INTRODUCTION

The Australian mental health system is in crisis; and not just a crisis of overwhelming demand for services, but one that goes to the heart of its fundamental approach. This branch of the health system appears least informed by evidence, least concerned with reliably quantifiable outcomes, and inexplicably nonchalant about the ineffectiveness of current suicide prevention initiatives.

The government and NGO mental health system, encompassing community, in-patient and a variety of education and awareness raising activities, is also the main vehicle for suicide prevention initiatives. As will be discussed, because of its unnecessary and potentially harmful use of pathologising language, and its conflation of suicide with mental ‘illness’, crucial suicide risk and preventative factors are overlooked. This conflation, and a misguided emphasis on depression, have also encouraged medical prescribing practices that are arguably flawed and liable to cause harm. These factors can only add to the burden of risk for many people whose experience renders them susceptible to suicide.

The article concludes by reflecting on the contradictoriness of some mental health campaigns focusing on stigma, and the need for a genuine attempt to demystify ‘mental health’ in order for a useful public conversation about it to occur.

Males are a major focus in the latter part of the discussion, because not only are males poorly engaged by the mental health system, they are most at risk of suicide, with by far the majority of completed suicides being male, and many males dying on their first attempt.¹ That said, the content of discussion is mostly relevant to both genders.

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WHY WORDS MATTER IN MENTAL HEALTH PROMOTION AND SUICIDE PREVENTION

The language used in the field of mental health has serious negative implications for the wellbeing of patients and clients. And it simply won’t do for mental health professionals to shrug this off because it is the accepted language of a dominant paradigm embedded in and accepted by mental health institutions.

Words, like the chisel of the carver, can create what never existed before, rather than simply describe what already exists. Martin Heidegger

Challenging the language of ‘disorder’ and ‘illness’

Take the example of individuals who experience situational distress, anxiety, or mood disturbance, and who seek professional support and help. For most, their GP will likely be their first port of call. They may quickly find themselves (often not more than 15 minutes later) with a diagnosis of depression, anxiety, or some other mental disorder or illness, as well as a script for medication.

Even if the GP is careful not to use the term disorder or illness, because so much broad scale advertising by large NGO mental health organisations describe depression and anxiety as disorders or illnesses, patients who have received a simple diagnosis, also discover they have been inducted into the category of ‘mentally disordered’ or ‘mentally ill’, and have medication to confirm and reinforce this status. Not uncommonly, they may then tend to redefine themselves, their competence and capacity, to fit their diagnosis and extra labelling, and the reinforcing daily routine of taking their medication. Like it or not, for many people this represents a retrograde shift in self-image, a potential negative alteration

¹ That said, the content of discussion is mostly relevant to both genders.
of life trajectory, and the creation of conditions whereby they are perceived and responded to by society negatively, and viewed by many mental health professionals more as objects than persons – objects of illness, diagnosis and treatment.

Words are not merely descriptive as one might imagine, they are causative.

Why do we persist in using this kind of language? In standard medical practice the use of diagnostic categories and terms has practical utility. But there is little reason to adopt this kind of language even in the most severe and debilitating cases of mental health difficulty. Granted, the use of such language does provide a kind of shorthand language for professional communication, but at what cost to patients and clients?

Employing language of illness and disorder benefits users of such terms by bestowing and implying professional authority and status. For allied health professionals, whose disciplines have always struggled for recognition alongside medicine, it has been opportunistically politic to adopt illness language as an occupational strategy: to achieve a better place and better conditions in the domain of professionals, and in the hierarchy of one’s own profession. It is also used to impress patients and clients, who unwittingly buy into the illusion that such language necessarily bespeaks knowledge and competence.

Does the use of illness language in mental health serve any defensible purpose? The answer to this question overlaps with the previous one. We do of course need to describe what we encounter in the experience and behaviour of people we seek to assist, but why not do so with language that avoids pathologising people – even if it requires a little more notation and effort? We would do well to remember the Hippocratic ethic, First, Do No Harm espoused by most if not all helping professions, which basically means that, in any given circumstance of patient or client care, it is better and more relevant to do nothing, than to risk causing more harm than good. This includes the potential harm that some forms of language can inflict.

