |
| Peru | 2007 | 10 | 2.1 | 5 | 0.9 | 13 | 5.2 | 3 | 0.9 |
| Poland | 2008 | 370 | 31.7 | 102 | 6.2 | 260 | 33.8 | 86 | 5.5 |
| Portugal | 2009 | 116 | 25.7 | 43 | 7.7 | 202 | 60.1 | 58 | 10.7 |
| Puerto Rico | 2005 | 29 | 23.3 | 6 | 3.9 | 20 | 23.1 | 3 | 2.4 |
| Rep. Moldova | 2008 | 43 | 47.9 | 15 | 11.1 | 9 | 18.5 | 9 | 9.6 |
| Romania | 2009 | 258 | 32.8 | 60 | 5.6 | 159 | 31.0 | 53 | 6.3 |
| Russian Federation | 2006 | 3,104 | 70.0 | 1,048 | 13.3 | 1,701 | 86.5 | 1,401 | 24.8 |
| Serbia | 2009 | 161 | 51.0 | 80 | 20.0 | 204 | 96.2 | 92 | 28.4 |
| Singapore | 2006 | 19 | 21.1 | 15 | 14.7 | 14 | 30.0 | 19 | 28.1 |
| Slovakia | 2005 | 36 | 24.3 | 11 | 5.0 | 40 | 45.3 | 11 | 6.2 |
| Slovenia | 2009 | 41 | 49.0 | 21 | 20.4 | 38 | 78.2 | 21 | 20.6 |
| Spain | 2008 | 339 | 19.4 | 118 | 5.8 | 484 | 32.9 | 154 | 6.6 |
| Sweden | 2008 | 110 | 34.2 | 33 | 7.7 | 108 | 43.2 | 42 | 8.7 |
| Switzerland | 2007 | 126 | 42.7 | 64 | 18.8 | 191 | 86.5 | 122 | 32.7 |
| Trinidad and Tobago | 2006 | 8 | 36.1 | 2 | 6.1 | 3 | 29.7 | 0 | 0.0 |
| UK | 2009 | 219 | 8.7 | 81 | 2.9 | 195 | 10.2 | 97 | 3.3 |
| Ukraine | 2009 | 862 | 53.3 | 313 | 11.2 | 532 | 66.3 | 313 | 15.4 |
| Uruguay | 2004 | 46 | 43.2 | 8 | 5.6 | 67 | 95.9 | 14 | 10.8 |
| USA | 2005 | 1,935 | 22.7 | 403 | 4.0 | 2,603 | 37.8 | 448 | 4.0 |
| Uzbekistan | 2005 | 42 | 12.0 | 12 | 2.9 | 13 | 8.4 | 7 | 2.7 |
| Venezuela | 2007 | 37 | 8.6 | 7 | 1.5 | 40 | 17.2 | 7 | 2.4 |

Source: WHO Mortality Data Bank

females, the tables show a similar situation, with the exception of the age groups 65–74 years in Latvia and in Estonia.

This is clearly a situation of a double violence: the self-inflicted violence that resulted in death and a long way of neglect and disguised violence towards the elderly that contribute to this outcome, and this is not fully acknowledged.

We know that many, perhaps most, cases of suicide can be prevented equally across all age groups, but there is a perverse tendency to accept suicide in late age as "normal". There is no justification for the presence of more than 300.0 % more cases of suicide in some age groups than in others.

**Table 4.6** Countries with the highest suicide mortality rates (per 100,000) among 65+ years old males, as compared to the national same-sex overall rate

| Country | National overall male rate (A) | 65–74 years old | % of (A) | 75+ years old | % of (A) |
|---|---|---|---|---|---|
| Austria (2009) | 23.8 | 36.3 | 151.0 | 78.7 | 330.0 |
| China (Hong Kong) (2009) | 19.0 | 33.2 | 174.0 | 46.6 | 245.0 |
| Colombia (2007) | 7.9 | 18.6 | 235.0 | 18.1 | 229.0 |
| Croatia (2009) | 28.9 | 46.1 | 159.0 | 97.2 | 336.0 |
| Cuba (2008) | 19.0 | 36.4 | 191.0 | 82.8 | 435.0 |
| Denmark (2006) | 17.5 | 35.2 | 201.0 | 54.5 | 311.0 |
| Dominican Republic (2005) | 3.9 | 7.3 | 187.0 | 2.0 | - 51.0 |
| Georgia (2009) | 7.1 | 15.0 | 211.0 | 19.9 | 280.0 |
| Panama (2008) | 9.0 | 16.8 | 186.0 | 7.8 | 86.0 |
| Portugal (2009) | 15.6 | 25.7 | 165.0 | 60.1 | 385.0 |
| Serbia (2009) | 28.1 | 51.0 | 181.0 | 96.2 | 342.0 |
| Slovenia (2009) | 36.4 | 49.0 | 135.0 | 78.2 | 215.0 |
| South Korea (2009) | 39.9 | 99.5 | 249.0 | 173.9 | 436.0 |
| Switzerland (2007) | 24.8 | 42.7 | 172.0 | 86.7 | 349.0 |
| Trinidad and Tobago (2006) | 17.9 | 36.1 | 201.0 | 29.7 | 166.0 |
| Uruguay (2004) | 26.0 | 43.2 | 166.0 | 95.9 | 367.0 |

## Suicide Prevention

The first well-documented systematic efforts for suicide prevention date back to the early twentieth century (1906), when the Salvation Army launched in London its program for suicide prevention while in the same year, the US National League started in New York the operations of "Save a Life" (Bertolote 2004).

