Violence: Contagion, Group Marginalization, and Resilience or Protective Factors

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The relationship between contagion, group marginalization, and resilience is a complex issue that does not lend itself to quantitative methodology but rather it is best studied using qualitative methods. Thus, having a historical perspective is an important attribute to understand appropriately the phenomena of violence as it relates to contagion, group marginalization, and resilience or protective factors. Furthermore, in order to have a coherent discussion about violence, we must first understand which type of violence we are focusing on, as violence is a very complex and multi-determined phenomena. In addition, we must understand the science.

THE NEED FOR GOOD SCIENCE

In order to understand this complex problem we must understand the need for good science. Unfortunately, there is a fundamental scientific problem with understanding violence, whether it is directed towards others or self-directed. The reality is that these phenomena, while being the third or leading cause of death for some populations groups, e.g. teenagers or young black males, respectively, are actually rare events. The reality is that suicide rates tend to be 11 suicides/100,000 (Goldsmith et al, 2002) and homicide rates are about 9/100,000 (Douglas and
Bell, 2011). Even if you focus on non-Hispanic black people who have rates of homicide of around 33/100,000 or gun homicides with rates of 58/100,000, these are low base rates and developing statistical power to differentiate between an experimental intervention and control is very difficult. Accordingly, the 2002 Institute of Medicine report, *Reducing Suicide: A National Imperative*, noted to prove a suicide prevention intervention is evidence-based a study would need 5 to 10 population studies with 100,000 people per study to get enough statistical power to show a suicide prevention intervention works (Goldsmith et al, 2002). Since the homicide rates are actually lower than the suicide rates, despite many scientific claims to the contrary, it is apparent you would need an equally large population to prove a homicide prevention intervention is evidence-based and neither of these two studies has been done.

**TYPES OF VIOLENCE**

Having formally studied the phenomena of violence for more than 30+ years, we proposed that there were many different forms of violence, which required different prevention, intervention, and post-vention strategies (Bell, 1997). As identified by Baker and Bell (1999), such types of violence include

- Group or mob violence
- Individual violence
- Systemic violence, such as war, racism, and sexism
- Institutional violence, such as preventing inmates from getting the benefit of prophylactic medications to prevent hepatitis
- Hate-crime violence, such as terrorism
- Multicide (e.g., mass murder, murder sprees, and serial killing)
- Psychopathic violence
- Predatory violence, also known as instrumental or secondary violence
- Interpersonal altercation violence, also known as expressive or primary violence (e.g., domestic violence, child abuse, elder abuse, and peer violence)
- Drug-related violence, such as systemic drug-related violence (whereby drug dealers kill to sell drugs), pharmacological drug-related violence (whereby an individual perpetrates violence because of drug intoxication), economic-compulsive drug-related violence
(whereby a drug addict uses violence to obtain drugs), and negligent drug-related violence (such as a drunk driver who kills a pedestrian)
- Gang-related violence
- Violence by mentally ill individuals
- Lethal violence directed toward others (homicide)
- Lethal violence directed toward self (suicide)
- Violence by organically brain damaged individuals
- Legitimate/illegitimate violence
- Nonlethal violence

OBSERVATIONS ABOUT TYPES OF VIOLENCE REGARDING ISSUES OF CONTAGION, GROUP MARGINALIZATION AND RESILIENCE

Culture Destroys and Culture Protects

_Culture destroys._ In Chicago, we have a tried and true saying that the "Chicago police hunt black males." Consider the science that illustrates white males perpetrate similar levels of violence as black males (DHHS, 2001), and engage in more illegal drug use; however, the majority of children and young adults who are incarcerated for these offenses are of color.

