Suicide prevention and the broad-spectrum approach to health promotion

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Suicide remains a significant cause of death in the UK. In highlighting this tragedy, the British government, in Health of the Nation (Department of Health, 1992) and Our Healthier Nation (Department of Health, 1998), set targets for Health Authorities to introduce positive interventions and reduce the rates of suicide in the populations for which they were responsible. This is reiterated in Standard 7 of the National Service Framework for Mental Health (Department of Health, 1999). Unfortunately, for both users and providers of services, the relevant literature reveals an immense and complex diversity in thinking as to how this might be achieved. Theories of causation, procedures for assessment and strategies for prevention are numerous, and result in a variety of theoretical frameworks and interventions being presented to those involved in suicide prevention (McElroy, unpublished). One option, however, is to target high-risk groups; in particular, individuals who have attempted suicide or deliberately harmed themselves (Department of Health, 2002).

Morgan (Morgan, 1994) and others (Department of Health, 2002) have maintained that almost all completed suicides have a history of mental illness. It might, therefore, be inferred that suicide can be prevented by improving our knowledge and treatment of mental illness. In Sweden, for example, claims of this sort have been made following programmes that educated general practitioners in the treatment of depression (Rutz et al., 1992). The literature, however, indicates serious problems with the role psychiatry (i.e. the medical treatment of mental disorder) plays in relation to deliberate self-harm (DSH), particularly as many individuals find the care they are offered undesirable or unhelpful (Morgan et al., 1993; Sainsbury Centre for Mental Health, 1998).

Suicide prevention and the role of psychiatry

In managing these behaviours the psychiatrist largely follows the methods and procedures of the physician, looking to diagnose and treat. For the majority of patients who deliberately harm themselves, however, the rationale and implementation of this approach is problematic. A fundamental difficulty is that if we are to recognize a mental illness, we must have some means of knowing what an illness is, and in what ways it differs from undesirable experiences and states of being which are not illnesses. The so-called functional psychoses, e.g. schizophrenia, are illnesses because they result from abnormal physical processes in the brain which are now seen to respond well to certain drugs (Carpenter et al., 1987).

The majority of self-harming patients and suicidal patients, however, have disorders where there is no question of a somatic foundation or organic disease. Their problems do not manifest physical symptoms of a kind that would enable us to
‘diagnose’ by reference to an organic abnormality. Admittedly there may be biological factors predisposing a person towards neurotic or ‘unusual’ behaviour, but these are not as specific as those involved in a psychosis (McGuffin et al., 1994; Farmer and Owen, 1996). In other words, psychotic abnormality may be qualitatively different from normality, whereas neurosis and personality disorders are largely indicative of quantitative differences. When stress is too severe, we are all likely to suffer neurotic symptoms of some kind, or even contemplate suicide, but we are not all likely to experience schizophrenia or manic-depressive attacks. The distress an individual may feel following bereavement is a very real and potentially disabling experience, but it is hard to conceive of it as a disease or an illness. Where we are clearly not dealing with diseases or illnesses, but with behaviour determined by life experiences, the disease concept (however defined) largely loses its meaning. It follows, therefore, that the majority of self-harming and suicidal patients require ‘psychological’ help rather than ‘psychiatric’ treatment. In my own research, which examined the psychiatric care of patients with a history of deliberate self-harm, low self-esteem—usually attributed to ‘a difficult childhood’—was invariably identified as central to the patients problems.

James (James, 1890) argued that low self-esteem arises when self-evaluation reveals a ‘gap’ between an individual’s achievement (real self) and their pretensions or aspirations (ideal self). A major ‘symptom’ of many suicidal and self-harming patients is the dissonance between the ideal and the real self. Consequently, the aim of care is to close the gap between the ‘real self’ and the ‘ideal self’.

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Enhancing self-esteem as part of inpatient psychiatric care

Cooley (Cooley, 1912) pointed out the importance of subjectively interpreted feedback from others as a main source of data about the self. When Cooley coined his phrase, ‘the looking-glass self’, he had in mind that self-concept is significantly influenced by what individuals believe others think of them. This looking-glass self arises out of interactions between an individual and his or her various primary groups. The face-to-face relationships within the group serve to produce feedback for the individual to evaluate and relate to their own self-image. A person will value his or her self as they perceive others value or demean them. The end result is that individuals will conceive of themselves as having the characteristics and values that others attribute to them. Relationships are, therefore, a particularly important factor in the care of patients with low self-esteem. The interactions patients have with staff are integral to the enhancement, or otherwise, of their self-esteem. Henry et al. (Henry et al., 1993) reported a significant relationship between the therapist’s attitudes, interpersonal behaviours and the way patients acted towards themselves. Where therapists held negative attitudes about patients, this was subtly conveyed and led to an increase in patient self-blaming statements. When the purpose of psychological care is to enhance self-esteem, then success will undoubtedly be affected by the quality of the relationships formed between the patient and members of the care team. These relationships are possibly the primary vehicle through which care staff can affect the patient’s self-esteem. The purpose of assessment and management is, therefore, the provision of a ward environment which has, as its treatment aim, the strengthening of the patient’s self-concept, and that this is achieved—in Kohut’s (Kohut, 1984) terms—within the provision of soothing and mirroring relationships that lead to the restoration of the self. However, despite their apparent importance, overall the patients in my study did not consider their relationships with staff to be ‘therapeutic’. There were some strong and consistent indications that particular aspects of the social environment exacerbated the patients’ problems, and there appeared to be a direct causal relationship between interpersonal encounters which occurred on the ward and incidents of DSH (McElroy, 2003). Albeit subtle and unintentional, certain staff behaviours were often the immediate cause of a particular episode of self-harm. Palmer (Palmer, 1993) noted the...
ambivalent feelings that nurses can have toward the self-harming patient, and Pyke and Steers (Pyke and Steers, 1992) indicated that professionals more often have difficulties in establishing relationships with self-harming clients than with other groups. According to Alston and Robinson (Alston and Robinson, 1992), these patients evoke in the nurse negative attitudes such as fear, anxiety, anger and an absence of empathy. Boyes (Boyes, 1994) suggested that repetition of DSH often provokes frustration in staff at their inability to ‘cure’ the patient.

