

Hearing the Suicidal Patient's Emotional Pain

A Typological Model to Improve Communication

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Abstract. *Background:* Escaping from emotional pain is a recognized driver in suicidal patients' desire to die. Formal scales of emotional pain are rarely used during routine contact between patients and their care team. No study has explored facilitators and inhibitors of emotional pain communication between staff and suicidal patients during regular care. *Aims:* To identify factors impeding or facilitating emotional pain communication between patients at risk of suicide and mental health professionals. *Method:* Nine patients with a history of a medically serious suicide attempt and 26 mental health (NHS) staff participated in individualized and focus group interviews, respectively. *Results:* A typological model was created, describing how patients either speak out or inhibit communication, and professionals may hear the communication or fail to do so. Four permutations are possible: unspoken/unheard, spoken/unheard, spoken/heard, and unspoken/heard. We found 14 subthemes of impediments and facilitators, which include misaligned, alienated and, co-bearing. *Limitations:* No male patients participated. *Conclusion:* Numerous factors influence whether emotional pain communication is responded to, missed, or ignored. Patients may try more than one way to communicate. Some patients fear that being able to speak out results in their emotional pain being taken less seriously. Knowledge of this model should improve the care of suicidal patients.

Keywords: suicide, emotional pain, communication, risk, qualitative

Escape from emotional pain has been a recurrent theme in suicide notes (Leenaars, 1989; Orbach, Mikulincer, Sirota, & Gilboa-Schechtman, 2003; Shneidman, 1979), and high psychological pain has been identified as a risk factor for suicide (Olié, Guillaume, Jaussent, Courtet, & Jollant, 2010; Troister & Holden, 2010). In a study of low-lethality versus high-lethality suicide attempts, Levi et al. (2008) found that over and above the level of pain experienced, it was the difficulty in communication that predicted the seriousness and lethality of the suicide attempt (see also Levi-Belz et al., 2014).

Researchers have deduced that eliciting information from suicidal patients specifically about emotional pain might indicate levels of suicidality, and developed scales to this end (Holden, Mehta, Cunningham, & McLeod, 2001; Orbach, Mikulincer, Sirota, & Gilboa-Schechtman, 2003; Orbach, Mikulincer, Gilboa-Schechtman, & Sirota, 2003; Mee, Bunney, Reist, Potkin, & Bunney, 2006). The collaborative assessment and management of suicidality (CAMS) model (Jobes, Wong, Conrad, Drozd, & Neal-

Walden, 2005) uses formal interview questions on emotional pain to guide therapeutic interventions.

Professionals may be reluctant to administer formal scales (Boswell, Kraus, Miller, & Lambert 2015) especially during routine contacts or when under time pressures. On the other hand, without such structured means, how do patients communicate this pain? How much of it can staff pick up and how? How do professionals detect emotional pain before the patient seeks to escape it through suicide?

To date, no studies have explored emotional pain communication between patients and professionals during routine mental health care. The aims of this study are therefore to:

- Clarify how patients communicate pain; and
- Identify the barriers or facilitators to communication to improve clinicians' ability to intervene more effectively.

Method

Design

The study comprised patients and professionals recruited from the same NHS Trust:

1. Focus groups of mental health staff, organized by profession, who work with suicidal adult patients.
2. Individual interviews with patients who self-identified as having emotional pain and who had engaged in at least one medically serious suicide attempt.

Staff Focus Groups

Professional focus groups were chosen to enable group dynamics to stimulate contributions (Kitzinger, 1994) and to elicit information about cultural rather than individual responses within each profession. In all, 26 staff members from the five core professions in a typical multidisciplinary NHS mental health team participated: occupational therapists, nurses, social workers, psychologists, and psychiatrists.

Patient Interviews

Ennis and Wykes (2013) report that high collaboration by service users in study design is correlated with better recruitment figures. A group of patients who had received treatment for suicidal behavior in the Trust were therefore invited to participate in the study design. These *experts by experience* indicated a preference for individual rather than group interviews and for an informal meeting with the researcher before the taped interview.

Of 10 patients attending a familiarization meeting, nine went on to complete the recorded interview. Having an introductory meeting followed by the formal interview was designed to allow patients thinking-time before being recorded, and the 10th patient, on reflection, decided to decline the second meeting.

Participant Recruitment

Criterion-based purposive sampling was used to recruit staff and patient participants.

