Sense & Sensitivity.

On situated questioning about self-harm and suicidal inclination in the primary care consultation.

Paul K. Miller

The Study.

- Emerges from a study of diagnosis of depression in primary care.
- Conversation Analytic methodology.
  - Don't panic!
- Data recorded during primary care consultations in NW England (NHS Ethics Approved).

Background.

- Link between depression and suicide is, in modern medical knowledge, a 'given'.
- Canons of contemporary psychiatry specify that 'suicidal ideation' (like the physical acts of self-harm and actual suicide) is at once:
  - A symptom of the illness and, simultaneously;
  - A 'characteristic' (if not inevitable) outcome (World Health Organization 1994; American Psychiatric Association 1994).

As A Symptom.

"Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide."

(American Psychiatric Association 1994:327)

As an Outcome.

"Depression is the leading cause of suicide…Nearly two-thirds of deaths by suicide occur in people with depression (that is, about 2,600 suicides per year in England alone)."

(NICE, 2009:594)

Important Note.

- Other eight listed APA/WHO symptoms (weight loss or gain, psychomotor retardation or agitation, depressed mood and so forth) all of are to some extent observable directly.
- 'Suicidal ideation,' unless directly actually acted upon, is *only* accessible through self-report by a patient.

Risk Assessment.

- Guidelines produced for British GPs regarding how to deal with a case, or suspected case, of depression clearly stipulate that a GP should explore the danger that a patient represents to themselves via a direct question on the topic.
- Official NICE guidelines on the management of depression in primary and secondary care explicitly states:
  - "Always ask people with depression directly about suicidal ideation and intent." (NICE, 2009:120)

Moreover…

- As the data explored in this presentation illustrates, in practical circumstances eliciting such information can actually become central to reaching the *diagnosis* itself.
- The question, therefore, is sometimes asked *before* the diagnosis is actually delivered.

Normative Guidelines.

- Institutionalisation of common-sense rules for 'getting the best results' in depression-related consultations:
  - Asking 'direct' questions;
  - Using 'open' questions;
  - Asking about feelings;
  - Not hurrying the consultation;
  - Employing a friendly and empathic style;
  - Asking for clarification of verbal cues;
  - Never interrupting a patient.

(All derivative of Paykel & Priest, 1996)

Cognitive Model.

- Guidelines such as this grounded in cognitive model of language-use.
- Language a simple means by which information moves from brain-to-brain.
- 'Efficient' and 'inefficient' methods for such information-capture – guidelines taken to be efficient.

Derek Edwards (1995, p. 582)

"Language can be conceived of in the first instance as a medium for social actions, rather than social actions being a windfall consequence of people representing things mentally in what turns out luckily, or for biological reasons, to be a shared symbol system."

- Pull yer socks up!

Harvey Sacks (1992:11)

"When people start to analyse social phenomena…you figure that [the speakers] couldn't have thought that fast. I want to suggest to you that you have to forget that completely. Don't worry about how fast they're thinking. First of all, don't worry that they're 'thinking'. Just try to come to terms with how it is that the thing comes off. Because you'll find they can do these things…So just let the materials fall as they may."

- Freedom fighter / terrorist.
- Exuberant / overbearing.

"Prescribed" Questions *Generic*.

- In everyday conversation, participants orient to prior turns and previously disclosed information in the design of questions and answers (Sacks et al. 1974).
- Suchman and Jordan (1990) and Antaki (2002) - prescribed questions (of any form) during an interaction may well violate this natural flow of talk.
- Putting aside, for a moment, the implications of asking prescribed questions *about self-harm or suicide*, it is still important to note that there are practical problems with asking 'set' questions of people in general.

Contd.

- Not only is the usual contextually and sequentially sensitive nature of everyday questioning likely to be *noticeably* absent, but the possible types of answer that can be produced are also limited.
- The upshot of this type of questioning, as Hutchby and Wooffitt argue, is that it may '…become very irritating to the respondent…' (1998:176) in a range of ways:

1. It may appear to request information that the respondent has already provided (i.e. appear 'irrelevant'),
2. It may constitute abrupt (and unaccounted for) changes of subject (i.e. seem 'out of place'),
3. It may prevent the respondent from disclosing information that has become contextually relevant from prior utterances.

