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Understanding Self-Harm in Victims of Intimate Partner Violence: A Qualitative Analysis of Calls Made by Victims to a Crisis Hotline in China

Susan P. Y. Wong¹, Cuiling Wang¹, Mei Meng¹, and Michael R. Phillips¹

Abstract
Text analysis of the transcripts of 26 calls made to a Chinese crisis hotline by victims of intimate partner violence (IPV) reporting thoughts or acts of self-harm abstracted information on victims' patterns of self-harm and the relationship of their self-harm to IPV. Specific violent episodes often triggered self-harm. Victims considered self-harm a method for airing painful emotions caused by abuse or as a last resort to escape by dying when they saw no other options and were no longer able to endure the violence. We also elaborate on callers’ discussions of barriers to accessing support, sociocultural pressures to preserve “face” and family, and restrictive gender roles that contribute to their self-harm behaviors.

Keywords
counseling, culture, mental health, safety planning

Introduction
Self-harm, herein defined as behaviors carried out against oneself that can lead to physical injury, is a common and potentially fatal outcome of intimate partner violence (IPV). Higher rates of self-harm behaviors and self-harm ideation have been observed in female

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victims of IPV compared to nonvictims (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008), and a meta-analysis determined that victims were three times more likely to have a history of self-harm than their nonabused counterparts (Golding, 1999). Severity of self-harm behaviors and ideation also appears to correspond with severity of IPV. A retrospective cohort study demonstrated that the frequency of emergency room visits for self-harm was positively correlated with the frequency of emergency room visits for injuries related to IPV (Boyle, Jones, & Lloyd, 2006). Victims with a history of self-harm have also been found to be at greater risk of being victims of homicide by their partners (Sato-DiLorenzo & Sharps, 2007), and victims who suffer multiple forms of IPV (physical, sexual, and emotional) endorsed more self-harm ideation than victims who experienced fewer forms of abuse (Houry, Kemball, Rhodes, & Kaslow, 2006).

In China, the reported prevalence of IPV against women ranges from 13% to 37% in urban areas (Gao, Xue, & Liu, 2004; Guo, Wu, Qu, & Yan, 2004), 7% to 66% in rural areas (Cheng et al., 2004; Zhao, Guo, Wang, Wu, & Wang, 2006), and 24% to 31% in psychiatric populations (Hu, 1996; Zou, Zhuang, & Huang, 2005). IPV has also been found to be a risk factor for fatal self-harm in Chinese communities in Hong Kong (Chen et al., 2006). In rural China, where suicide is the leading cause of death among young women (15-35 years; Phillips, Li, & Zhang, 2002), one third of women identified in emergency rooms for treatment of medically serious self-harm disclosed having been victims of IPV (Pearson, Phillips, He, & Ji, 2002).

The reasons for and functions of self-harm can be extremely diverse. Self-harm may be a means to alleviate acute negative feelings, to end a dissociative experience, to assert one’s autonomy and interpersonal boundaries, to modify another’s behavior, to express feelings or needs, or to derogate oneself (Klonsky, 2007). Self-harm may also be a coping strategy to escape unbearable pain and suffering. Nonfatal self-harm may be carried out to forego terrifying urges to die (Klonsky, 2007). In the context of trauma, survivors may also self-harm to reenact traumatic experiences so as to communicate or externalize previous or remembered trauma (Connors, 1996).

The cultural symbolism of self-harm in China may add distinct motivations for self-harm among Chinese victims of IPV. In China, fatal self-harm is stigmatic and those associated with the decedent may be blamed for his or her death. As a result, fatal self-harm can serve as a means for IPV victims to confer blame and punish violent partners or others for wrongdoing (Pearson & Liu, 2002). In Chinese women’s literature, heroines were extolled for acts of self-harm, which were portrayed as affirming bravery, righteousness, and innocence (Hsieh & Spence, 1980). For Chinese women who hold a lower status in society and in the home, the eternal fame that follows a woman who dies from self-harm can also bring victims ultimate recognition after years of being spurned or neglected by partners or others (Meng, 2002). Cultural acceptability of self-harm and internalization of positive conceptions of self-harm may ultimately lower the threshold for self-harm in victims.

