Title page for Clinical Insights

The Role of Clinician Fear in Interviewing Suicidal Patients

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The Role of Clinician Fear in Interviewing Suicidal Patients: Are we a modifiable risk factor?

Abstract

Researchers are increasingly interested in how clinicians should screen for suicide ideation (SI) in care settings and the merits of doing so (Berman & Silverman 2017, Dazzi, Gribble, Wessely, & Fear, 2014; Law et al., 2015, Ross et al., 2016, and Snyder et al., 2016). A common finding is that screening does no harm, and may do good, insofar as once the subject of suicide is broached clinicians can conduct a suicide risk assessment to determine the course of safe care. To date, little has been published about just how clinicians should ask "the ask" about SI (Berman & Silverman, 2016). The aim of this article is to suggest that the difficulty clinicians seem to have in initiating a verbal probe for SI has less to do with patient characteristics than it does with clinician anticipatory anxiety about learning that a patient is positive for SI. Face-negotiation theory and politeness theory are offered as possible explanations for why a simple direct question is so difficult to ask. Future research directions are suggested and an absence of data from public health gatekeeper training is offered as argument for clinicians to be more direct in their probes for SI.

Keywords: ideation-suicide-screen-clinician-fear

No one disagrees that suicidal ideation (SI) is poorly defined and less well measured (Valtonen et al., 2009, p. 53), or that just how to ask about SI remains a challenge. More research is needed. But before we get too far into the details about how to ask the ask, it might help to explore the problem of why clinicians and others don't ask at all, even when suicide warning signs are present.

Clinician failure to ask about SI in a frank, straightforward fashion may not be because they don't know how to ask a simple question, but because they fear a positive answer. An old saw in medicine says, "If you don't want to know if your patient has a fever, don't take her temperature." In probing for SI, the saw is, "If you don't want know if your patient is suicidal, don't ask." Or, if you must ask, ask a question that will get you an answer you can handle, not an answer you can't handle. *You're nothing thinking of suicide are you?* works quite well.

In one study of 1776 patients interacting with 48 primary care physicians in which depression and SI was explored via analysis of verbatim taped interviews, 75 cases endorsed SI on the pre-visit PHQ-9. Of these positives, only 13 had a subsequent suicide-related discussion with their physician (Vannoy & Robins, 2011). Translation: the majority of patients endorsing SI on a screen were never provided the opportunity to discuss ending their own lives with their doctor. The authors further noted that physicians frequently used language that encouraged suicidal patients to deny the SI they had just reported on their pre-visit paperwork. Here is one example: "Since we talked on the phone the other day, I know you're down, but you're not thinking of hurting yourself or anything?"

Answer, "No."

We might well ask, “What is going on here?” And, “Is it possible that our failure to ask about SI directly in someone endorsing SI in a paper screen is interpreted as tacit permission to proceed?”

We can’t blame patients for failure to disclose when they check positive for SI on a screening tool. We can blame clinicians for failure to explore positive endorsements of SI. Most likely, this failure is due to fear (Hendin et al., 2006). Fear drives avoidant behavior and clinician discomfort with suicidal patients is now being explored by a few researchers (Jahn, et al., 2016, Roush et. al, 2017).

From these reports, suicide-focused training is critical to mental health professional comfort in working with suicidal patients, but only if the practitioner believes their training was sufficient. Perceived insufficient training was associated with greater fear of suicidal patients (Jahn, et al., 2016). In the second study, approximately one third of mental health professionals reported not asking every patient about current or previous suicidal thoughts or behaviors at index appointments. Further, it was comfort, not fear, which was positively associated with conducting evidence-based risk assessments at first appointments (Roush, et al., 2017).

Given the dramatic training deficit among mental health professionals in how to work with suicidal patients (Schmitz et al., 2012), we might reasonably conclude that how to ask the ask is much less a problem than the fear to ask it at all. To date, no one can say how much training is required to reduce clinician fear about openly exploring suicidal behavior with their patients.