Structurally, we understand that most mid- and large-size cities have more absolute numbers of low-income white people than poor black people, but there are few low-income white ghettos because poor white people have scattered site housing - thus it is easier to catch black people using illegal drugs than it is to catch white people using illegal drugs; ergo, one of the reasons for the disproportionate percentage of incarcerated black people. Canada's monocultural ethnocentric culture had little value for First Nation culture. Thus, First Nation children were removed from their families and told them their culture was not acceptable, resulting in First Nation people having to give up their cultural protective factors which ultimately led to many First Native people engaging in the risky behaviors of suicide and intra-group homicide. Within these communities, alcoholism is common and for every one child in Canadian juvenile
detention centers without fetal alcohol syndrome there are 19 children with fetal alcohol spectrum disorders (Popova et al, 2011). Bell (2012) has proposed many disruptive behaviors leading to incarceration results from fetal alcohol exposure (FAE) as it is well known FAE is the leading cause of speech and language disorders, Attention Deficit Hyper Activity, Specific Learning Disorders, and Mild Mental Retardation (Strattonk et al, 1996) which are often responsible for affect dysregulation leading to disruptive behaviors leading to incarceration. These phenomena increase marginalization thus facilitating fertile ground for promoting the contagion of violence. A perfect example was the police mob victimization of Rodney King by police that spread into the African-American community resulting in mob violence deemed a riot. Thus, when we talk about violence and the contagion of violence, we must also discuss the systemic violence of racism and imperialism that historically spread across the world. 

*Culture protects.* While doing HIV prevention work in Durban, South Africa it was striking that 40 percent of the Zulu people were HIV-positive, 6 percent of the white South African people were HIV-positive, but only 1 percent of the Indian South African people were HIV-positive. The conclusion was that the Indian South African people’s culture protected them while the Zulu people’s culture and its protective influence had been stripped from them making them vulnerable to risky behaviors, such as risky sexual behavior, substance abuse, and violence. As white culture is not immune to erosion (Murray, 2012), white South African culture also is eroding and resulting in higher levels of HIV-positive individuals.

**Contagion of suicide and mass murder**

In discussing self-directed violence, we understand the phenomena of contagion of suicide (Phillips et al, 1992) and how the mass media can cause what is referred to as cluster suicide, copycat suicide, and suicide contagion. Accordingly, in an effort to reduce this
phenomenon of contagion, this recognition resulted in the Reporting on Suicide: Recommendations for the Media. Given that certain types of mass murders often lead to suicide (Petee et al, 1997), it is proposed that these mass murders are actually suicides preceded by mass murder (Bell and McBride, 2010a). One could hypothesize that when the media publicizes events such as the ones that occurred in Columbine High School, Platte Canyon High School, an Amish school in Nickel Mines, Pennsylvania, Virginia Tech, and Northern Illinois University, such "suicides preceded by mass murder" are inadvertently promoted. We understand the high level of public interest in sensational news stories; nevertheless, unless we understand that an individual suicide is the dynamic driving the mass murder behavior, we will continue to inadvertently encourage this behavior. The difficulty is that electronic media is so ubiquitous; it would be difficult to design a study as Phillips (1974) did when we only had to contend with local print media. We need a consensus meeting to discuss these issues and figure out how to responsibly report on "suicides preceded by mass murders," or the hypothesized contagion will likely continue.

Interpersonal Violence

Regarding the type of violence known as interpersonal violence, we understand this type of violence is responsible for most violence. Furthermore, although different cultural, racial, and ethnic groups have different rates of different types of violence (e.g. Latinos have more gang-related violence) we understand that interpersonal violence is more common in the African-American community, but African-American domestic violence went from 16/100,000 to 3/100,000 (Greenfield, 1998). Why? Because the number of domestic violence shelters increased dramatically, reducing the number of battered African-American women who turn to

committing violence against their partner as a means to stop being battered. This reduction in African-American domestic violence is largely responsible for the large drop in National homicide statistics over the past 10-15 years. The relative decrease in interpersonal altercation homicides has led to a relative increase in gang-related homicides that currently has cities like Chicago concerned. Additionally, like infectious micro-organisms, because behavior is contagious, we frequently see patterns of violence migrate from one cultural, racial, ethnic group to another different group.

Other Forms of Violence

One form of violence that has not been adequately studied is violence by organically brain-damaged individuals (Bell et al, 1985; Bell, 1986; Bell, 1987; Bell and Kelly, 1987). Although, there is no evidence for the reason for this lack of study, it can be hypothesized the major reason for this oversight is the marginalization of those afflicted with head injury that ultimately results in their explosive behavior. It is hoped the recent "discovery" of this problem in football players will reduce the marginalization of this population resulting in appropriate study of the issue yielding more prevention and treatment strategies. The issue of legitimate verses illegitimate violence is another issue we must struggle with as we have these conversations - especially when there is a question of a shooting death of an unarmed black male.

PROTECTIVE FACTORS THAT CULTIVATE RESILIENCY AGAINST VARIOUS TYPES OF VIOLENCE

Social fabric prevents contagion of violence

As the Director of the Institute of Juvenile Research, where child psychiatry began and where the issue of family and community violence was addressed more than a hundred years
ago, I am aware of a great deal of relevant history that pertains to contagion, group marginalization, and resilience or protective factors as they relate to violence. The lessons learned from this history are quite instructive to this discussion. In Chicago in 1871, the great fire created a lot of instability in a city with a population that was 70 percent either foreign-born or first generation. The results were families who, due to being disrupted by poverty and unfamiliar community circumstances as result of immigration were not able to provide stable family environments and to flourish. Evidence of this problem was the extraordinarily high rates of European immigrants’ domestic violence in Chicago from 1875 to 1920 (Adler, 2003). Seeing the problem, Jane Addams made efforts to found Hull House to aid in the solution of the social and industrial problems which are engendered by the modern conditions of life in a great city. In 1889, Jane Addams and her colleagues established a Juvenile Court in Illinois to distinguish between delinquency and criminality. The procedures of this new institution were not to be adversarial, rather it was primarily protective and educational rather than punitive, and the commission of a child to a correctional institutions is deemed to be for his welfare and not for the sole purpose of inflicting penalty. Ten years later, in 1909, these foresighted women convinced the State of Illinois to discover the cause of delinquency and the Juvenile Psychopathic Institute (later called the Institute for Juvenile Research -IJR) was created, and the neurologist William Healy was hired to be the first director. Later, IJR researchers Shaw and McKay (1942) noted delinquency was due less to biological, ethnic, or cultural factors and more due to social disruption eroding formal and informal social control in specific transitional neighborhoods (delinquency areas) in a city. Fifty years ago, the science was not as advanced as it is now. The research designs were empirical and qualitative instead of being quantitative, and much of the IJR research was mostly biographical. Thus, the statistical methodology was very
primitive by today’s standards and multivariate influences could not be adequately studied statistically. However, despite this lack of scientific methodology, it is interesting that the IJR’s observations were correct. Their observations were that children’s biology was not causing delinquency, but rather it was the lack of social fabric in the new immigrant communities. Of course, this finding predated by fifty years the seminal research of Sampson et al. (1997) that coined the term “collective efficacy.”

Another example of how protective factors cultivate resiliency, which in turn is protective against contagion of violence, specifically cluster or copycat suicide, is found in building protective factors around vulnerable populations of potentially suicidal individuals. Because 20,000/100,000 people in the United States suffer from depression; 5,000/100,000 attempt suicide; and 11/100,000 actually complete suicide, something must be protecting people (Health Care Innovations Exchange Team, 2012). Accordingly, because youth engage in multiple risky behaviors due to their immature brain development - we have likened adolescents to be like cars, i.e. they are all gasoline - no brakes or steering wheels, and, they need brakes and steering wheels, i.e. community or social fabric to reign in their recklessness (Bell and McBride, 2010b). These protective factors can be cultivated (Bell, 2001) and have been proposed as a strategy of suicide prevention (National Alliance for Suicide Prevention, in press). A specific example of infusing protective factors to prevent suicide occurs when in an effort to prevent copycat or cluster suicide, after a successful suicide, the victim’s friends are screened for suicidality and then provided with preventive services (Brent et al, 1989).

Research has indicated that children who are sexually and physically abused are more likely to engage in suicidal behavior compared to children who are not abused (Goldsmith et al, 2002). However, children with protective factors in their lives have fewer traumatic stress
drivers of suicidal and other-directed violent behavior than children who do not have these protective factors (Griffin et al, 2011). Thus, it is possible to cultivate resiliency in these populations as well.

Finally, based on years of public health research and work, the Seven Field Principles for Health Behavior Change are appropriate universal guiding principles to infuse protective factors in populations at risk for various types of violence: 1) Rebuilding the village; 2) Access to modern and ancient technology; 3) Connectedness; 4) Building self-esteem (a sense of power, uniqueness, connectedness, and models); 5) Cultivating social and emotional skills; 6) Re-establishing the adult protective shield; and 7) Minimizing trauma. These efforts have led to the maxim that “risk factors are not predictive factors due to protective factors.” (Bell et al, 2008).

References


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