Furthermore, gender inequality in China—as manifested in women’s lower rates of educational attainment, incomes, and property ownership—may also lead to self-harm as a coping strategy for women who have few resources to face IPV and other forms of adversity (Law & Liu, 2008). A recent interview study found that Chinese women with prior
self-harm perceived more gender inequality than women without prior self-harm behavior (Zhang, Jia, Jiang, & Sun, 2006). A surge of feminist activities following the 1996 Fourth World Conference on Women in Beijing led to major reforms of the China Marriage Law in 2001, including the prohibition of violence between husband and wife (Article 3), and the granting of immediate divorce (Article 31) and financial compensation to victims of spousal violence (Article 46). However, nonmarried couples are not protected under the Marriage Law, there is no standardization to the award of financial compensation, and evidence of spousal violence must be proven by the victim (Ye, 2006). Revisions to the Law for the Protection of Women’s Rights and Interests also outlawed violence against women (Article 35), but are restricted to violence resulting in physical injury and there remains no standardization of the criminal prosecution and punishment of perpetrators (Milwertz, 2003). A further problem in rural China is that, as marriages are usually patri-linear and land titles are held by the husband’s family, divorce settlements often favor men in retention of common property (Zhang, 2006). To avoid undue hardship for the children, women often reluctantly agree to place children in the care of the husband’s family after divorce. Faced with this situation, IPV victims may turn to self-harm as a functional strategy to deal with feeling trapped and overwhelmed.

Clearly, more detailed exploration of the self-harming behaviors of IPV victims is necessary to inform screening, counseling, and prevention of self-harm in this vulnerable population. In-depth interviewing of these individuals is needed to explicate the complex network of factors that link IPV to self-harm. One source of such information is the calls that such individuals make to telephone crisis hotlines. In the current study, we analyze calls made to a crisis hotline in China by victims of IPV, who also report thoughts or acts of self-harm, to ascertain their reasons for self-harm and the relationship of their self-harm to their experience of IPV. We also discuss the cultural values placed on self-harm, the role of the family, and the culturally scripted gender roles in China to further contextualize and interpret their motives and experiences.

**Method**

**Beijing Suicide Research and Prevention Center’s Crisis Hotline**

Very few dedicated IPV hotlines exist in China, so victims may seek the help they need from psychological crisis hotlines and women’s hotlines. Crisis hotlines and women’s hotlines have emerged in large urban areas in China such as Shanghai, Guangzhou, and Beijing over the last 15 years. Their growth and potential contribution to mental healthcare in China are promising. Mental health care services are underdeveloped in China, particularly in rural areas. These services are appealing because of their accessibility, convenience, and anonymity.

The calls used for this study have been sampled from the Beijing Suicide Research and Prevention Center’s (BSRPC) Crisis Hotline, a national toll-free crisis hotline specializing in self-harm crises and depression. BSRPC hotline operators are men and women with previous education in mental health, who complete 4 months of hotline certification training and supervised calls before they are permitted to handle hotline calls independently.
The BSRPC Crisis Hotline is unique in that it routinely audio-records all calls and uses the audio recordings for operator training, hotline assessment, and quality assurance. On dialing into the hotline, a prerecorded message is played to callers stating that all calls will be audio recorded to assess the quality and characteristics of the service and that all identifying information is kept strictly confidential. Audio recording is computerized and begins automatically following the conclusion of the prerecorded message and transfer of the call to a hotline operator. The hotline operator has no discretionary ability in deciding which calls will be audio recorded and cannot override the computer system to stop audio recording. Hanging up the call terminates audio recording.