- These problems manifest particularly in 'structured interviews'.

"Prescribed" Questions *Specific*.

- Is there ever really a "good" time in conversation to ask if someone has considered harming/killing themselves?
- We tend to assume that there is a global 'stigma' attached to the substantive issue that might cause people to "recoil." BUT:
- Evidence shows that <u>the manner in which an issue is handled in specific interactions themselves</u> is far better arbiter of how questions "sensitive" topics are received than theorised stigmas. (Jefferson & Lee, 1981; Heritage & Sefi, 1991; Silverman, 1997; Maynard, 2004).

Interactionally…

- Question as a diagnostic tool (pre-diagnosis) or as 'risk assessment' (post-diagnosis) carry different interactional implications.
  - Post-diagnosis – diagnosis itself a sense-making resource for patients.
  - Pre-diagnosis – very much dependent upon context - presented symptoms etc.
- Data examined here address cases of the latter.
- *Operational socio-linguistic problem for GP: <u>HOW</u> to accomplish a potentially tricky interactional task when patient might well not be expecting it.*

Issues.

- Problem in prescribing both what and *how* in interaction (McLeod, 1994; Silverman, 1997) – renders all of problems with structured interviews.
- Evidence from study indicates GPs actually very good at negotiating tricky moments, though NOT necessarily by following normative guidelines.
  - Use of practical, ad-hoc social skills.

Issues.

- GPs use these skills to achieve several specific outcomes in such questioning.
- Two most common methods:

1. Formulating question to accommodate the fact that it might sound "out of place" at that stage in the consultation.
   - i.e. adapt the question to the interactional context.
2. *Making* question situationally relevant, which often involves *creation* of relevance.
   - i.e. adapt the interactional context to the question.

Indirectness.

Analysis 1.

- Silverman (1997), however, has demonstrated at length the manner in which such perturbations (or, in his terminology, 'turbulence') are routinely utilised by speakers to explicitly display an orientation towards the embedded material of an utterance as 'delicate' or 'unexpected.'
  - have you at any (.) er::: (.) ti::me? (.8) wo::ndered or (.) well:: (.) thought that it might not be (.) you know (.) °well:: ° (.8) worth it?
- 'Vagueness' here, moreover, is something actually worked up in the phrasing of the question, formulation in the most everyday, ordinary terms available for this topic:
  - 'thinking it might not be worth it' vs. 'thinking about committing suicide' or 'having suicidal thoughts'.
  - Also reference to occasional ('at any time'), formless ('wondered') and non-determinate ('might') thinking about this matter.

Analysis 2.

- Structure of question here both forewarns patient that issue might be delicate (i.e. seem out-of-place), and also allows for easier disclosure should answer be affirmative.
- Indicates that GP reasons question may be received unfavourably.
- Patient only has to admit to occasional thoughts, rather than firm ideation – a starting point for discussion – rather than negotiate down from a "direct" question.
  - Indicates inference that directness often has the character of accusation.
  - Everyday life situation – we allow people to enter difficult admissions on easier terms. "Is it possible that you accidentally..?"

Relevance.

Analysis 1.

- "Interruption" *preserves* a particular point of consensus:
  - "You don't know how to cope" – not *really* a question, more a summary.
- Sequenced from this assertion, follow-up question seems very *relevant* indeed:
  - "Do you ever think that its just all too much or that you can't carry on?"

Analysis 2.

- Question itself more direct than in first example (though still framed indirectly to a degree) because relevance has been manufactured *through* the interruption.
- Evidence from general social life: making our point relevant, "steering" a conversation rather than running on *non-sequiturs*.

Concluding Thoughts.

- Over-commitment to normative frames for "good practice" in communication often leads us to overlook the good sense in what people are doing.
  - Instead evaluate productive actions as "correct" or "incorrect" according to deductive frame.
- GPs often interpret the "spirit" of the rules, rather than the letter of them – there are often positive functions in putatively "dysfunctional" activity.
- Normative guidelines display no apparent understanding of *when* in interaction, just what and how.
- Timing and wording are reflexively aligned – to address the latter without the former risks doing as much harm as good when trying to elicit sensitive information.