The objection that might arise here is in relation to mental health difficulties that are potentially highly disruptive to people’s lives, like bi-polar difficulties, psychosis, severe depression, severe obsessive compulsive behaviour, and difficulties arising from fractured personality. Shouldn’t these conditions qualify as illnesses? Even if it could be argued that in some cases this is justified, the most important question is, how are patients or clients affected by disorder or illness labelling? That is surely what is of paramount importance? With any of these difficulties professionals providing therapy or treatment are still at liberty to discuss symptomatology, or orthodox classification of conditions with each other, whilst using non-pathologising language with patients and clients.

Consider someone experiencing schizophrenia. Despite its potential severity, even this does not necessitate being referred to as an illness, nor does it even require a diagnostic label for that matter. It is possible to help a person explore their experience, and to acknowledge how life has been severely disrupted for them by delusions, hallucinations, and other cognitive difficulties without labelling them as disordered or having an illness. They will almost invariably need help and support to formulate a way of responding to their experience – including with prescribed medication if that is clearly indicated. ‘Adding insult to injury’ by unnecessarily pathologising them with derogatory labels, without clear justification, constitutes injurious clinical practice.

Changing broad definitions

There is much debate about what mental health actually is. Is it a state of happiness, being able to cope and having a certain degree of self-confidence, or perhaps some state or degree of wellness or wellbeing? Some suggest it is simply the absence of mental illness.

The idea of mental illness is also hotly debated; though many mental health professionals, the media, and governments are prone to using the term as a ‘catch all’ phrase for any significantly challenging or troubling mixed experience of mind, thoughts, emotions, bodily sensations, or behaviours, other experts in the field strongly disagree. They argue that even the term mental health derives from and is the inevitable opposite of mental illness, and that the former would not exist without the latter.

Critics of the mental illness/mental health way of thinking argue that this wrongly frames ordinary, albeit sometimes very challenging and painful human experience or distress (which, yes, people will sometimes need help to get through) as illness, when it isn’t illness at all. They argue that there is no such thing as mental illness, only physical illness. If an organic, bio-chemical, or physical cause is responsible for disrupted emotional or mental functioning or behaving in a strange, dangerous, or self-defeating way, that is simply a physical illness or process that is having unwanted effects in a person’s experience and behaviour, not a mental illness. Further, they argue that the very term mental illness tends to demean, depersonalise and label people, and creates conditions where they are perceived and responded to by society negatively, and viewed by mental health professionals more as objects than persons, objects of illness, diagnosis and treatment.

For purely practical purposes the term mental health may (for the time being) need to be retained since it is almost irrevocably embedded in common use; to create completely new language might falter and have little impact if it is too far removed from the current language being used by medical and mental health professionals; language that is now deeply embedded in the community psyche. The term also provides a familiar and provisional starting point implying some sort of desirable wellness. A definition of mental health may encompass:
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An agreeable and functional quality of everyday experience involving one’s mental activity, emotions, physiology, reflexive and behavioural responses, and capacities.

An undesirable disruption of this experience – a disruption of mental health could simply be called – a mental health difficulty, encompassing the broad spectrum of emotional and mental functioning psychiatrists refer to as ‘mental disorder’ and ‘mental illness’. The severity of this difficulty could be registered as either a low intensity mental health difficulty or a high intensity mental health difficulty, thus avoiding the words disorder and illness altogether. This simple substitution may help preserve people’s dignity and enhance their wellbeing, whilst at the same time not trivialising complex difficulties the experience of which may on occasions be so painful, distressing, and seemingly inescapable, they can lead to potentially tragic consequences. To clarify further: anyone can experience a mental health difficulty; and everyone likely will at some stage of their lives. A mental health difficulty in most cases does not emanate from a physical illness or mental disorder. It is a common human challenge to be tackled creatively and constructively, including sometimes with the use of psychotherapy, and yes, medication, should that genuinely have something to contribute.

A Low Intensity Mental Health Difficulty interferes with a person’s usual or preferred mental, emotional, and social capacity, and perhaps as well, their experience of feeling capable and competent. Low intensity mental health difficulties are usually associated with major life changes and challenges, like: unemployment, sickness, loss and grief, money troubles, relationship difficulties, conflict, and stress. Low intensity mental health difficulties are common and are usually resolved through a person’s own coping ability, adjustments to lifestyle, and the support of friends and family. Of course, professional help may also be important, particularly if a person becomes ‘stuck’ and can’t seem to recover or move forward.

