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How do healthcare professionals interview patients to assess suicide risk?

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Abstract

Background: There is little evidence on how professionals communicate to assess suicide risk. This study analysed how professionals interview patients about suicidal ideation in clinical practice.

Methods: Three hundred nineteen video-recorded outpatient visits in U.K. secondary mental health care were screened. 83 exchanges about suicidal ideation were identified in 77 visits. A convenience sample of 6 cases in 46 primary care visits was also analysed. Depressive symptoms were assessed. Questions and responses were qualitatively analysed using conversation analysis. χ^2 tested whether questions were influenced by severity of depression or influenced patients' responses.

Results: A gateway closed question was always asked inviting a yes/no response. 75% of questions were negatively phrased, communicating an expectation of no suicidal ideation, e.g., "No thoughts of harming yourself?". 25% were positively phrased, communicating an expectation of suicidal ideation, e.g., "Do you feel life is not worth living?". Comparing these two question types, patients were significantly more likely to say they were *not* suicidal when the question was negatively phrased but were not more likely to say they were suicidal when positively phrased ($\chi^2 = 7.2$, df = 1, p = 0.016). 25% patients responded with a narrative rather than a yes/no, conveying ambivalence. Here, psychiatrists tended to pursue a yes/no response. When the patient responded no to the gateway question, the psychiatrist moved on to the next topic. A similar pattern was identified in primary care.

Conclusions: Psychiatrists tend to ask patients to confirm they are not suicidal using negative questions. Negatively phrased questions bias patients' responses towards reporting no suicidal ideation.

Keywords: Suicide, Risk, Communication, Assessment, Conversation analysis, Mixed methods, Mental health care

Background

Almost one million people die by suicide every year worldwide, equating to one suicide every 40 s [1]. Suicide risk screening and appropriate intervention is clinically important in both secondary and primary care. Around one in four people who take their life have been in contact with mental health services the year before death in the U.K. [2] and around one in three in the U.S. [3]. The majority of depressive disorders are diagnosed and treated in primary care [4–6]: 45% of people who took their life had been seen in primary care the month before death in the U.K. [7] with a similar figure of 47% in the U.S. [3]

Communicating about suicidal ideation is a delicate activity for both clinicians and patients. Omerov et al. [8] note a widely-held belief among professionals that enquiring about suicidal ideation can increase suicidal tendencies. Cole-King and Lepping note that professionals in the U.K. may feel disinclined to enquire too deeply because of lack of confidence in knowing how to ask and how to respond [9]. From the patient's perspective, communicating about suicidal thoughts and plans is complex. Patients may disclose suicidal thoughts, be ambivalent and not fully disclose them or may have made up their mind to attempt suicide and make every attempt to conceal this [10]. Moreover, suicidal thoughts are dynamic and can change rapidly [11]. People with experience of suicidal thoughts and attempts report that willingness to disclose distressing thoughts and plans is dependent on trust and the relationship [12, 13].

Silverman and Berman [14] suggest that assessing suicidal risk in clinical practice is influenced by the skills and philosophy of the individual clinician. Nonetheless, there

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are various guidelines on what to assess including life history, previous suicidal attempts and mental state [15–17], `along with helpful frameworks for how to assess risk [12, 18, 19]. There is considerably less guidance, however, on how to interview patients about suicidal ideation. This is important because *how* doctors and other professionals ask questions, i.e., the words and phrasing that they use, influences the patient's response [20]. Some guidance recommends asking neutral or non-leading questions [21] and/or direct questions (e.g., "Have you had any thoughts about killing yourself?) [22].

A growing body of research on medical interaction has found that yes/no questions are prevalent in medical interaction and communicate an expectation in favour of either 'yes' or 'no' responses through their grammatical structure and specific words that favour 'yes' or 'no' responses [23], e.g., "Are you feeling low?" is framed positively, inviting agreement to "feeling low" [24, 25]. Conversely, "Not feeling low?" is negatively framed inviting agreement to "not feeling low". Specific words with positive or negative polarity further reinforce bias in medical questions [26]. Words such as 'any,' 'ever,' 'at all' reinforce negative bias (e.g., "Any negative thoughts?") while words such as 'some' reinforce positive bias (e.g., "Do you have some pain here?") [26].

However, there are no observational studies of how patients are interviewed about suicidal ideation in practice. Hence, this study aimed to analyse how psychiatrists ask questions about suicidal ideation and how patients respond in community mental health care. A small convenience sample in primary care was also analysed.

Discussion

There were three main findings from this study. Firstly, questions about suicidal ideation were closed yes/no questions designed to constrain the patient's response to a yes/no. All were leading questions with three-quarters inviting the patient to confirm they were not feeling suicidal. More than half of the psychiatrists always framed the question negatively, with a minority always framing the question positively. Secondly, a subtle difference in the wording of the question biased the patient's

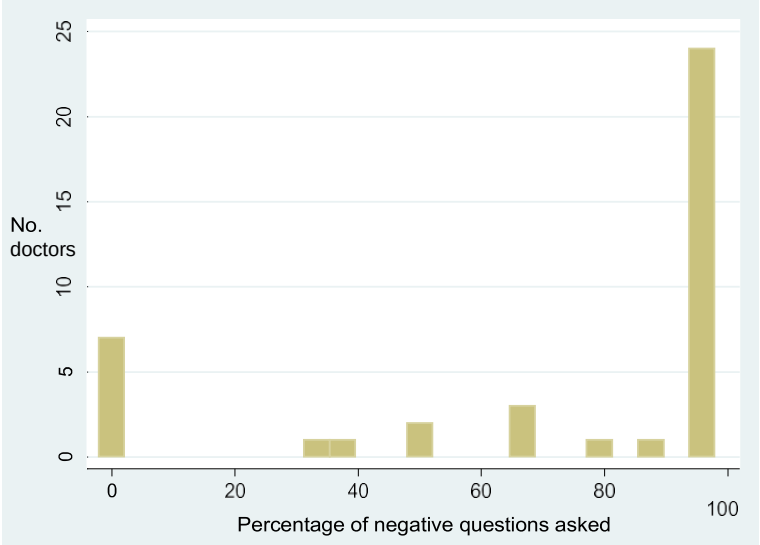

Fig. 2 Distribution Of Questions Designed For No

response. Negatively framed questions significantly biased the patient's response towards a no 'suicidal ideation' response. If the patient responded yes, further information gathering was conducted. However, if the patient responded no, the psychiatrist moved on to other topics with no further risk assessment.

Finally, patients responded with a narrative in one-quarter of cases. Narratives conveyed some suicidal thoughts and were pursued with closed yes/no questions.

That questions about suicidal ideation were more likely to be negatively framed is consistent with other research on doctor questioning. Typically, doctors design questions for the 'best case' patient outcome, e.g., "Not feeling low?", identified as the principle of optimization, a default feature of medical questions [25]. Previous research also found that doctors' questions bias patients' responses. In a randomised controlled trial, doctors who asked "Do you have *some* other concerns you would like to discuss?" inviting a yes, versus "Do you have *any* other concerns you would like to discuss?", inviting a no, were significantly more likely to elicit and reduce unmet concerns compared before and after the visit [31].

In asking about suicidal ideation, optimized or 'no problem' questions are problematic because they minimise the disclosure of suicidal ideation, a tension also described in other medical settings [35]. Gao et al. [36] found that patients were more likely to minimize the frequency and severity of suicidal ideation during clinician ascertained assessment compared to self-report. The current study sheds some light on these and other findings from the U.K. National Confidential Inquiry into Suicide [37] that most people who took their life were classified as 'low risk' in contacts with mental health services. In the U.S., Smith et al. [38] also found that most patients dying by suicide "denied suicidal ideation" in their final contact with services. Furthermore, Haynal-Reymond et al. [39] found that psychiatrists' written predictions predicted 22.7% of future attempts. However, psychiatrists' nonverbal behaviour, specifically frowning and gazing at the patient for longer, predicted around 90% of future attempts. This suggests a perception of risk, of which doctors are not consciously aware, that is overridden by verbal communication.

The findings should be considered in light of the study's strengths and limitations. This is the first systematic analysis of how psychiatrists interview patients about suicidal ideation using real time data. Conversation analysis shows how one word can tilt the question positively or negatively. Although the findings were similar over time across different psy- chiatric samples, they may be specific to these patient groups and settings. The data, although collected across urban, semi-urban and rural settings, were col- lected in the U.K and practice may vary across coun- tries. This qualitative study did not study factors such as diagnosis, sex and previous suicide attempts. A gold standard assessment such as the Columbia Sui- cide Severity Rating Scale was not used. However, such scales are not used in routine practice. Never- theless, psychiatrists' choice of questioning may reflect their intuitive assessment of risk. Finally, the consent rate was less than 50%: patients who consented may not be fully representative of the patient population.