Staff Participants

Inclusion criteria for staff, recruited via in-house communication, were:

- Qualified or trainee in nursing, social work, psychology, psychiatry or occupational therapy; and
- Working with adults at risk of suicide within the NHS Trust hosting the research.

Patient Participants

Primary recruitment agents were staff members involved in the focus groups, who helped recruit patients via snowball sampling, plus strategically placed posters so that patients could self-refer. Inclusion criteria were as follows:

- Current patients of Adult Mental Health Services who identified themselves as having direct, lived experience of emotional pain via the Emotional Pain Brief Screening Inventory, a self-report measure designed specifically for the study (Dunkley, 2014).
- A past history of one or more medically serious suicide attempts (MSSA) plus current suicidal ideation. An MSSA is an incident in which the patient has expressed intent to die, and has engaged in a self-injurious act requiring hospitalization for at least 24 hr (Levi-Belz et al., 2014).
- Willing to be audiotaped (or if unable to communicate verbally to submit other forms of material that could be coded as part of the study).

Three quarters of the way through the study it became apparent that only female patients were being referred using these criteria, and the study team debated at length the issue of altering the recruitment method, finally deciding against proactively seeking male participants.

Patient numbers were deliberately low as each one produced around 600 units of speech to be analyzed, sorted, and re-sorted into meaningful categories.

There were no exclusion criteria for staff or patients who met the inclusion criteria listed.

Data Collection

In both focus groups and interviews, participants read a list of prompting questions and then were asked to begin with items they considered the highest priority, even if this meant moving away from the written prompts. All groups and interviews were digitally recorded.

Focus Groups

Groups were conducted where staff could access them easily; in three in-patient units and two mental health team bases across a wide geographical area.

Participants described their observations of emotional pain in their patients, their own experiences of being in receipt of pain communication, and factors they believed might inhibit or facilitate open communication. After approximately 45 min, participants read a list of categories of responses made by general practitioners to emotionally laden communications from patients. This was to act as a further prompt, building on research already conducted (De Coster, 1997).

Patient Interviews

Interviews were conducted either at the patient's home, hospital ward, or usual treatment center. Patients completed the Mental Pain Scale (Orbach, Mikulincer, Sirota, & Gilboa-Schechtman, 2003).

The interview schedule contained questions about the experience of having emotional pain, barriers to communicating this pain to the mental health team, and anything that would inhibit or facilitate communication.

Ethical Considerations

The study was approved by an NHS Ethics committee, which decided that no participant who wished to contribute should be refused on medical grounds. Patients consented to their mental health record being accessed so that the researcher could view their most recent risk assessment. All interviews were conducted by a skilled mental health professional with extensive experience of helping patients in crisis, in case the content triggered suicidal urges.

Data Analysis

Iterative, inductive thematic analysis was conducted on all interview data. Text fragments were coded into categories that were grouped into subthemes and then overarching themes. Themes were subject to ongoing peer-review. A critical realist approach to analysis was taken, based on the work of Bhaskar (1978) and Houston (2001). This offers a philosophical stance between constructivism and positivism, where a single reality may have multiple interpretations.

Results

Participants

Staff

Staff were all employees of a large NHS Trust in Adult Mental Health Services. The nurse and psychologist focus groups were all female; the others were mixed gender. Clinical groups represented were:

- Five mental health community treatment teams (urban and semirural locations);
- An assessment and brief intervention team;
- An assertive outreach team;
- Two psychiatric inpatient units;
- A psychiatric intensive care unit (PICU);
- Two psychological therapies services; and
- A mother and baby mental health inpatient unit.

Patients

All patient participants were female, aged 27–58 with more than one admission to hospital as a result of suicidal actions.

Emotional Pain Communication Model

Themes, subthemes, and categories were assembled into a typology model describing four main types of emotional pain communication (Figure 1).

Type 1: Unspoken/unheard. When emotional pain is neither spoken by the patient nor recognized by the professional; for example, where a patient deliberately withholds communication.