A High Intensity Mental Health Difficulty usually significantly impairs a person’s ability to function on a day to day basis and noticeably interferes with their usual or preferred mental, emotional, or social capacity, and their experience of feeling capable and competent. Such a difficulty, which may in some cases be a progression of a low intensity mental health difficulty, usually requires more than a person’s own coping ability, lifestyle adjustments, and support of friends and family. At least initially, it will may require mapping and analysing by a qualified health professional (a doctor, psychotherapist, psychologist, or, in some cases a psychiatrist), who will also suggest and perhaps provide appropriate psychotherapy (psychological therapy). In some cases, a General Medical Practitioner or Psychiatrist will also recommend prescription medication, which should be carefully considered for its potential to harm, evidence supporting its effectiveness (efficacy), and its appropriateness for the difficulty. If prescribed, it should be regularly reviewed both for any side-effects, and for whether it is genuinely helpful or still necessary.

A particular difficulty could, for the purpose of professional notation be accompanied by specific observations about a person’s disclosed experience, behaviour, physical and physiological effects, without ever having to suggest illness or disorder. Nor would this preclude doctors or allied health professionals consulting diagnostic manuals for clarification of the relationship between their observations and those published and discussed for their benefit by their academic or professional peers.

What is being suggested here is not really that radical, though it may be difficult to do in some settings in which traditional illness language use is entrenched. Nonetheless, each of us can do our part to change the status quo in our institutions and places of work, and the experience of our patients and clients, to that of one characterised by respect for the dignity of the individual, striving to ‘do no harm’ and to achieve the best outcomes for them.

CLARIFYING THE WRONGLY PRESUMED RELATIONSHIP BETWEEN SUICIDE, SELF-HARM, AND MENTAL ILLNESS

People with high intensity mental health difficulties have an elevated risk of suicide. These people may be much in need of and may benefit from timely and competent professional support. However, with many suicide deaths, there is no evidence of previous mental disorder.

Discredited research

Despite the now discredited ‘research’ suggesting a high prevalence of mental ‘disorder’ associated with suicide, much of the current approach to suicide prevention is still erroneously premised on a presumption of mental disorder. Whilst conditions like major depression may sometimes be implicated in cases of suicidal ideation and completed suicide, and are an important consideration in the design of appropriate preventive measures, this should not be considered license to assume an association with suicide to a degree that is unsupported by evidence.

Limiting preventive strategies to those built upon the unfounded presumption of mental disorder will simply not help many, perhaps the majority, of those at risk of suicide.

Effective suicide prevention requires that measures of prevention are non-pathologising, gender specific, and part of a broader more encompassing approach that takes account of social determinants. For this, we need to alter the language we use to better characterise the experiential context of suicide. The following language and definitions are suggested as an alternative with utility for working with patients and clients, and for adopting in verbal and written communications.
Situational and circumstantial distress as distinct from ‘mental disorder’

Situational distress encompasses a significantly challenging or troubling mixed experience of mind, thoughts, emotions, bodily sensations, or behaviours, associated with an apparent decompensating event, such as bereavement, a change in health status, relationship breakdown, financial, or occupational difficulties. This distress may significantly overlap with many of the symptoms usually taken to suggest mental ‘disorder’ (such as those associated with depression and anxiety). Where more severe or high intensity mental health difficulties* appear not to fit within the definition of situational distress, and require a more cautious and interventive helping approach, every effort should still be made to avoid unnecessarily pathologising individuals by using illness or disorder labels.

Circumstantial distress, in common with situational distress, encompasses a significantly challenging or troubling mixed experience of mind, thoughts, emotions, bodily sensations, or behaviours, yet is associated with apparent decompensating circumstances arising from a wider context than is usually the case with situational distress (such as the failure of a local employing industry, natural disaster, or community tragedy). As with situational distress, circumstantial distress may significantly overlap with many of the symptoms usually taken to suggest mental ‘disorder’ (such as those associated with depression and anxiety). Where more severe or high intensity mental health difficulties appear not to fit within the definition of circumstantial distress, and require a more cautious and interventive helping approach, every effort should still be made to avoid unnecessarily pathologising the individual.

Circumstantial distress is often associated with wider social determinants which affect not just an individual but a whole cohort of individuals. How an individual is affected may constitute their situation, but circumstantial distress arises from wider influences than those evident in an individual’s situation.

* In the event that situational or circumstantial distress lead to a high intensity mental health difficulty, therapy or treatment should not be confined to an individual problem oriented approach, but should be properly considerate of contextual correlates (outside influences and factors impinging on the experience of the individual). Not to do so, may exacerbate an individual’s sense of powerlessness and distress, and compound their difficulties. This is an important consideration particularly given that research suggests that for many men, their contact with the mental health system is unhelpful.