These first steps to prevention were inspired by religious, humanitarian and philanthropic principles, conducted by society groups. They did not have a scientific basis. Several initiatives aimed at the prevention of suicide ensued, most of them inspired by clinical principles – usually individual approaches that reflected ideological and theoretical orientations, not always with a scientific basis.

The methodological weaknesses, and above all, limited results, of these initial programs did not fit the requirements of public health, particularly when compared to others with better scientific validation and more satisfactory results, both in terms of efficacy and cost-benefit.

In 1998, based on the available evidence, WHO identified, with the help of a distinguished panel of experts from different regions of the world, the following 3 priority areas for the development of suicide prevention activities:

- Treatment of people with mental disorders.
- Restricting access and methods used in suicidal behavior.
- Appropriate approach by the media when covering news and information related to suicidal behavior.

**Table 4.7** Countries with the highest suicide mortality rates (per 100,000) among 65+ years old females, as compared to the national same sex overall rate

| Country | National overall female rate (A) | 65–74 years old | % of (A) | 75+ years old | % of (A) |
|---|---|---|---|---|---|
| Austria (2009) | 7.1 | 13.8 | 194.0 | 15.8 | 225.0 |
| Bulgaria (2008) | 6.2 | 11.4 | 184.0 | 18.7 | 301.0 |
| China (Hong Kong) (2009) | 10.7 | 17.9 | 174.0 | 28.9 | 167.0 |
| Croatia (2009) | 7.5 | 13.5 | 180.0 | 24.5 | 326.0 |
| Cuba (2008) | 5.5 | 16.8 | 305.0 | 13.1 | 238.0 |
| Denmark (2006) | 6.4 | 14.1 | 220.0 | 10.6 | 166.0 |
| Estonia (2008) | 7.3 | 4.9 | 67.0 | 16.5 | 226.0 |
| Georgia (2009) | 1.7 | 3.7 | 218.0 | 5.8 | 341.0 |
| Germany (2006) | 6.0 | 9.1 | 152.0 | 13.7 | 228.0 |
| Israel (2007) | 1.5 | 3.9 | 260.0 | 3.0 | 200.0 |
| Latvia (2009) | 8.2 | 4.9 | 60.0 | 21.4 | 260.0 |
| Lithuania (2009) | 10.4 | 11.1 | 107.0 | 24.0 | 231.0 |
| Moldova (2008) | 5.6 | 11.1 | 198.0 | 9.6 | 171.0 |
| Panama (2008) | 1.9 | 2.9 | 153.0 | 4.5 | 236.0 |
| Portugal (2009) | 4.0 | 7.7 | 193.0 | 10.7 | 267.0 |
| Puerto Rico (2005) | 2.0 | 3.9 | 195.0 | 2.4 | 120.0 |
| Russian Federation (1995) | 9.5 | 13.3 | 140.0 | 24.8 | 261.0 |
| Serbia (2009) | 10.0 | 20.0 | 200.0 | 28.4 | 284.0 |
| Singapore (2006) | 7.7 | 14.7 | 191.0 | 28.1 | 365.0 |
| Slovenia (2009) | 9.4 | 20.4 | 217.0 | 20.6 | 219.0 |
| South Korea (2009) | 22.1 | 34.2 | 155.0 | 77.2 | 349.0 |
| Switzerland (2007) | 11.4 | 18.8 | 165.0 | 32.7 | 286.0 |

In 2004, a group of experts from 15 countries from all continents gathered in Salzburg, Austria, under the auspices of the International Association for Suicide Prevention in order to conduct a systematic review of the scientific evidence on the effectiveness of virtually all strategies and interventions already proposed for the prevention of suicide (Mann et al. 2005).

This high level group of experts confirmed the relevance of the 3 above proposed areas, and added 2 more, whose evidence had arisen subsequently namely:

- Appropriate education and information for schools, the general public and workers in the health and social sectors.
- Active and systematic screening of people at high risk for suicidal behavior.

The report of this meeting was published in 2005 by the Journal of the American Medical Association (Mann et al. 2005).[1]

[1] More recently, the World Health Organization has released the report Preventing Suicide: A Global Imperative www.who.int/mental_health/suicide-prevention/world_report_2014

## Conclusion

Suicide is an immemorial, multifarious, complex and challenging form of violence. Due to the individual, family and collective suffering it creates, coupled with personal, material and economic losses it causes, it has become a serious public health problem. In addition, it hits in an unequal proportion different segments of society adding another layer of violence to an already tragic condition.

Although we have already an impressive armamentarium to prevent and cope with it, not always, not everywhere, and not for everybody it is sufficiently articulated and implemented. Well-conducted efforts, organized around national strategies, can make a real difference in order to reduce this avoidable form of violence.

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