**Purposeful Sampling of Hotline Calls**

Linked to each audio recording is an electronic record containing detailed structured data on the characteristics of the caller, including the operator’s categorization of the major issues discussed during the call. We selected calls made to the hotline between January 2003 and October 2007 and that were classified as “domestic violence,” “beaten by spouse,” “beaten,” “abuse,” or “rape,” in which the victim’s abuser was her intimate partner (current or former recurrent sexual partner, boy/girlfriend, or spouse) and in which the caller also reported thoughts or acts of self-harm. Based on the rationale that callers would most fully describe the history of their self-harm and IPV during their first conversation with hotline operators, we only selected first-time calls. Desiring calls with in-depth discussion of self-harm and IPV, we only considered calls lasting for at least 15 min.

**Qualitative Data Analysis**

The basic data used in the qualitative analyses were the transcribed audio recordings of the 26 selected calls that meet the above criteria and that had been purged of all personal identifiers. The length of call ranged from 37.8 to 87.4 min ($M \pm SD = 57.4 \pm 15.6$); one call was unexpectedly terminated 74 min into the call due to connection problems.

We employed the analytical methods of Glaser and Strauss’ (1967) grounded theory approach to qualitative analysis, rigorously and methodically examining the data to assign codes to discrete phenomena and to identify explicative themes based on evidence iterated by the codes. Three coders (SW, CW, and MM) immersed themselves in the data, listening to the audio recordings and performing a line-by-line text analysis of the transcripts. Transcripts were coded for phenomena relating to the callers’ crises, experiences of IPV, and self-harm thoughts and/or behaviors; on average it took a coder 2 hr to complete the coding of one tape. Atlas.ti v.5.0 (Atlas.ti Scientific Software Development Gmbh, Berlin) qualitative analysis software was used to assist in coding the transcripts and in organizing the data. All calls were conducted in Mandarin Chinese and all analyses were conducted in Mandarin Chinese; results were translated to English for this Research Note.

The three coders independently coded each transcript and later compared the results for consistency, completeness, and consensus in the interpretation of the calls and designation of codes. All discrepancies were documented and arbitrated until coders reached agreement.
The three coders analyzed and discussed the first four calls; remaining calls were evaluated by two coders (SW and either MM or CW). Results were examined for emergent themes that clarified the relationship between IPV and self-harm and the counseling methods used by operators.

This study was approved by the Institutional Review Board at University of Pittsburgh and the Ethics Review Board at Beijing Hui Long Guan Hospital.

**Results**

**Demographic Characteristics of Callers**

Twenty-six callers, all of whom were women, met our inclusion criteria and were analyzed for this study. There were 11,575 female callers (whose calls lasted longer than 15 min) to the hotline during our study period. Table 1 provides a summary of the demographic characteristics of the 26 callers. All callers were currently in abusive heterosexual relationships: 24 women were in their first marriage, one caller was in her second violent marriage, and one caller was living with her intimate partner. The age range of callers was 24 to 61 years; the mean (SD) age was 34.3 (7.6) years. The majority were long-distance callers (i.e., from outside of Beijing), had greater than middle school education, and were currently in paid work. For 20 callers, their call to the hotline was their first interaction with any mental health services.

### Table 1. Characteristics of 26 Callers

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beijing residence</td>
<td>7</td>
<td>27</td>
</tr>
<tr>
<td>Female</td>
<td>26</td>
<td>100</td>
</tr>
<tr>
<td>Married</td>
<td>25</td>
<td>96</td>
</tr>
<tr>
<td>Middle school education or less</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Unemployed or laid off</td>
<td>11</td>
<td>42</td>
</tr>
<tr>
<td>Diagnosis of mental illness</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Previously sought help for her mental health needs</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Abuse disclosed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>26</td>
<td>100</td>
</tr>
<tr>
<td>Physical abuse during pregnancy</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Injury as a result of abuse</td>
<td>19</td>
<td>73</td>
</tr>
<tr>
<td>Sexual</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Verbal</td>
<td>21</td>
<td>81</td>
</tr>
<tr>
<td>Self-harm disclosed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts of self-harm</td>
<td>26</td>
<td>100</td>
</tr>
<tr>
<td>Previous acts of self-harm</td>
<td>14</td>
<td>54</td>
</tr>
<tr>
<td>Thoughts of self-harm and killing partner</td>
<td>3</td>
<td>12</td>
</tr>
</tbody>
</table>
Disclosure of IPV