SERIOUS CONCERNS ABOUT THE USE OF ANTI-DEPRESSANT DRUGS IN SUICIDE PREVENTION

As mentioned previously, whilst conditions like major depression may sometimes be implicated in cases of suicidal ideation and completed suicide (as are high intensity mental health difficulties such as schizophrenia, and bi-polar affective disorder), and are an important consideration in the design of appropriate preventive measures, this should not be considered license to assume an association with suicide in general to a degree that is unsupported by evidence. In light of this, doctors prescribing anti-depressants, for suicidal ideation, for risk managing suspected suicide potential, or after a suicide attempt, need to consider the appropriateness of their decision to do so.

Flawed basis for antidepressant prescribing

There are several reasons for caution in prescribing antidepressants associated with suicidality. Firstly, the efficacy of anti-depressants are greatly overrated and appear to have a relatively small effect in patients broadly classified as having depression (which is the condition most commonly suspected by prescribers). 2 Secondly, when antidepressants are prescribed to risk manage suicidality, attention may be deflected away from situational or circumstantial factors that have greater relevance as targets of intervention for resolving the underlying distress that is giving rise to suicidality. To be blindsided in this way may have tragic consequences for suicidal patients/clients. Thirdly, it is incumbent on prescribers to consider current evidence suggesting that antidepressants may actually increase the likelihood of suicide.

Serious concerns about antidepressants

For some years now we have been aware that antidepressant medications are contraindicated for use with young adults. In the USA, the Food and Drug Administration (FDA) proposed that manufacturers update the existing warnings on their products’ labels to include the warning that anti-depressant medications can increase the risk of suicidality in 18 to 24 year olds during initial treatment. 3

Studies are now showing that we should also be concerned about the correlation between antidepressants and increased risk of suicide in adults. For example, a study published in Social Psychiatry and Psychiatric Epidemiology, in 2014 found that such drugs could make people nearly six times more susceptible to suicide. 4

In a study conducted by the US federal government, it was shown that in a pooled-analysis of short-term, placebo-controlled trials of nine antidepressant medications, patients taking an antidepressant had twice the risk of suicidality in the first few months of treatment than those taking placebo. 5
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In an issue of the British Medical Journal, research showed that antidepressants were estimated to cause 10 to 44 deaths in 1000 people over the period of a year, depending on the type of antidepressant. Interestingly, it only took 7 in 1000 cardiac events with patients prescribed the painkiller Vioxx, for the drug to be taken off the market.7

According to Harvard professor, Joseph Glenmullen, antidepressants are even in the frame for being associated with many murder-suicides.8

Antidepressant use in Australia

The latest health ‘snapshot’ of OECD nations has indicated that Australia is currently the second-highest prescriber of anti-depressant drugs. Australian use of antidepressants has doubled over the last decade.9

When these data are set alongside the fact that suicide mortality in Australia has increased by over 42 percent in the last decade, any presumption of antidepressant efficacy should be seriously questioned; likewise, the potential harm that arises from factors associated with antidepressant use in suicide prevention.10

SOME ‘HOME TRUTHS’ ABOUT THE ‘PROBLEM’ OF STIGMA

In recent times, we’ve been bombarded with media messages and images about ‘mental illness’ and ‘mental disorder’. For some people who themselves experience mental health difficulties, this language of illness and disorder hardly makes them feel normal; in fact, it reinforces the very stigma that some mental health campaigns (which themselves use this language) claim to be addressing. One also has to wonder whether in fact we are becoming desensitised by too much ‘marketed awareness’, and not enough understanding – at least of a kind that is helpful?

Demystifying mental health

What we do know, is that people fear what they don’t understand. And given that mental health difficulties are often happening within a person’s own experience rather than being exhibited in their behaviour or other outward signs, it is understandable that we have some trouble appreciating their significance, defining for ourselves what they are, and feeling comfortable in what is rather cloudy territory. All of this can interfere with how we usually like to ‘size a person up’ or read their mood and experience – something we are doing all the time in our relationships with others. What we can’t easily make sense of, we can find unnerving and disquieting. And of course, someone else’s experience of a mental health difficulty, should they happen to be a friend, family member, or partner, may by association, seem to imply something about us we would prefer it not to.