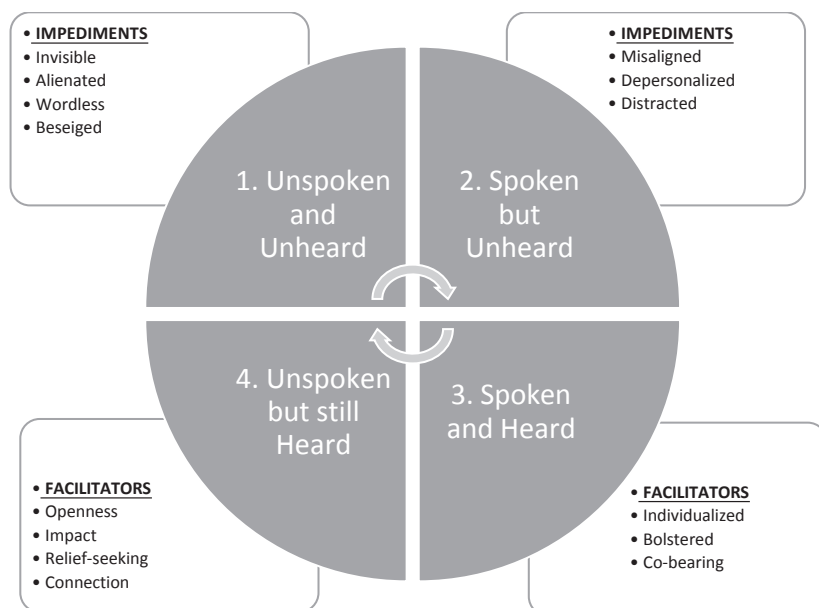


Figure 1. Emotional pain communication model.

Type 2: Spoken/unheard. When emotional pain is expressed by the patient, but they perceive that this message remains unheard; for example, when a patient's phone call has not been returned.

Type 3: Spoken/heard. When emotional pain is spoken and the patient perceives that the message has been heard; for example, when a staff member is visibly moved by the patient's plight.

Type 4: Unspoken/heard. When emotional pain remains unspoken, but the mental health professional detects this and allows the patient to feel heard; for example, when the patient's out-of-character behavior alerts a staff member to their pain.

Here, we present a selection from the 14 subthemes, which encapsulate some of the novel findings of the study. Note, all subthemes cannot be expanded upon here due to word limit restrictions. See Dunkley (2014) for further analysis. A complete coding table is included at the end of the results section giving short notes on each subtheme.

Unspoken Communication – Alienated and Wordless

Staff members reported Type 1 communication (unspoken and unheard) to be the most worrying, since they were often unaware of the patient's emotional pain until a critical incident occurred. "Alienation" and "wordlessness" were just two reasons that patients gave for inhibiting their communication or underplaying the extent of their pain.

Captured within the alienated subtheme, perceived *distance* between patient and caregiver can be a factor. This can be due to patients' memories of past communication that did not elicit a helpful response.

"When over the many years when you do try [...] and communicate [...] it's not heard or the right questions aren't asked. [...] I haven't used [the out-of-hours service] for years purely because if I rang [...] it was because I was in desperate need of help [...] and to phone up, wait for the phone call to come back and actually often not actually be asked how I'm feeling, but instead, 'well, ring your care coordinator, ring your doctor in the morning' is actually worse than having no help at all." (patient)

Another reason for distance was perceived *differences* between the patient and the mental health professional. Examples included gender differences, power/authority differentials, or social inequalities.

"I suppose on a personal level I struggle trying to communicate [...] emotional pain... to male staff, [...] I don't know whether it's a, what is it?, 'men are from Mars, women are from Venus' or just y'know with my personal history... I'm on the defensive I suppose, of these male parties who through, you know, a bit of paper or certificate have control over my life." (patient)

"And then I saw [psychiatrist] who appears a very pleasant jovial very nice psychiatrist but he doesn't live in the same world that I live in, he doesn't live in the world where you have to pay a mortgage, where you have pay for your food, [...] y'know everything that everybody has to organize." (patient)

Worryingly, patients reported that being able to express their experience verbally may somehow diminish their message:

"It's like if you actually can *say* you're in emotional pain, well, they think, well, you're in control, you're thinking logically, you've said this and all the rest of it, so we don't need to bother with you." (patient)

Spoken But Unheard – Misaligned

This subtheme refers to a misalignment of patients' expectations with staff behavior; patients sense that their communication is not heard because what they receive back from the mental health professional does not seem appropriate to the message they transmitted.