In examining alternatives to psychiatric care Hawton et al. (Hawton et al., 1998) conducted a review of the effectiveness of psychological interventions. Although two interventions were regarded as promising—Problem-Solving Therapy (Salkovskis et al., 1990) and Dialectical Behaviour Therapy (Linehan, 1993)—no intervention produced a statistically significant reduction in the repetition of self-harm. In addition, the methodological quality of research was regarded as poor; in particular, many studies were small and none included enough participants to give a reliable answer to the important question about the effect of either approach on suicide rates. Few used standardized measures of outcomes (such as mood or quality of life) other than repetition (Hawton et al., 1998). This heterogeneity in aims, coupled with widely varying study populations and interventions, meant that little conclusive data has been produced.

In summary, it is generally accepted that clients who deliberately harm themselves present mental health services with difficulties they are ill-equipped to resolve (Jones 2002), when low self-esteem is a feature of the individual’s problem the psychiatric system may actually exacerbate their problems.

**Suicide prevention through health education**

It is self-evident that prevention is always preferable to cure. This is especially so when, as is often the case with suicidal and self-harming behaviours, the treatments on offer are patently inadequate. The challenge for health educators, then, is whether they can reduce the need for psychiatric care in adulthood, by providing programmes for children and adolescents that have a positive, and lasting, influence on their self-esteem. In their description of a broad-spectrum approach (BSA) to mental health promotion, Mann et al. (Mann et al., 2004) argue that this is possible, and that the self concept should be regarded as a core element of health promotion and as a ‘fruitful basis’ for the prevention of a range of mental disorders. For example, they describe the critical role low self-esteem plays in the development of eating disorders in female school children and adolescents, and cite programmes in which the promotion of self-esteem is used as a main preventive tool in such disorders. They also suggest that the BSA would prevent a different manifestation of the same problem, as might occur when only specific symptoms or problems are addressed. For example, an eating disorder could be replaced by another type of symptom, such as alcohol abuse, smoking, social anxiety, or depression. They suggest that:

By encompassing the individual as a whole, within the BSA, the risk of such an eventuality could be reduced. (Mann et al., 2004)

Based on the evidence supporting the role of self-esteem as a protective factor in the development of mental disorders and social problems, they advocate a generic preventive approach built around the ‘self’. Support for this contention is contained in the suicide prevention strategy for England (Department of Health, 2002), which advocates promoting mental health among children, young people (aged under 18 years) and the wider population. The strategy also stresses the importance of general measures to improve mental health, and to address aspects of people’s life experiences that may damage their self-esteem and their social relationships, e.g. bullying in schools or in prisons, low educational achievement, racial discrimination, family conflict, isolation, violence and abuse. Standard 1 of the National Service Framework (Department of Health, 1999) for adult mental health adopts a similar broad
approach by stating that health and social services should value the importance of general measures to improve mental health and enhance self-esteem.

A BSA focusing on the enhancement of self-esteem could, therefore, have practical applications in preventing suicides. However, the development of self-esteem depends on a wide range of factors, some of which may be difficult for health educators to influence. For example, attachment and unconditional parental support during childhood and adolescence are critical factors in developing positive self-regard. In contrast to secure, harmonious parent–child relationships, poor family relationships are associated with internalizing problems and depression (Kashubeck and Christensen, 1993; Oliver and Paull, 1995). Approval and support from peers are also important determinants of self-esteem (Harter, 1999). Garber and Flynn (Garber and Flynn, 2001) found that negative self-worth develops as an outcome of low maternal acceptance and negative feedback from significant others. In short, ‘real’ relationships are the primary vehicle through which self-esteem is developed. Schools—regarded as an ideal setting for implementing BSA programmes—are complex social systems which have, in some particularly tragic cases, been causally related to the suicide of young people.

The design of future policies for mental health promotion and the prevention of mental disorders is currently an area of active debate (Hosman, 2000). A report by the Mental Health Foundation (Mental Health Foundation, 1999) summarized the evidence on mental health promotion for children and young people. It highlighted the significance of supporting parents during pregnancy and after birth with home visits, high quality child care, and helping through schools and community networks. Given the evidence supporting the role of self-esteem as a core element in suicidal behaviours, and the absence of effective ‘cures’, the potential for prevention in the form proposed by Mann et al. (Mann et al., 2004) must also be fully explored. However, a key question in the discussion is whether or not the sort of programmes they propose can compensate for school and/or home environments which damage rather than enhance self-esteem?

References


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