Maybe it is more than fear

A quick sortie into linguistics and face theory might clarify why what should be a simple question is so difficult to ask, and perhaps why suicidal patients don't just tell us they are experiencing SI. In Goffman's original article *On Face Work* he writes, "In any society, whenever the physical possibility of spoken interaction arises, it seems that a system of practices, conventions and procedural rules comes into play which functions as a means of guiding and organizing the flow of messages. An understanding will prevail as to when and where it will be permissible to initiate talk among whom, and by means of what topics of conversation" (Goffman, 1967).

In other words, there is a dance of conversation about certain topics that all cultures seem to share, and which accounts for why people do not speak frankly about taboo subjects. According to politeness theory, (Brown & Levinson, 1987), there are some things people just don't ask about directly. Sex is one such subject. Suicide is another (Pinker, private communication, 2007). Instead, there is a unique conversational logic and language that very carefully avoids what could be interpreted as intrusive, rude, or disrespectful and that might lead to an unpleasant confrontation, or as Goffman would say, a "face-threat."

Depending on the nature of the relationship of the two parties, asking directly SI is a potential face-threat. Asking about a patient's sex life was a face-threat in the 1950s, but no longer. Likewise, telling your doctor you are going to kill yourself is a face-threat. Suicidal people often use indirect language to communicate suicidal desire and intent to avoid a face-threat to others who, once confronted, may feel obliged to rescue or take some sort of action. In his book *Stuff of*

Thought, Pinker explains that the function of indirect speech is to negotiate potentially difficult areas of communication around such things as sex and suicide (Pinker, 2007). Pinker argues, "Polite indirect speech can use any hint that cannot be pinned down as a request by its literal content, but that can lead an intelligent hearer to infer its intended meaning."

The *You're not thinking of suicide?* probe is a polite, face-threat avoidant way to ask about a very taboo subject. The patient – an intelligent hearer – reads this true message between the lines: *If you are suicidal, please deny it now so we can move along to other matters.* Since patients are polite, too, the subject changes (Vannoy & Robbins, 2011).

The polite probe that begins with, *There is a question we have to ask everybody...* is a pre-apology for a pending face-threat question. The heavy employment of the PHQ-9, the Columbian-Suicide Severity Screening Rating Scale, and other paper-and-pencil screens – especially if filled out by patents in waiting rooms and handed to support staff in a bundle of paperwork – could be considered systemic policies and procedures designed to avoid potential clinician face-threats to suicidal patients. In a sit down face-to-face interview, face-threat avoidance is impossible if a direct question about SI is asked. As a result, anxiety-provoking, deep, and even existential encounters with patients struggling with whether or not to live or die are avoided.

Likewise, the *Are you thinking of harming yourself?* is a polite inquiry almost unrelated to suicidal self-directed violence. As Berman and Silverman point out, the difference between NSSI and a planned pistol shot to the brain in next hour are great (Berman and Silverman, 2017) . As Mark Twain said, "The difference between the almost right word and the right word is really a large matter – 'tis the difference between the lightning-bug and lightening"

Given the unacceptability of death by suicide around the world, the suicidal patient takes a terrible risk of being rejected and losing face if he or she is blunt in a statement of suicide desire or intent. If an unequivocal request for help with SI is made, the risk of ridicule, disbelief, or rejection loom large, as in some emergency rooms by some staff. Just as no teenaged boy asking a girl for a first date can deny the anticipated terror at loss of face if she says no, neither can suicidal patients deny the guilt and shame they will experience if their clearly stated desire to die causes the clinician to rock back in his or her chair, fold arms, and change the subject.

Why do we mince our words on both sides of this possible conversation when the subject of suicide is opened? From a fly-on-the-wall perspective, patient and clinician alike have no way avoid face-threat comfortably once SI is plainly owned by the first, and openly acknowledged by the second. Both are trapped in an office with one of the world's most unpleasant topics right there on the table between them. No one has a loophole through which to escape with face intact. And neither has plausible deniability that what asked by the clinician or answered by the patient was not intended.

Conversational Implicatures to the Rescue

A conversational implicature (Grice, 1975) is the means by which the speaker uses words to imply meaning without spelling out exactly what that meaning is. We all do it. *It's too dark in here to read* is an indirect request for the person closest to the lamp to turn it on. A clinician's observation that, *Some people with depression also think about suicide* is not a face-threat but a rhetorical statement to which the patient may respond, or not. By saying nothing, the patient is given an escape route and, without speaking, the two decide to accept the literal statement and skip the inherent question.

Because we all know how to "read between the lines" and decode messages, conversational implicatures are perfectly designed for clinicians and suicidal patients to talk about suicide while not actually talking about suicide. If a suicidal patient says *I'm suicidal and I'm going to kill myself*, the clinician must act. But if the patient says, *Nothing seems worth it anymore, I can't go on any longer,* the clinician can choose to ignore the implied message, offer some blandishment that things will get better, and change the subject. Likewise, the clinician can ask, *I trust you've had no thoughts of harming yourself?*, which can be decoded by the patient to mean, *If you are having thoughts of suicide I really don't know how to help you.*

Vannoy and Stevens addressed this "dancing without touching" style of clinical interviewing (Vannoy & Stevens, 2011). They identified words and phrases used by physicians to secure a negative answer to the SI probe even though the patient had earlier endorsed SI on the PHQ-9. To quote the authors, "We know of no research investigating the impact of micro-linguistic interviewing strategies on patient disclosure of suicidal ideation." Further, the authors' state, "...that when physicians ask about suicidal ideation, they often do so with negative polarity, which may inhibit full disclosure." In other words, they choose not to take the patient's temperature for suicide risk.

Suicide Prevention Gatekeeper Training

Many suicide prevention gatekeeper training programs teach participants to ask about SI. Some programs specifically teach scripted questions in how to do so. In one example, the QPR Gatekeeper Training for Suicide Prevention program, in which "Ask a question, save a life" was

first scripted in 1995 specifically to address the avoidance of the subject, the letter Q stands for the question to use in "the ask." (Quinnett, 1995). Because many suicide warning signs are indirect or oblique, trainees are taught how to ask clarifying question(s) to determine the real meaning of what is often a polite, face-saving effort to communicate terrible personal distress.

Some questions are more polite, e.g., *You know, when people are as upset as you seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way, too*. Other questions of the five taught are entirely direct, e.g., *Are you thinking about killing yourself?* It is the relationship of the gatekeeper to the person in crises that determines the form of the question chosen, e.g., a job supervisor might use one kind of question, whereas a friend and confidant might use another. Much more research in this area is needed,

What is also specifically taught in the QPR program is how *not* to ask the ask, e.g., *You're not thinking of suicide are you*? This how-not-to lesson is taught for the express purpose of helping gatekeepers avoid using a polite implacture that would allow a potentially suicidal person to retract any face-threat and deny current SI to the helper. In this program, the role of gatekeeper fear is acknowledged and countered directly through explicit language-use training and role-play practice.

The Absence of Data is Still Data

Nearly three million gatekeepers have been trained in QPR worldwide since 1995. Yet program leadership has yet to receive a single report that a suicide attempt or death has been

precipitated by asking directly about suicide during what must be thousands of interventions with potentially suicidal people over more than 20 years.

During WW II the RAF had hundreds of planes shot down by German anti-aircraft fire. Pilots and crews needed armor to protect them. But where to place the armor? The intuitive solution was to put the armor where the most bullet holes where, i.e., in the wings and fuselage. But Abraham Wald, a Hungarian-born mathematician, argued for just the opposite. The armor should go where there was no data, i.e., no bullet holes. Why? Because aircraft with bullet holes in those places did not return. The absence of data explained where aircraft were vulnerable to enemy fire; aircraft could fly with Swiss-cheese wings, but not Swiss-cheese engines. Thus, the absence of data was used to place armor around engines and saved the lives of hundreds of RAF airmen.

Might we save lives now by using a similar absence of data from citizen gatekeeper training? If thousands of gatekeepers are doing something wrong in asking directly about SI surely we would know it by now. Perhaps clinicians could use this absence of data to embolden them to be more direct in their probes about SI - in which case just about any direct question should work just fine.

References

Berman, A.L, & Silverman, M.M. How to ask about suicide? A question in need of an empirical answer. *Crisis*, 2017 Jul:38 (4):213-216. Doi: 10.1027-5910/a000501.

Dazzi, T., Gribble, R., Wessely, S., & Fear, N. T. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? *Psychological Medicine, 44*, 3361–3363.

Grice, H. P. (1975). Logic and conversation. In P. Cole & J. L. Morgan (Eds.), *Syntax & semantics 3: Speech acts*. New York: Academic Press

Hendin, H., Haas, A. P., Maltsberger, J. T., Koestner, B., & Szanto, K. (2006). Problems in psychotherapy with suicidal patients. *The American Journal of Psychiatry, 163,* 67–72. http://dx.doi.org/10.1176/appi.ajp .163.1.67

Jahn, R. J, Quinnett, P., & Ries, R. (2016). The influence of training and experience on mental health practitioners' comfort working with suicidal individuals. *Professional Psychology:]Research and Practice.* 47 (2), 138. http://dx.doi.org/10.1037/pro0000070

Law, M. K., Furr, R. M., Arnold, E. M., Mneimne, M., Jaquett, C., & Fleeson, W. (2015). Does assessing suicidality frequently and repeatedly cause harm? A randomized control study. *Psychological Assessment, 27*, 1171–1181.

Pinker, S. (2007). *The stuff of thought.* New York: Viking.

Pinker, S. (2007) Personal communication.

Quinnett, P. (1995). *QPR: certified QPR gatekeeper instructors training manual*. Spokane, WA: The QPR Institute.

Ross, A. M., White, E., Powell, D., Nelson, S., Horowitz, L., & Wharff, E. (2016). To ask or not to ask? Opinions of pediatric medical inpatients about suicide risk screening in the hospital. *Journal of Pediatrics, 170*, 295–300.

Roush, J. F., Brown, S. L., Jahn, D.R., Mitchell, S.M., Taylor, N. J., Quinnett, P., and Ries, R. (2017). Mental Health Professionals' Suicide Risk Assessment and Management Practices. https://doi.org/10.1027/0227-5910/a000478. © 2017 Hogrefe Publishing.

Schmitz, W. M., Allen, M. H., Feldman, B. N., Gutin, N. J., Jahn, D. R., Kleespies, P. M., ... Simpson, S.(2012). Preventing suicide through improved training in suicide risk assessment and care: An American Association of Suicidology Task Force report addressing serious gaps in US mental health training. *Suicide and Life-Threatening Behavior*, *42*, 292–304. 10.1111/j.1943-278X.2012.00090.x Crossref, Medline

Snyder, D. J., Ballard, R. D., Stanley, I. H., Ludi, E., Kohn-Godbout, J., Pao, M., & Horowitz, L. M. (2016). Patient opinions about screening for suicide risk in the adult medical inpatient unit. *Journal of Behavioral Health Services and Research, 44,* 364–372.

Valtonen, H. M., Suominen, K., Sokero, P., Mantere, O., Arvilommi, P., Leppämäki, S., & Isometsä, E. T. (2009). How suicidal bipolar patients are depends on how suicidal ideation is defined. *Journal of Affective Disorders, 118*, 48–54.

Vannoy S. D. & Robins L. S. Suicide-related discussions with depressed primary care patients in the USA: gender and quality gaps. A mixed methods analysis. *BMJ Open* 2011;2: e000198. doi:10.1136/bmjopen-2011-000198