"I find sometimes... they just write down in the notes and say, 'ok, fine,' you know, 'when are you next seeing your care coordinator?' And that's it. So I get nothing back from them so I leave here feeling exactly the same as when I got here." (patient)

"... I said to her, 'I feel absolutely awful, I just want to die, I cannot cope with life' and I think she said to me, 'oh well, you'll feel better tomorrow,' and I think I came away and just took a lot of tablets and I think that was probably induced by the fact I felt so valueless and pointless." (patient)

In the latter quote, the patient's perception was that she communicated emotional pain intense enough for her to want to die, but this was not heard. One interpretation is that a less resource-intensive response gives the message, "we don't hear your pain." A staff member details a possible barrier to this approach:

"If everybody who came to you saying, 'I've got suicidal thoughts and I'm going to,' y'know, 'take all my medication'... and you said, '... you obviously need to go into hospital' then [...] the hospitals would be full, so there's a point where [...] you have to use some sort of professional judgment and not necessarily connect an actual suicide attempt with an expression of emotional pain." (social worker)

Time is another resource that mental health professionals have the power to allocate. Patients interpreted rushing or censoring of emotional pain communication as an indication that they were not heard. One staff member reported:

"I think there are times when I would choose not to get them to talk about emotional pain, if I didn't feel equipped, or it wasn't the right situation to do it..." (occupational therapist)

One nurse challenged the wisdom of this strategy:

"... The concerns about opening a can of worms... I don't necessarily buy into that [...] I think even if you haven't got a lot of time sometimes just acknowledging actually how distressing that is for people can be helpful. [...] I think it's a bit of a myth that we have to wrap things up because actually clients don't wrap things up and it's going round in their head the whole time, so I think it can be quite validating if we notice something." (nurse)

Some patients reported instances of underreporting (e.g., to appease staff) or overreporting pain (to get more resources, or avoid discharge).

Spoken and Unheard/Heard: Depersonalized Versus Individualized

Every patient referred to the phenomenon of one-size-fits-all care. Routinized responses (saying the same thing to different people, or repeatedly to the same person) seem to devalue the message.

"... like the answers they give you generally are out of books, [...] and I think, well! [...] What's that all about? They haven't actually got any answers apart from what they're taught to tell you. [...] they just reel off these things to everybody instead of proper talking to you." (patient)

Being given information out of books may be a description of evidence-based practice, but these exchanges clearly left the patient feeling unheard.

Another example of patients feeling depersonalized is the poor recording and memory of a patient's details. One patient reported her feelings following such an interaction:

"You're thinking [...] What? I've told you that last week! But then you think, well I can't expect them to remember when they're seeing hundreds of people. So it makes you feel like you're nobody, like you're just somebody like a robot." (patient)

By contrast, patients reported that staff remembering personal preferences or things they had said was hugely impactful in them feeling heard.

"There was [sic], like, 15 of us [in a therapy group], and she'd remember something, like she'd say, 'oh -(whatever your name is)- you said last week...' [...] And I'd think, God that's really amazing! [...] and it made you think she's listening, and you felt like... comfortable, that you could engage with her." (patient)

Patients asserted that continuity of relationships over time helped them feel understood as an individual.

A particularly emotive topic for patients was experiencing responses as patronizing or dismissive – indicating that the intensity of their pain had gone unrecognized.

"Very patronizing, I think that makes it absolutely dreadful, if somebody says to me [mimics earnest tone] 'oh you've done *really* well today, you're doing...' you know, 'you're doing *really* great,' and you think... I don't really want to hear that." (patient)

Although the content of the words may convey, "I hear how much you're suffering," something in the tone or delivery has the opposite effect on the patient. Broken promises – for example, in not following up with a phone call – also left the patient feeling unheard.

Spoken and Heard: Co-Bearing

This concept goes a step beyond empathy as it includes a sense that patient and professional are bearing the emotional load in partnership. Staff actions that helped the patient feel co-bearing included being physically present to sit with the patient through emotional pain, without judging or necessarily trying to solve it.

"... Adult placement concept was quite good in that y'know you could have a safer environment and somebody who'd sit alongside you, not necessarily treat you, or force you to change but just to actually, like, just be there alongside you." (patient)

Another action that demonstrated that the patient had been truly heard was staff members showing emotion – for example, as this patient noticed:

"Oh my God she's crying! Oh! And it was it sort of, y'know the emotion, you know, showing emotion and not being the 'I've-got-the- certificate-I-know-more-than-you.'" (patient)

Staff also described how they help patients feel that they are not alone with their problems:

"Things I do, definitely would be the noticing it, sitting with it, feeling it with the person. I think there's definitely something about that 'feeling it with them' validation [...] 'it's understandable that you'd feel that way.'" (psychologist)

Table 1 list the categories that can act as brief guidance notes for clinicians, indicating the contents of each sub-theme.