All callers voluntarily disclosed their abuse to operators (three of whom were male) without direct prompting. Two women were hit for the first time just prior to calling the hotline, but the others reported repeated experiences of physical abuse. Several callers reported other controlling behaviors by their partners, including limiting contact with friends and family, coercion with the threat of violence, forbidding the taking of a job, and refusal of money for personal, family or household use. Nineteen women reported living in fear of their partner or his abuse and four believed that their partners might kill them.

Disclosure of Self-harm

As part of the routine assessment of all callers, each of the 26 callers was directly asked about current or previous thoughts or acts of self-harm, but several of them disclosed this information before being asked. Thirteen women had prior acts of self-harm with the express intent to die: slashing their wrists, ingesting pesticides, swallowing pills or attempting to drown themselves. Five women described self-harm such as wrist cutting and hitting oneself without fatal intent. Three women disclosed thoughts of wanting to kill their partners and then themselves, however none of them had a specific plan to carry out these ideas.

Relationship Between IPV and Self-harm

Self-harm thoughts and behaviors were most often triggered by specific episodes of violence. Thematic analysis identified several themes reflecting the motivations of victims’ self-harm and the intense feelings brought on by the violence. Self-harm was carried out to express intense distress about, extricate oneself from, or end the unbearable states of exhaustion, hopelessness, and oppression engendered by the abuse.

Life as Too Difficult to Endure

Nine women described their self-harm as a result of years of “enduring (renshou)” the abuse, with statements such as “I can’t endure it any longer, I am 60 years old, since I was 24 he has been hitting me. Up till now he still hits me. I really can’t take it, I don’t know how to keep on living, I don’t know what to do.” Most had endured their violent marriages for the sake of their young children and with the hope that their relationship would improve, whereas a few were influenced by their belief and/or their partners’ assertion that enduring suffering was what women should do: “I believe that to be a woman one must be—or at least, I think of myself as—quite virtuous, dutiful, delicate and even pretty. So why does he always hit me? He says I shouldn’t speak up, I should surrender, endure, and to not care if it is right or wrong to endure; women should just endure.” Yet the unrelenting violence left women feeling worn down and consummately exhausted: “I think living is so tiring [. . .] I have become numb to him ignoring me, hitting me. I don’t speak up anymore. Doing things makes me tired. My heart is so tired.”
Their drive to continue to endure was diminished by their belief that a life with violence was meaningless. Four women made similar statements: “There is no meaning to spousal violence. People should be harmonious and at peace, [my husband and I] are each other’s enemies. I think being alive has no meaning.” Seeing life as meaningless was accompanied by low self-esteem, which exacerbated their despondency: “When I think of [my marriage], I think to live like this is very tiring and meaningless. When I think of my situation, I feel like a failure.” Furthermore, the belief that others also did not value them affirmed that their life was not worth living: “My life is good-for-nothing: one, because it has no meaning; two, because I despise myself. And because I despise myself, others do not respect me. A life like this is no better than death; one might as well be dead.”

Death as the Only Remaining Option

Many callers saw themselves as having only few and discouraging options to deal with the violence. As described, staying with their partners and bearing the violence was unviable. The absence of any effective social and family support made callers feel powerless to end the violence:

There is no end with [my husband], I can’t take it anymore. I sought out his father, hoping he could solve the problem but he could not, it was useless. Then I started seeking out people in our circle of friends. I located his older sister, who lives quite far from us, in hopes that she could talk to him and turn him around. But it did no good [. . .] I have tried talking to him, I told him that when he is [violent] it makes me think of dying. At first he is apologetic, and maybe things might be alright, but then once he loses his temper, he is back to his old ways.

Sixteen women discussed situational impediments, such as unemployment, pregnancy, and physical illness that hampered their ability to leave their partners. Callers with little economic means, education, “social connections (guanxi)” and/or social standing were frightened that if they left their partners, child custody would not be granted to them or they would not be able to afford being single parents:

If we divorce, my child will have a single parent. I will need to struggle hard because I have no education, my financial situation is very unstable and I don’t know how quickly society will develop. I have been at home for three years now so there is a lot out there that I will have to adjust to. I am not one of those people with a brain. Suffering is what I know how to do.

Loss of “face (mianzi)” through divorce was regarded by four women as being as unfavorable as the violence itself: “If I get hit, I am certain that I wouldn’t be able to take it anymore. But to divorce, I can’t decide, I think it is shameful.” Fear of prejudice and of losing face also precluded callers from seeking out support from health care professionals, family, friends, and social institutions, who might be able to help them end their relationships. A few callers who desired to leave their partners had to seriously consider whether
divorcing their partners would lead to an escalation of violence or to more erratic behavior in their possessive partners:

At the beginning I already discovered his violent tendencies. But the minute I mentioned it, he said he was going to burn down the house. Our apartment walls were covered with paper and he set my bedding and pillows on fire, the door frames were on fire. Another time I ended the relationship, he used his fist to break a window, everything, his veins were all cut open. And then there was the time he crashed his car. His family was very scared, I was really scared.

Ultimately, both leaving and staying in the relationship seemed impossible for eight callers, and death emerged as an option to free themselves from their entrapment:

I think about getting hit by a car or lying on the train tracks to end it all, to free myself; if I end the marriage I couldn’t bear to think of how it will effect my kids, but if I don’t end the marriage, I will have to endure it only to be bullied to death.

Self-Harm as a Means to Express Emotions

All callers developed significant depressive and psychological symptoms from the abuse. Five women described:

It is like my heart feels so heavy, and at times I feel like my heart is in pain. I am so depressed I want to hit my head and scold myself. I am so depressed sometimes I think I will go crazy, that the pain will tear me open and explode from me.

Women were often isolated from social support and had no one to appeal to. Thus, many women made statements such as the following:

I feel very weak. Everyday when I open my eyes, I see my husband. When I close my eyes, I see him. There is no one around me to interact with but him. When I am feeling dejected, I have thoughts of abusing myself, I want to explode, to strike my head.

Fear of losing face also kept women from reaching out to others to talk about the abuse:

Last week he hit me and there was nothing I could do, I couldn’t fight him off. There was this throbbing in my head and I had to hit my head against the wall, to vent. You are the first person I have told about the situation with my marriage. Over these decades, I had preserved “face” by not telling anyone about it.

Unable to find an outlet to express their pain, women used self-harm as a means to vent their emotions:
One time I went into the kitchen and turned on the gas. My husband came in and dragged me out. I often seriously hurt myself. I wouldn’t dare hit other people, I wouldn’t dare hit my child, and when I fight with my husband, I don’t dare hit him either. And so I hit myself. I use things to hit myself. I think I can’t control my mood, I don’t know what to do, I really want to vent. Before I never used to throw things, now I throw things, I mean, I throw myself.

Discussion

The calls analyzed in this study underscore how powerful IPV is as a precipitator of repeat self-harm thoughts and behaviors. Self-harm can lead to significant injury and death, particularly in rural China where the preferred method of self-harm is ingestion of pesticide, a highly lethal substance often stored in homes (Phillips, Yang, et al., 2002). Death itself, however, is rarely the desired goal of self-harm (Hawton, 2000) and qualitative analysis of the self-harm crisis of IPV victims permits elucidation of the circumstances and motivations of self-harm from the victims’ perspective.

