The only truly important problem

During the years 1990 to 1994 suicide was the second leading cause of death among US Air Force (USAF) personnel on active duty, accounting for 23% of all deaths in this population.[1] In 1996 the USAF implemented a comprehensive suicide prevention strategy that addressed suicide not only as a medical but also as a community issue. The strategy emphasized early intervention and protective factors such as support networks, a sense of belonging, coping skills and help-seeking behaviours. From 1994 to 1998 the suicide rate decreased significantly, from 16.4 to 9.4 suicides per 100 000 personnel, and the estimated rate for 1999 was 2.2 per 100 000. Suicide rates in other military services did not demonstrate a sustained decline over the same period; this suggests that the USAF strategy was effective.

The idea that incidence of suicide might reflect degrees of social integration was first introduced by Emile Durkheim's *Suicide* (1897), which demonstrated that Catholics were less likely than Protestants to commit suicide, that single people were more likely than married people to commit suicide and that rates of suicide decreased in inverse proportion to family size. On the basis of these observations Durkheim proceeded to develop an influential typology of "egotistical," "anomic" and "altruistic" suicide. He was subsequently criticized for explaining suicide by reference to social correlates only and for failing to account for personal motivations for what Camus called "the only truly important problem of philosophy."

For those who subscribe to the medical model, suicidal ideation is not, as Camus would have it, the reasoned expression of free will, but a neurochemical malady mediated by the genetic, biochemical and social milieu of the patient. Whereas it is both expected and appropriate for physicians to treat the biochemistry, it is less expected and logistically difficult for them to help patients establish social connections and networks. Surely some of this responsibility lies with the communities and forums such as the family, the neighbourhood and, increasingly, the workplace — where these connections should arise.

Recent research has furthered our theoretical and empirical understanding of the link between social networks and health.[2] Traditionally these networks have rested in the private domain of family and friends. But as both men and women spend longer hours at work, it is incumbent on employers and managers to foster social support at work. A recent longitudinal study of an occupational cohort demonstrated that marital status, social support within and outside the workplace and social networks predicted the likelihood of subsequent psychological distress. These results were similar for men and women and were independent of baseline mental status. A high level of social support in the workplace was associated with a reduction in short-term leave for psychiatric illness.[3,4]

On the other hand, with the exception of studies on sexual harassment, there is surprisingly little in the literature on the prevalence and costs of abuse, bullying and intimidation in the workplace.[5] Yet, as our patients sometimes tell us, such conflicts in the workplace do exist. Perhaps it is time for mental health research to focus on the workplace and, for a moment, to consider employee suicide as the only truly important problem of occupational health.

References

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