Discussion

The study showed that emotional pain communication is complex. Interestingly, no clinicians referred to using a validated scale to assess emotional pain levels, suggesting that this thematic model, if adopted as a concept by mental health professionals, may be more practicable than formal assessment methods.

Table 1. Coding table complete with categories

Type of emotional pain communication	Subtheme	Categories in this subtheme
<p>1. Unspoken and unheard</p> <p>Subthemes summarize impediments to patients being able to speak out about their emotional pain, or to otherwise communicate it in a way that can be heard by the mental health professional</p>	Invisible	1 Staff members do not see signs
	Alienated	2 Staff members reassured by presentation
		3 Memories of past unhelpfulness
		4 Aloneness and withdrawal
	Wordless	5 Inequality and difference between patient and clinician
		6 No common language
		7 Inadequacy of words
	Besieged	8 Inadequate questioning
		9 Physicality of experience
		10 Pervasiveness of emotional pain
		11 Overwhelming emotions
		12 Fear of unwanted procedures
<p>2. Spoken but unheard</p> <p>Subthemes summarize impediments to patients having their communication heard even when they do speak out to mental health professionals in what they perceive to be a very clear way</p>	Misaligned	13 Professionals misjudge severity
	Depersonalized	14 Insufficient time and poor timing
		15 patients over or underreport
		16 One-size-fits-all
		17 Annotated but unremembered
	Distracted staff	18 Patronized or dismissed
		19 By anxiety about patient safety
		20 By concern about professional issues
	Individualized	21 By perceived pressure to do something
		22 Invite, listen, and remember
<p>3. Spoken and also heard</p> <p>Subthemes summarize facilitators that enable patients to speak out about their emotional pain and perceive that it has been heard</p>	Bolstered	23 Tailor strategies to individual
		24 Attend to continuity and context
		25 Role-inspired confidence
		26 Positive risk-taking
	Co-bearing	27 Peer support and home life
		28 Physically present in the here and now
		29 Show emotion to patient
	Openness	30 Accept discomfort of not solving
		31 Nonjudgmental and validating
		32 To unspoken signs
<p>4. Unspoken but still heard</p> <p>Subthemes summarize facilitators that allow professionals to pick up signs of emotional pain despite the inability of the patient to speak these out overtly</p>	Impact	33 To mixed media messaging
		34 To communication from family and others
		35 No-way-out hopelessness
	Relief-seeking	36 Out-of-character behavior
		37 Clinician's intense emotion and worry
		38 Self-harming
	Connection	39 Avoiding
		40 Somatizing
		41 Establish emotional safety
		42 Provide physical comfort
		43 Keep in contact

Rather than patients being categorized by either reluctance or ability to disclose emotional pain, this study suggests that patients adopt two forms of communication, one is overt and direct, the other veiled or unspoken. Linehan (1993, p. 69) notes that having “no emotional skin” can mean even contact with potential helpers can be painful. Unsuccessful communication attempts can deter patients, as shown in the *misaligned* and *depersonalized* themes, forcing professionals to rely on unspoken signs. Herein lies another danger – that the ability to speak out one’s emotional pain is somehow seen as a sign that it is less intense. Patients find it a challenge to verbalize distress to obtain help as this can imply their need is not as great as someone who has fallen silent.

The conceptualization of co-bearing, although sharing similarities with empathy and togetherness, is novel to this study, as it implies the professional communicating an element of taking on the pain. The researchers propose that while empathy is something felt by the clinician, co-bearing is something felt by the patient, akin to a lightening of their load, achieved by the staff member’s ability to stay connected with their pain. Evidence-based approaches can appear depersonalized if not presented with care.

In the misaligned subtheme, staff assume that resource-intensive reactions were required to match the patient’s intensity. By contrast, the factors mentioned by patients focused much more on moving the clinician emotionally and establishing connection.

The study provides a succinct and useful summary of factors influencing emotional pain communication that, if incorporated into staff training across disciplines, should significantly enhance the ability of care workers to open up channels of emotional pain communication.

Limitations

One limitation is that only female patients participated in the study. The gender most at risk of suicide (Canetto & Sakinofsky, 1998) was unspoken and unheard in this research. Males may be more reluctant to admit emotional pain (Scourfield, 2005) or seek help (Cox, 2014). There is evidence for gender differences in the neurobiology of emotional pain (Vangelisti, Pennebaker, Brody, & Gunn, 2014). Attending to and reducing emotional pain may thus be different for men and women. Some aspects of the model may consequently be less reliable with a mixed population. Future research could involve testing this model with a male group.

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