In this group of victims, some women had turned to self-harm because of no longer being able to “endure (renshou)” their partners’ violence, which they had done for so long to preserve their families. Renshou is culturally scripted as a characteristically female virtue whereby women “swallow bitterness (chiku)” for the sake of harmony (Tiwari, Wong, & Ip, 2001). Thus, to endure the violence is not necessarily a misplaced hope that the relationship will improve, but may be perceived as the culturally correct and self-affirming approach to dealing with the violence. Being unable to have a harmonious home left hotline callers seeing life as meaningless and themselves as failures. In Chinese society, where the family is paramount, a broken home can be devastating. A qualitative study of 10 IPV victims in China revealed that in spite of how difficult it was to endure the violence, all victims willingly strived to employ other strategies to cope with the violence rather than to seek divorce as a solution (Liu & Chan, 2007). In our study, callers believed that divorce would harm their children and ruin their “face (mianzi)” or dignity.

Although entrenched values placing primacy on renshou, family, and mianzi can prevent IPV victims from ending the violence, callers also cited multiple situational barriers, such as economic hardship and child custody battles. Turning to self-harm and death reflects the magnitude of the duress felt by victims who possess few resources and a narrow range of options to resolve the violence in their relationships. It also suggests how educational, financial, and legal impediments can be as powerful in terms of self-harm risk in IPV victims as intrapsychic factors.

Given that women in China are commonly socialized to bury their pain to maintain virtue or mianzi and that they have few resources and places to appeal for help when facing IPV, it is not surprising callers felt that the painful emotions they were harboring were going to burst from within them. Self-harm functioned both as an expression of internal pain and as a method of self-soothing. As reported in other studies (e.g., Farber, 2002), the shame and stigma surrounding abuse dispossess victims of their “voice” and severely limits their access to supportive persons with whom they can communicate their trauma. Moreover,
disclosure of abuse to other social actors may lead to retribution from violent partners, so self-harm may be a means for women to self-regulate and suppress their desires to speak out against partners.

Limitations

Close examination of 26 cases affords greater detail and understanding of the phenomenon of self-harm in IPV victims, but may not capture all experiences and explanations. Thus, this relatively small qualitative study is not representative of all IPV victims in China with self-harm or, indeed, of all hotline callers with IPV and self-harm crises. The depth and range of topics regarding callers’ experiences of IPV and self-harm available in the transcripts were limited to the extent to which hotline operators pursued issues callers felt comfortable with disclosing. Furthermore, callers who experienced IPV who had more urgent or immediate problems were not categorized as IPV by the operator, so they were not included in the current analysis. Last, follow-up calls from these callers were not assessed, so it was not possible to characterize the evolution of IPV and thoughts or acts of self-harm over time.

Conclusion

Current safety planning approaches with IPV victims emphasize devising strategies to avoid or reduce violence. Our study suggests that safety planning should perhaps also include screening for and addressing the severe psychological reactions and self-harm elicited by abuse. Increasing victims’ safety should include addressing all immediate life-threatening dangers, including self-harm.

Given the confidentiality, immediacy, and accessibility afforded by hotlines, they serve as an ideal avenue to conduct screening for and counseling on IPV and self-harm. The fact that the majority of callers reported that their hotline call was the first interaction with any mental health services suggests that hotlines may be the preferred first contact with mental health services for IPV victims. Although a relatively small number of callers experiencing IPV and self-harm were identified from the BSRPC hotline registry using our selection criteria, it cannot be assumed that self-harm in IPV victims is a minor phenomenon. Increased efforts are needed to train current hotline operators in identifying and counseling on IPV and self-harm and to spread awareness that these services exist.

Studies conducted elsewhere suggest that, in some cases, increases in female partners’ power or autonomy can result in greater, rather than less, IPV (Ellsberg & Heise, 2005). Nevertheless, increased efforts on the part of the government and nongovernmental organizations to ensure gender equality in law, education, and employment, and to increase women’s autonomy and decision-making power in the family will likely reduce the institutional precipitants of self-harm, increase women’s options for ending or escaping IPV, and erode barriers to accessing help and increasing safety. Such efforts will also challenge conservative positions on women’s roles, the family unit, and IPV that restrict victims’
options. Self-harm is a salient articulation of victims’ painful experiences of IPV; social and systemic changes are needed to combat this important public health problem.

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References


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