A new report on violence – a welcome and a warning

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> Some women . . . enjoy tremendously being told they look a mess – and they actually thrill to the threat of physical violence. I've never met one that does, mind you, but they probably do exist. In books. By men.
>
> Alan Ayckbourn, *Round and Round the Garden*, 1975

Closing the gap between myth and reality is a Herculean task that will never be completed. As some myths are dispelled, new ones will arise. However, the influential philosopher Karl Popper once said, 'Science must begin with myths, and with the criticism of myths' (Popper, 1957).

In the summary publication of the first *World Report on Violence and Health* (for the full report see World Health Organization, 2002*a*), the authors see their mission clearly: 'the purpose of the first *World report on violence and health* is to challenge the secrecy, taboos and feelings of inevitability that surround violent behaviour' (World Health Organization, 2002*b*: p. 1). It is a thoughtful exposition, recognising the difficulties of such basic demands as defining and measuring violence. Furthermore, while ambitious in proclaiming the message that violence can be prevented, it is modest in recognising that '[r]aising awareness of the fact that violence can be prevented is, however, only the first step in shaping the response to it' (p. 1).

The report espouses a public health approach to violence, stressing that the approach is science-based – '[e]verything . . . must be based on sound research and informed by the best evidence' (p. 3). The emphasis is multi-disciplinary, making use of 'a wide range of professional expertise, from medicine, epidemiology and psychology to sociology, criminology, education and economics' (p. 3). This must raise the hopes of all those who have over the years questioned medical dominance in matters of health. Indeed, there is a muted criticism in the report of the health sector's response to violence that it has hitherto been 'largely reactive and therapeutic'. Traditionally, psychiatrists have treated individual patients and dealt with illness and disease rather than being involved in prevention. In contrast, the public health approach – which is strongly advocated – acts on a wider stage, focusing on the health of communities and populations as a whole rather than on individual patients. So psychiatrists – together with many other medics – will recognise that this report is attempting to shift the balance.

THE PUBLIC HEALTH APPROACH

The crucial stance of the public health approach is to focus on prevention: that is, preventing disease or illness from occurring, rather than dealing with the health consequences. The further shift is to try to think of violence in these terms. The arguments are seductive and it would be churlish for someone who has advocated more 'upstream' thinking (to use a term pervasive in the report) to challenge the basic tenets of the report – that is, that prevention is better than cure. However, mission statements are produced by missionaries, and missionaries rarely point out the underlying problems of their mission. In this respect, in reading the report, I realised that I am an academic, not a missionary and perhaps not even a scientist. A scientist, as Kuhn (1962) has explained, works within a paradigm, and challenges to a paradigm – especially a new one – are often met with stiff resistance. The task of an academic is perhaps rather different. Irritatingly, the academic will tend to identify tensions and problems rather than consensus and solutions. For the missionary and perhaps for the scientist, in contrast, all will be resolved if one accepts their vision of the world.

The public health approach is not new, as McKeown (1976) pointed out when he first stimulated the debate in the 1970s about the effects of medical intervention on human health. In fact, over the past 150 years or so, one can identify three phases of activity. The first phase began in the industrialised cities of northern Europe as a response to the appalling toll of death and disease among the working classes living in abject poverty. The response to this situation was the gradual development of the public health movement, such as the appointment of sanitary inspectors and their staff, supported by legislation such as the National Public Health Acts of 1848 and 1875 in England and Wales. The second phase was a more individualistic approach ushered in by the development of the germ theory of disease and the possibilities offered by immunisation and vaccination. The third phase has been identified as the therapeutic era, dating from the 1930s, with the advent of insulin and other drugs. The beginning of this era coincided with the apparent demise of infectious diseases on the one hand and the development of ideas about the welfare state on the other. This all meant a shift of power and resources to hospital-based services and the downgrading of the public health approach. In fact, the individualisation of illness – whether orchestrated by the medical profession or by the government – was one of the crucial ingredients of the health policies of the 1980s and early 1990s. Such an approach masks the social causes of ill-health. However, the Acheson Report (Acheson, 1998) laid the foundations for a wider and more inclusive approach emphasising a variety of solutions to health problems. The *World Report on Violence and Health* is part of the recent shift of focus towards seeing problems within a wider framework.

THE PREVENTION MODEL

At first glance violence would seem to excite less controversy than health. After all, the 'health police' encouraging us to stop smoking seem to be on a stickier wicket than anyone trying to prevent violence. More will support the freedom to continue smoking than to continue committing violence. However, psychiatrists have recognised that espousing the prevention model is perhaps not so straightforward as some missionaries would have us believe. Locking up people who are highly likely to commit serious violence but who have not yet done so is a facet of the prevention model. In doing so, however one dresses

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up the language, there is some compromise to the notion that everyone is innocent until proven guilty. This strikes at the heart of the underlying philosophical assumptions that a prevention model appeals to.

A prevention model is essentially forward-looking, whereas a more reactive model, where symptoms or injuries are presented, is backward-looking. This is familiar territory in discussing philosophies of punishment where normative theories of punishment are typically classified as either 'consequentialist' or 'non-consequentialist' (Duff & Garland, 1994: p. 6). As Duff & Garland remind us, a consequentialist holds that the rightness or wrongness of any action or practice depends solely on its overall consequences. It is right if its consequences are good (at least, as good as those of any available alternative) and wrong if its consequences are bad (worse than those of some available alternative). This is utilitarianism, in which practices are seen as right or wrong in so far as they promote or destroy 'the greatest happiness of the greatest number'. It is to this philosophy that one might appeal if a potential serial killer were to be incarcerated prior to committing an actual crime. In contrast, a non-consequentialist insists that actions may be right or wrong by virtue of their intrinsic character, independently of their consequences. In this approach it is the guilty, and only the guilty, who deserve to be punished. The potential serial killer must be allowed to become an actual killer, in the absence of overt evidence of any suffering that the person has actually caused.

Forensic psychiatrists know that neither of the alternative stances produces much comfort. The protection of civil liberties, may seem a high price to pay for local carnage. However, at the national and international level the dilemmas and tensions are even more stark. The problem here is that it is the powerful who may be the perpetrators of the most violence, just as it is at the domestic level.

DENYING REALITY

In a groundbreaking study which is as thought-provoking as it is disturbing, Stanley Cohen's book *States of Denial: Knowing about Atrocities and Suffering* deals with public reactions to information, images and appeals about inhumanities (Cohen, 2001). He explores the various states of denial that exist in modern society.

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'Turning a blind eye' and 'burying one's head in the sand' are two expressions of denial frequently used at an individual and societal level. With worrying regularity, we are saturated with media images of atrocities and suffering from all over the world. These images have become normalised. They are commonplace. So, too, is our apparent indifference.

Moving from the personal to the political, Cohen examines how organised atrocities, such as the Holocaust and other genocides, are denied by both perpetrators and bystanders. Bystander nations are those who do nothing, frequently claiming in the aftermath of an event that they were unaware of what was taking place. As for the perpetrators, one of the strategies they use is what Cohen describes as 'interpretive denial', claiming that what is happening is really something else. This is particularly evident in the euphemistic language used by organisations devoted to committing atrocities. The Nazi 'euthanasia' programme for killing those with mental disabilities and other supposedly unworthy people was renamed the Charitable Foundation for Institutional Care. Such deliberate misrepresentation is not unique.

There is much else that is unpleasant and questionable in the exercise of power beyond genocide alone. Mary Daly, a radical feminist, in a classic study (Daly, 1978) pointed to the male domination of women (patriarchy), which she suggests is everywhere expressed through the systematic destruction or mutilation of women. Different cultures express this – both historically and in the contemporary world – in different ways: *suttee* (the burning alive of widows) in India; foot-binding in China; female circumcision in Muslim Africa; the burning of witches in Europe; and gynaecological therapies such as hysterectomy in modern America ('gynocide', as Daly terms it). Perhaps more universally there is domestic violence, which is still frequently denied. Should there be international intervention to stop practices that reflect the male domination of women?

Concerns over the threats posed by international terrorist organisations took centre stage with the horrific events at the World Trade Center and the Pentagon in the USA on 11 September 2001. Terrorists represent a real threat to us all, yet there is a danger that politicians will use this to justify introducing increased powers of surveillance for the state, which may be at the expense of individual civil liberties. Here, we are perhaps less comfortable about intervention that affects our own lives. International terrorism is being fought by global alliances, a reminder that we have newer versions of crimes committed against the physical environment itself: for instance, pollution, the threat of chemical warfare, the aftermath of weapons used in previous engagements such as the Gulf War and Kosovo. Is this violence against humanity? These are complex matters (Soothill *et al*, 2002).

Although the *World Report on Violence and Health* provides an invaluable and welcome service in trying to strip away some of the myths about violence and to expose the facts about violence, this is – as the authors recognise – only a beginning. So what is the warning? The warning is that there are massive moral and political issues to confront in shaping our response to violence. Assuming that consensus is easily achieved – or even achievable – may be a way of burying our head in the sand and turning a blind eye to some very real issues.

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