There is good reason then, why any public mental health promotion campaign will consider the importance of endeavouring to demystify mental health difficulties, providing people with up-to-date clear and accessible information; information communicated in a way that does not reinforce stigma, and that helps people feel more not less comfortable talking about mental health difficulties. The fact is, none of us are immune to such difficulties, they are common, and, more often than not, associated with adverse life experiences – something none of us are exempt from or privileged to escape.

Personal versus public conversations

As a community, we do need to become more comfortable talking about mental health difficulties and genuinely supportive of people who experience them. Nonetheless, when it comes to an individual talking about and disclosing his or her own emotions and very personal struggles and experience, privacy and confidentiality are a paramount consideration. Since these issues are especially important to men, we advise them of the following:

Each of us is entitled to personal privacy, and no, there should be no pressure to disclose anything you don’t want to. Sure, there needs to be a public conversation about mental health difficulties, but when it comes to your personal mental health, it is up to you to choose what you disclose, to what degree and to whom.

Of course, if you’re struggling to cope emotionally or psychologically and are developing or appear to have developed a real problem with your mental health, then you’re best off seeking out appropriate professional assistance and support. And when you do, you have every right to want to preserve your personal privacy, and to expect to be treated in a way that is sensitive to your experience and needs.

Health professionals and service providers have an obligation to provide proper confidentiality to all clients, and an approach that is respectful, informed, and appropriate to them. That this doesn’t always occur (and this is more of an issue for male clients) is precisely why some men don’t seek support and assistance when they need to, and is why some service providers have a poor track record of engaging with men. So, you need to be an informed and discerning consumer, and on occasions may need to ‘stick up for yourself’.

Examining venues where men must go to receive mental health support or psychological therapy, quickly reveals that confidentiality isn’t what it should be. It may be compromised by having to attend appointments at a conspicuous public facility, sitting on display in a public waiting area, and then having one’s name called out. Not quite what you’d expect confidentiality to look like. Sure, the notes the practitioner might take are confidential, and what is said in the interview room may be, but the rest of the experience can leave a lot to be desired. The effects of factors of this kind need to be understood for what they are and not conveniently hidden behind a more general notion of stigma.
Discussing mental health difficulties with a GP is favoured by some men for good reason, because though sitting in a public waiting area is quite uncomfortable for most men, at least in a general medical centre men can do so without anyone knowing why they are there. The challenge comes if the GP thinks referral to a psychotherapist, psychologist, or mental health practitioner is needful but such a service isn't offered discretely on the same premises. Incidentally, if you do go to see your GP about a mental health concern, be sure to book an extended or long appointment, so that your GP can give the time that is needed to properly hear and assess your needs. Further, we would suggest to men:

If you are referred on by a GP for some kind of psychological or mental health support or therapy, don't hesitate to ask the GP about the approach the professional or agency to which you are referred is known for in dealing with men. You might also like to ask the service provider how best they can ensure proper confidentiality for you. Yes, they may have to adjust their approach for you, and they may find this challenging, but they have a responsibility to provide a service to you that is in line with their charter of healthcare rights, or their value statement about client or patient confidentiality (nearly all services have these). It is time we challenged the way men are dealt with, and the discrepancy between rhetoric and what actually happens in some places where services are offered.

Difficulties we all share in common

One further issue to consider when it comes to cultivating a more public discussion of mental health difficulties, is the way in which current mental health literature and institutions communicate about them. Too often these difficulties are couched in technical terms, and are inappropriately described using the language of illness. The bulk of mental health difficulties can be explained simply, and should not be considered or referred to as illnesses or disorders. It only serves to reinforce stigma when these difficulties are unnecessarily medicalised and pathologised (referred to and depicted as a disease), rather than seen as a commonplace challenge that a good percentage of us will face at some time across our life-span.

Viewed as common and prevalent, and simply explained, mental health difficulties are more likely to become part of open community communication, and to elicit appropriate support for people experiencing them. We need to dispense with demeaning labels and see mental health difficulties as a common part of our shared human existence. As someone once said, 'Labels are for jars not people'.

Insiders admit that the mental health ‘system’ and its approach, is long overdue for an overhaul but is also strongly resistant to change. Be that as it may, each of us can contribute to a potent impetus for change, by becoming a little better informed about mental health and mental health difficulties, and by challenging language, labels, literature, slogans, and the practices of some service providers that do not show due concern or respect for human individuals experiencing difficulties to which all of us are potentially vulnerable.

REFERENCES:


