Editorial

Why There Is a Need for an International Nomenclature and Classification System for Suicide

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The Status Quo

There is no internationally agreed-upon set of terms, definitions, or classifications for the range of thoughts, communications, and behaviors that are related to self-injurious behaviors, with or without the intent to die. Nor is there an agreed taxonomy that encompasses the full spectrum of what are often clinically defined as suicide-related behaviors. The suicide literature remains replete with confusing (and sometimes pejorative) terms, definitions, descriptors, and classifications that make it difficult, if not impossible, to compare and contrast different research studies, clinical reports, or epidemiological surveys, or to make generalizations or extrapolations. The relative rarity of suicide phenomena, especially fatal events, would make particularly desirable the aggregation of data from different research groups. This would allow for performing meta-analytic evaluations and make parsimonious use of the small amount of money dedicated to suicide research worldwide.

A uniform nomenclature and classification for suicidal ideation and behavior has been the subject of considerable international attention and debate (De Leo et al., 2006; O’Carroll et al., 1996; Silverman et al., 2007a, 2007b). Measures of suicide and nonfatal suicidal behavior (encompassing with this term all self-injurious behaviors inclusive of self-harm and suicide attempt) continue to be hindered by the lack of: (a) a standard nomenclature and classification system (De Leo et al., 2004, 2010; Rudd & Joiner, 1998; Silverman et al., 2007a); (b) clear operational definitions (Arensman & Kerkhof, 1996; Silverman, 2011, 2016); and (c) standardized lethality measures (Berman, Shepherd, & Silverman, 2003). It has been pointed out that not only must we use the same terminology and definitions, but that these terms must be easily understood, applied, and consistent, and should relate to each other in a way that has utility, meaning, and relevance to the real world of at-risk individuals (Silverman, 2006).

The need for clear and consistent use of terms to guide research and clinical practice has provided the impetus for efforts to develop standard operational definitions and nomenclature to classify suicide and self-injurious thoughts and behaviors (e.g., Crosby, Ortega, Melanson, 2011; De Leo et al., 2006; Posner, Oquendo, Gould, Stanley, & Davies, 2007; Sheehan & Giddens, 2015; Silverman et al., 2007a, 2007b; World Health Organization [WHO], 2011, 2014a). However, as Heilbron, Compton, Daniel, and Goldston (2010) have noted, implementing a standard nomenclature for clinical and research purposes has long been recognized to be a complex task (Litwack, 2001; Wakefield, 1992; Wilson, 1993).

There are currently several nomenclatures and/or classification systems that are available in the US (e.g., Brenner et al., 2011; Posner et al., 2007; Silverman et al., 2007b) as well as internationally (De Leo et al., 2006). No classification system has been fully tested to date in terms of determining whether the terms (and their definitions) actually describe in an accurate way the phenomenology and, in fact, distinctly classify the range of thoughts, actions, and behaviors associated with the suicidal process.
The WHO (2002) defines 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. (p. 5)

Self-directed violence encompasses a range of behaviors, including acts of fatal and nonfatal suicidal behavior and nonsuicidal intentional self-harm (i.e., behaviors where the intention is not to kill oneself, as in self-mutilation; Hjelmeland & Knizek, 1999).

Despite the large volume of data on certain types of self-directed violence, the utility and reproducibility of the resulting information are sometimes questionable. Mortality data are problematic for several reasons: geographical differences in the definition of suicide and how equivocal cases are classified; jurisdictional differences in the requirements for the office of coroner or medical examiner affecting the standard of proof required to classify a death as a suicide; and differences in terms of the extent to which potential suicides are investigated to accurately determine cause of death (De Leo et al., 2010; Tait, Carpenter, De Leo, & Tatz, 2015). The quality of the data on nonfatal suicidal behavior is even more problematic than that of suicides. The concerns about discrepancies in nomenclature and accurate reporting apply here even more than with suicides. Also, apart from rare exceptions, there is neither systematic nor mandatory reporting of nonfatal suicidal behavior, nor is there routine systematic collection of nonsuicidal, intentional self-harm data.

There is no agreed-upon nomenclature and classification system that currently exists within nations, let alone between and among nations. There is an abundance of terms to describe the range of suicidal behaviors and suicide-related behaviors, such as nonsuicidal self-injury, deliberate self-harm behaviors, etc. There is no agreement on the terminology, let alone the definitions for the key components of the suicidal process: suicidal ideation (vs. death thoughts), intent, motivation, planning, threats, gestures, behaviors (e.g., preparatory, aborted, interrupted, self-inflicted, nonlethal, lethal, near-lethal, etc.). There remains much confusion about what constitutes suicidal behavior and what is classified or labeled as other forms of self-injury, accidents, etc. (Angelotta, 2015; Beaurtrais, 2001; De Leo, 2015; Linehan, 1986). There remains debate about whether the presence/absence of intent should be a qualifying characteristic for labeling self-injurious behaviors as suicidal. There is also debate as to whether the degree of lethality involved in the self-injurious act should serve as the major determinant to categorize the behavior as suicidal, nonsuicidal, deliberate self-harm, etc. (Berman et al., 2003).

It is recognized that categorizing self-directed violence behavior into suicidal and nonsuicidal categories can be difficult. This is due to several considerations: first, that the behavior is multidimensional rather that unitary and not always occurs in a dichotomous way (present/absent) – meaning by this that suicidal individuals may perform nonsuicidal acts and nonsuicidal individuals may end by performing suicidal acts – and, second, that if information is collected only from an individual’s self-report, the way the individual perceives his/her intent can change within moments, not mentioning the possibility of disguising or exaggerating the intent (Silverman & Berman, 2014). Nevertheless, owing to the essential nature of this information to clinical and public health decision-making, it is critical to try to obtain it.

The repetitive nature of some types of self-directed violence make it important to separate counts of the number of individuals affected from the number of incidents of self-directed violence. This difficulty is compounded by the varying procedures used by different data collection sources. Health-care organizations may file and treat each event separately, or they may record repeated incidents in the same patient file. In addition, there are social barriers to obtaining accurate self-directed violence surveillance data. These barriers include the stigma associated with the topic (societal, religious, etc.); self-directed violent acts remain illegal in some countries; the guilt and shame that inhibit a patient’s admission that the act was intentional; and the lack of training and other concerns that inhibit health-care personnel’s capacity to elicit and record accurate accounts of self-directed violence in official records. Furthermore, it appears that only a minority of individuals engaging in self-directed violence behavior ever seeks help from the health-care system (De Leo et al., 2010).

Surveillance and Analysis

In the WHO World Report on Violence and Health (2002), the chapter addressing self-directed violence notes: “Data on suicide and attempted suicide should be valid and up-to-date. There should be a set of uniform criteria and definitions and – once established – these should be consistently applied and continually reviewed” (p. 204). One of the key recommendations of the WHO’s Preventing Suicide: A Global Imperative (2014b) is for governments to establish national surveillance systems for all forms of suicidal behaviors. From our perspective this can only occur with first developing and testing a nomenclature and classification system.

To address only the suicide-related component of self-directed violence as a public health problem would require the sustained and systematic collection, analysis, and dissemination of accurate information on the incidence, prevalence, and characteristics of fatal and nonfatal suicidal behavior. Official suicide rates have been used to chart trends in suicide; to monitor the impact of change in legislation, treatment policies, and social change; and to compare suicides across regions, both within and across countries. In addition, suicide rates afford a method by which to assess population-based risk and protective factors for geographical areas (regions, states, and countries). However, there exist serious inadequacies in the availability and quality of mortality data.

Inconsistent reporting of self-directed violence has significant consequences for public health and for application in problem description, in the assessment of risk and
protective factors, in understanding the longitudinal course and outcome of self-directed violence processes, and in the development and evaluation of effective preventive and treatment intervention strategies. Differential under-reporting for certain groups means that our understanding of that population’s risk and protective factors for self-directed violence may contain significant inaccuracies. This could result in inattention to an at-risk population: If the true rates of self-directed violence are higher than the official statistics indicate, not only is self-directed violence likely to be viewed as a less important problem among this population, but the self-directed violence risk factors identified by researchers might more accurately reflect the self-directed violence process for some other group. When these faulty conclusions become the basis for developing prevention programs, these might miss opportunities to address the factors more involved in the targeted population (De Leo et al., 2010, 2015; Williams, Doessel, Sveticic, & De Leo, 2010). To correct this process, we need accurate data on each group.

Although most, but surely not all, nations have some surveillance and reporting systems for lethal outcomes (i.e., violent deaths, suicide, accidents, overdoses, unintentional deaths, intentional injuries, etc.), the collection of data on suicidal deaths lags far behind the surveillance of other forms of death (such as cancer, heart disease, etc.). Furthermore, not only are there no standardized data collection systems for deaths by suicide, there are no internationally agreed-upon data collection systems for attempted suicide/self-harm behaviors. As a consequence, there is a lack of comparability of existing registries/monitoring systems of all forms of suicidal and self-harm behaviors. Some countries, for example, identify suicide attempts in their medical records, others record deliberate self-harm—a category that includes suicidal behavior, but also includes other forms of self-harm (e.g., nonsuicidal self-injury, deliberate self-poisoning without suicidal intent, deliberate self-cutting, etc.). In fact, hospitals in most Western countries still use a variety of denominations pertaining to nonfatal behaviours that normally do not permit any immediate assessment (WHO, 2014b). This is problematic because it constitutes an obstacle to timely trend analyses and interventions.

The WHO/EURO Multicentre Study of Parasuicide (Platt et al., 1992) tried to provide an answer to the definitional issue by introducing the encompassing and overinclusive term of parasuicide. The term was meant to cover all nonfatal self-harming behaviors, regardless of the intention behind the act (whether suicidal or not), in an attempt to homogenize data collection among the 35 centers eventually participating in that historical study (Schmidtke, Bille-Brahe, De Leo, & Kerkhof, 2004). Unfortunately, the implementation of the new term proved both difficult and misleading, bringing further confusion to the field. To obviate this problem, in 1999, the WHO investigation was renamed as the Multicentre Study of Suicidal Behaviour and the preferred term to substitute parasuicide was the equally overinclusive, outcome-based, nonfatal suicidal behavior (De Leo et al., 2006).

**Future Efforts**

There are no clearly identifiable criteria or procedures for determining which data elements could plausibly be collected by national, state, and local surveillance systems, or which ones have the highest priority. Some institutions participating in a surveillance system may be able to collect only a subset of data elements. Definitions of terms might need to be operationalized (i.e., made measurable) in different ways, depending on the source of the data.

There is a strong need for a cross-cultural, internationally applicable nomenclature for suicidal behaviors. Without agreed-upon terms, uniform definitions, and classification systems it will be virtually impossible to compare and contrast data between and among nations. To this aim, the International Association for Suicide Prevention (IASP) has approved the formation of a Task Force on Nomenclature and Classification. The task force will try to generate an international nomenclature of all terms within the area of suicidology, inclusive of death wishes, assisted suicide, and bereavement. The aim is to obtain an international standardization of terminologies that may render research and surveillance more comparable across the globe. Our plan consists of a number of steps:

1. Review database of IASP–WHO Global Survey;
2. Review experiences in collecting and analyzing surveillance data for the WHO World Suicide Report;
3. Review existing nomenclatures, definitions, and classification systems;
4. Identify strengths and weaknesses of different approaches;
5. Determine the reliability of data collected in existing data sources;
6. Agree upon standard terminology and uniform definitions;
7. Develop common data elements for surveillance;
8. Identify obstacles to cross-country collaboration with data elements that allow for cross-country comparisons;
9. Present a summary of the draft definitions and recommended data elements at several national, regional, and international suicide prevention conferences and solicit comments from audience members; and
10. Incorporate selected comments from the various groups into the nomenclature and classification system.

From this work, open to all contributors with knowledge (or experience) of these challenges, we hope to obtain a number of potential benefits; for example, we could be in the position to propose core elements (i.e., terms, definitions, etc.) and requirements (e.g., sustainability) of registries of self-directed violence. We could improve the national and international reporting of all forms of self-directed violence/self-harm, highlighting the benefits of national registries of self-directed violence to governments, WHO, policy developers, and other key stakeholders. Needless to say, the availability of different datasets based on shared definitions would create the grounds for meta-analytical investigations with superior statistical power (De Leo, 2009).
For a relatively limited domain such as the one of suicide-related phenomena, the development of a uniform standardized nomenclature and internationally accepted classification system remains an elusive goal. Previous attempts have failed to reach a truly transnational dimension. Even intranationally there are habits and perspectives that are hard to change. The objectives of the task force are very challenging; however, the combination of efforts via multinational teams may produce significant gains. Widespread awareness of the problems inherent to the lack of a standardized nomenclature is probably the first of these possible gains, with the benefits described before all at reachable distances. Aggregation of scholars and researchers around those important goals would be essential to the success of the initiative.

References


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