Foreword

I met psychiatrist, specialist, and master in science, Adalberto Campo-Arias, at a psychiatry congress at the start of this century in Santa Marta, where I live, while attending a keynote address on one of his scientific research papers. Interested in his different articles, I have regularly maintained communication with him. Over the years, he came to work as a professor at the same university where I have taught occasionally for more than 15 years. Since then, I have joined Dr. Campo-Arias, collaborating on different projects and publications. Therefore, it is not only an honor to write the foreword for his book, but a great responsibility. I can witness his scientific rigor even when speaking of any subject: seemingly born to become an investigator, deeply committed to the scientific method as he is.

This book deals with the phenomenon of suicide, a lofty goal given the different theories framing this public health problem worldwide. Just in its title, *Suicide behaviors: 21st-century perspectives*, it spans the manifold references —not only theoretical— in existence, always under the guidance of scientific

evidence, which has always been the author's lodestar during his academic life.

He divides his book into eight parts, each dealing with a particular or concrete topic, leading the reader, either lay or expert, by keeping his interest in the subject matter, given his ability to explain such a complicated phenomenon. This way, one can comprehend from the first chapter, "Self-injurious behavior with suicidal purposes," the value of knowing the frequency of this behavior. It is well known that this phenomenon ranges from a person having suicidal ideation to the execution of the idea, which consists of having self-injurious thoughts —even if they lack a strategy for carrying out the suicide— until they manage to establish a detailed plan for accomplishing death by suicide.

Although this type of behavior is more often found in people who meet the criteria for a major depressive disorder, the exhaustive review of the scientific evidence reveals this does not occur in 10 % of the population who die by suicide; for which emotional or behavioral alterations accounting for the existence of a mental disorder are ruled out. Because of this, suicidal behavior also represents a nonspecific manifestation of emotional suffering that deserves a personalized and integrated evaluation varying by the country for several reasons; self-injurious behaviors for suicidal purposes are taken as indicators, in his own words, "of major psychological distress in public health," something the author points to for its comprehension and suggests a respective set of preventive actions.

Throughout this work, the author mentions the complex overlap between self-injurious behaviors for suicidal purposes and predisposing biological behaviors with demographical characteristics, where it is possible to determine the little practical or predictive usefulness of biological findings. In contrast, some demographical characteristics —such as gender— must be considered for carrying out actions or prevention plans. The chapter "Psychosocial stressors and suicidal behaviors" points out that suicidal risk is proportional to the convergence of widely variable stressors such as physical illnesses, which may or may not lead to hospitalization; epidemics, such as the coronavirus pandemic, which can lead to suicidal ideation and death by suicide; bullying at school or the workplace, physical violence, the stigma-discrimination complex, among many others detailed and explained thoroughly in this chapter, concluding that problem-focused coping strategies should be established for helping reduce these behaviors.

After that, he takes us through "Suicide behaviors and society," in which the determinant aspects are: familial context (such as dysfunctional families); being adopted or not; religiosity, in which attitudes toward suicide vary significantly; or the way communication media depict or showcase news about suicides, having a significant influence on communities since they frequently describe methods used in suicide acts or attempts, which, in many instances of the ideation phase, the subject is not yet aware of; coupled with the variety

of possible methods, from the least harmful to the most lethal ones, even as these vary from one population to another. Additionally, the author illustrates how wars and armed conflicts influence the presentation of the suicidal phenomenon without overlooking other aspects, such as an individual's social capital, socio-economic situation, and their country's macroeconomic situation, which influence the issue of suicide. Thus, social and cultural aspects are decisive in explaining differences in the frequency of self-injurious behaviors between countries and regions.

In the chapter called "Self-injurious behaviors in clinical practice," the author shows that the biomedical perspective gained the most significant relevance for addressing this public health problem, the importance of personality traits and disorders, where self-injurious behaviors are frequently associated with a mental disorder diagnosis. The relevance of legal and illegal substance consumption, previous suicide attempts, and survivors of the suicide attempt is not overlooked; here, the author emphatically explains that the integration of clinical, demographic, social, and cultural aspects of each case is essential for their study.

Resuming this interweaving leads us to "Self-injurious behaviors in differentiated populations." This chapter illustrates how the frequency of suicidal behavior varies widely depending on ethnic-racial and cultural characteristics, diverse sexual identities, and migration status; that is, minority groups are considered

to be at high risk for this type of behavior, and the urgent need to take into account differential approaches to prevent self-harm from becoming a reality in these groups is stressed.

The author proceeds with "Non-suicidal Self-Injurious Behaviors," indicating how awareness of the complex relationship between non-suicidal self-injurious behaviors, non-suicidal self-injurious behavior disorder, and suicide is required so strategies aimed at their reduction can be implemented in health programs. Nevertheless, displaying his honesty and humility as a scientist, he warns us of the limitations that only future research can help us overcome.

The author ends the book dedicated to prevention measures and reducing suicide behaviors, emphasizing how previous failures invite us to regard new approaches that consider the plurality of associated protective measures and risk factors.

Please enjoy reading this book, and thank you, Dr. Campo-Arias, for writing it.

Guillermo Augusto Ceballos Ospino
Psychologist, specialist
Suicide scholar

Suicidal self-injurious behaviors: Definition and frequency

Definition

In general, self-injurious behaviors can be classified into two broad categories (Hasley et al., 2008; Kapur and Gask, 2009; Silverman et al., 2007a). After a careful clinical evaluation, the first category includes those without a clear intention of death. The other category encompasses a set of self-inflicted injuries with a clear purpose or expectation of death (Bennett et al., 2011; Hawgood and De Leo, 2008; Kerr et al., 2010; Silverman et al., 2007b; Wilkinson and Goodyer, 2011).

In the last decade, self-injurious or suicidal behaviors have been renamed to address the wide polysemy in biomedical sciences, humanities, and social sciences and construct operational definitions applicable for all areas interested in understanding suicidal behaviors (Hasley et al., 2008; Ioannou and Debowska, 2014; Kapur and Gask, 2009; Silverman et al., 2007a). Suicidal behavior can be operationally defined as follows:

1. Any behavior that may result in death, regardless of the outcome (fatal or not).
2. The person has the deliberate or premeditated intent to injure themselves.
3. The behavior's possible results are known, and a lethal effect is desired or expected.
4. The person involved in the act has the idea or desire of death as an instrument for inducing a significant change in their emotional or personal state, or their immediate social context.

These criteria allow us to have three large groups for self-injurious behaviors, ranging from ideation to execution of the idea (Hawgood and De Leo, 2008; Silverman et al., 2007b). The spectrum of suicidal ideation is defined as repeated thoughts about one's death, recurrent ideas of harming oneself without a plan, and those thoughts about death that are more elaborate and of longer duration generally, in which the person has an organized and plausible plan to end their own life (Herrera et al., 2006; Silverman et al., 2007b).

The second group includes "suicidal communications," which consider a wide range of non-verbal manifestations or behaviors and explicit expressions of suicidal threat (Hawgood and De Leo, 2008). Moreover finally, the third group compiles behaviors evidently suicidal or with a clear goal of causing death by suicide (Libeu and Dinwiddie, 2017). On the one hand, there are suicide attempts, regardless of the intention of dying

by carrying out the act, and at the other extreme, there is death by suicide (Campo-Arias and Caamaño, 2018).

The spectrum of self-injurious behaviors can be observed in different daily life situations and clinical contexts (Mingote et al., 2004). These behaviors are considered one more symptom of a wide range of personality traits (Brezo et al., 2006; Victor and Klonsky, 2014) and major mental disorders (Balhara and Verma, 2012; Chesney et al., 2014; Harris and Barraclough, 1997; Hawgood and De Leo, 2008; May and Klonsky, 2016).

Self-injurious behaviors may be present in people who meet the criteria for major depressive disorder (Cardoso et al., 2018; Chesney et al., 2014), schizophrenia (Balhara and Verma, 2012), bipolar disorder (Cardoso et al., 2018; Chesney et al., 2014), panic disorder (Hawgood and De Leo, 2008), and substance use disorders (Arsenault-Lapierre et al., 2004), among other formal diagnoses.

In the same way, in a rate of around 10 % of cases of death by suicide, for example, a detailed and exhaustive review does not show emotional or behavioral alterations that indicate the existence of a mental disorder (Arsenault-Lapierre et al., 2004; Milner et al., 2013). In general, self-injurious behaviors represent a nonspecific manifestation of emotional suffering that deserves a personalized and integrated evaluation (Mingote et al., 2004); that is, the extensive review of diagnostic criteria included in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatry Association, 2014) and the International Classification of

Diseases for mortality and morbidity statistics (World Health Organization, 2019).

Prevalence

In the global context, the frequency of self-injurious behavior varies significantly. The prevalence of suicide attempts and suicide deaths is related to the techniques for measuring the phenomenon (Rockett et al., 2011; Tollefsen et al., 2012).

Official records show that the global suicide rate is 14.5 per 100,000 inhabitants, numbers lower than 1.0 per 100,000 inhabitants. The rate may be significantly higher in Iran and Lithuania, where 40.0 per 100,000 inhabitants are recorded (Hawton and van Heeringer, 2009; Hawton et al., 2012). In the United States, the suicide rate is 11.5 per 100,000 inhabitants, and in Latin America, not including the Antilles, the suicide rate varies between 1.0 and 16.0 per 100,000 inhabitants. The lowest rates are found in Peru, Brazil, and Mexico, and the highest are reported in Cuba and Uruguay (Organización Panamericana de Salud, 2014).

In Colombia, the suicide rate observed in the most recent decade is between 4.2 in 2008 and 5.7 in 2018 per 100,000 inhabitants (Macana, 2019), lower than the estimated average for the Americas, 9.1 per 100,000 inhabitants (Organización Panamericana de la Salud, 2014). However, it is necessary to remember that the suicide rate varies significantly between cities, departments, and regions.

In 2018, the suicide rate in Bogotá was 5.11 per 100,000 inhabitants. For other capital cities, the lowest suicide rate was found in San Andrés (1.43 per 100,000 inhabitants) and the highest in Mitú (17.73 per 100,000 inhabitants). By departments, the lowest suicide rate was observed in the Archipelago of San Andres, Providencia, and Santa Catalina (1.79 per 100,000 inhabitants) and the highest in Vaupés (15.41 per 100,000 inhabitants) (Macana, 2019). These differences could be due to the disparities in each territory's proximal, intermediate, and distal social determinants. These determinants will be reviewed in the following chapters.

In young people between 10 and 24 years old, the frequency of self-injurious behaviors in the course is widely variable; these prevalences are between 4.1 % and 41.5 % (an average value of 16.1 %) (Botega et al., 2005; Kessler et al., 2005; Muehlenkamp et al., 2012; Young et al., 2006). The prevalence in the last twelve months can have frequencies as low as 2.5 % or as high as 21 %. It is necessary to keep in mind that the frequencies are conditioned by the social and cultural contexts of the country and the methods used in quantifying self-injurious behaviors (Muehlenkamp et al., 2012). In this population, it is necessary to specify that suicide explains 6 % of all deaths (Patton et al., 2009).

In adults, the lifetime prevalence of self-injurious behavior is between 0.75 % and 6 %. The lowest value was observed in Lebanon and the highest in Canada's population (Soomro, 2008).