Suicide prevention in mental health care – time for new ideas?

Many authors have recently pointed out problems associated with the current recommendations for a risk-factor-based approach to the assessment of suicide risk and suicide prevention in mental health care. Here we will outline an alternative approach, which may be more appropriate with regard to suicidal patients.

We have previously pointed out that the *Nasjonale retningslinjer for forebygging av selvmord i psykisk helsevern [National guidelines for the prevention of suicide in mental health care]* (1) may have unintended and detrimental consequences for clinical practice (2). However, Mehlum and collaborators (3) and Emblemsvåg (4) defend the guidelines by comparing suicide prevention in mental health care to safety measures in road traffic.

This reinforces our concern that the ability to see each individual will be overwhelmed by the standardised assessments of risk factors that are emphasised in the guidelines. Straume appears to share our concern when asking, based on the guidelines' clear recommendations for emphasising risk factors in assessment of suicide risk: «What would be the effect of alternative use of time in terms of suicide prevention?» (5).

What is the alternative?

The risk-factor mindset is based on the biomedical illness model. Even though the notion of causality in itself is not always made explicit, this model is based on an idea of a linear cause-and-effect relationship that regards suicidal behaviour as the result of (caused by) various risk factors (6, 7). In terms of philosophy of science, however, speaking of *causal* explanations of human *behaviour* is questionable (8).

One alternative is to emphasise intentional/teleological explanations. Key questions in the assessment of suicide risk and its follow-up are consequently: What is communicated by suicidal thoughts or actions? What does this person wish to achieve through a suicidal act? What problems is this act intended to solve? (9) Thereby, the communicative aspect inherent in suicidality is included (9–11). Such questions will help reveal the subjective meaning(s) that the suicidality/suicidal act has for the individual.

Hereby, suicidality is linked to the context in which it appears. From the perspective of communication theory, suicidality is regarded not (only) as a matter *within* the individual, but as a matter *between* people – i.e. it is regarded in a relational and contextual perspective (11). This also includes the relationship between the client/patient and the therapist. For example, Jobes says that when suicidal persons seek help from a therapist, they are seeking for a *relationship* that may help them go back to wanting to live (12).

Belongingness and interaction in a given context provide a crucial background for understanding the *meaning* of suicidality to individuals, which in turn is important for being able to develop and provide adequate help (9). In clinical practice, understanding suicidality as communication may thus help the therapist to focus the treatment by systematically identifying the aspects that need to be reinforced, developed or changed in this person's interaction with his or her specific environment. This has been described in several models (10, 11) and may, for example, relate to improving the patient's self-perception, working to achieve a change in the environment or training in more appropriate communication skills.

Conclusion

It is possible that a communicative perspective on suicidality is being applied in clinical contexts somewhere. In the national guidelines, however, it is totally absent (10), despite the fact that two of the founding fathers of American suicidology, Farberow and Shneidman, described suicidal behaviour as acts of communication more than fifty years ago (13). Moreover, eight years before the publication of the national guidelines, Bøe and Thomassen pointed out the detrimental consequences of standardised procedures in psychiatric institutions with regard to matters such as suicidality (14). They found that such procedures were a hindrance to individual assessment and the opportunities of the professionals to exercise their competence.

A communicative perspective on suicidality paves the way for this. Today, when the problems associated with standardisation and the strong emphasis on risk factors in assessment of suicide risk and prevention of suicide in mental health care are being pointed out from several quarters, perhaps a change of perspective is worth a try?

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