How to use non-verbal signs in assessments of suicide risk

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Many tools routinely used by health professionals to assess suicide risk rely heavily upon verbal information received from patients during the course of an interview, despite the majority of interpersonal communication in the health care setting being of a non-verbal nature. A verbal statement of suicidal intent may be of little value as the person may be performing according to interviewer expectations and interview context. To facilitate more accurate and meaningful suicide risk assessment and effective clinical judgement, the non-verbal components of patient behaviour must be addressed and more specifically measured.

According to the World Health Organization (2002) suicide is on the increase worldwide. The previous UK administration placed suicide and its prevention firmly on the health care agenda by aiming for a 15 per cent decrease in overall rates by the year 2000 (Secretary of State for Health, 1992). The current government is aiming for a further decrease of 17 per cent by 2010 (Secretary of State for Health, 1998). Both these reports postulate that some suicides are preventable. However, there is no clear evidence that any single intervention is effective (Gunnell and Frankel, 1994).

Targeting suicide prevention services at high-risk groups, such as individuals who have previously attempted to take their own lives, is perhaps the best way forward. Hawton and Fagg (1988) point out that people in this group are a hundred times more likely to die by their own hand than the general population. Foster et al (1997) reported that 20–25 per cent of suicides in Northern Ireland had presented to a general hospital following an episode of self-harm in the year prior to death.

However, attempts to reduce suicide rates by targeting services at this group have been unsuccessful (Gunnell and Frankel, 1994). Accurate measurement of the impact of any such service is problematic but it may be that interventions are based on inaccurate risk-assessment strategies.

Proof of intent

Taylor and Gilmour (1997) note that the majority of suicidal acts are undertaken with confused and ambivalent intentions. Suicidal intent is therefore difficult to ascribe to the majority of cases. Furthermore, there is an apparent incongruity between the stated intent of those who self-harm and their significant others. James and Hawton (1985) compared the behavioural explanations of 34 self-harming individuals with those given by their significant others. The authors found that 41 per cent of the self-poisoners cited suicidal intent as the reason for their self-harm but only one of the significant others in this study felt this was the case. Cutcliffe and Barker (2004) reinforce this incongruity by suggesting that the verbalisation of suicidal intent does not constitute convincing evidence of its existence. Practitioners must therefore be careful not to oversimplify the entire process of suicide risk assessment.

The isolated employment of various individual assessment tools may not yield sufficiently accurate information to gauge overall risk. As pointed out by Cochrane-Brink et al (2000), when it comes to assessing risk no single clinical scale or combination of such scales can replace a thorough psychiatric mental health state assessment.

The effects of suicidal behaviour are felt by more than just those who attempt suicide. There is a potential vicarious impact on the professional who becomes involved in the assessment of risk and for the significant others of the suicidal individual.

Public perception of suicide may have been adversely influenced by the nature of its reporting in the media. Philo et al (1994) examined the media coverage of mental health issues in April 1993. Reports of incidents of self-harm were the third most commonly reported category and significant coverage was given to those with a bizarre or sexual dimension.

Regardless of the seriousness of a suicide attempt, it has the potential to cause distress in anyone within its sphere of influence. It is even possible that those close to people who have attempted suicide could become so distressed that their own mental health is impaired. This would dovetail with the work of Long et al (1998) who posit that family members of those who attempt suicide may require counselling or education in order to equip them to cope with the suicidal behaviour of their significant other.

REFERENCES


Assigning blame

A further complication is the well-recognised tendency for families, practitioners and to some extent society in general to assign blame. Professionals may collude in this, albeit unwittingly, to shift perceived blame away from themselves.

Joseph et al (1993) draw attention to the links with attribution theory, which highlight the notion that people are driven to seek explanations for various life events and circumstances. In particular there is a need to explain unusual, unwanted or unexpected events. One of the ways this can be achieved is through the apportioning of blame. Research has shown that if such causal attributions are seen as controllable and internal, then symptoms such as depression, anxiety and guilt may result (Joseph et al, 1993). People who experience guilt in the wake of an unexpected or traumatic event may find it difficult to access support, which is vital in the facilitation of recovery (Dougall et al, 2001).

Health professionals and carers alike may experience suicide as a traumatic event (Murphy et al, 2003). This is in keeping with the cognitive appraisal model as evidenced by Janoff-Bulman (1985). He suggested that people react unfavourably when confronted by an event that shatters certain basic assumptions they hold about the world. In particular, he cites personal invulnerability, the perception of the world as meaningful and comprehensible and viewing ourselves in a positive light. From the practitioner’s perspective, this may manifest itself in a tick-box mentality. From the perspective of the relative or carer, this could lead to a reliance on passive, emotion-focused coping strategies such as wishful thinking. This is a potential barrier to accessing more productive ways of coping (Dougall et al, 2001). It may also leave people disinclined to receive communication effectively about suicidal intent in their relative outside that delivered by the verbal channel. Indeed, they may engage in avoidance strategies and so lose the opportunity to communicate entirely.

It should be remembered that the experience of attempting suicide could also be traumatic from the suicidal person’s perspective. The act of attempting suicide is a significant manifestation of non-verbal communication. It is often the only regularly recorded behavioural element of suicide risk assessment and is frequently misinterpreted thereafter. The chaotic state of mind that can occur in the wake of any traumatic event may make any verbalisation of suicidal intent unreliable and, paradoxically, encourage the professional to rely more heavily on such verbalisations.

Assessment

Many of the assessment tools routinely used by health professionals in the assessment of suicide risk – such as the Beck’s Depression Scale, the Beck’s Hopelessness Inventory, the Scale for Suicide Ideation and so on – rely heavily on verbal information received from patients during the course of an interview. A verbal statement asserting or denying suicidal intent may be of little value as the person may be ‘performing’ according to the interviewer’s expectations and interview context.

From the literature, it is known that non-verbal communication is also crucial as a guiding mechanism for assessing someone’s state of mental health (Devito, 2000; Corey, 1996; French 1994; Argyle, 1983).

Woods et al (2004) examined aspects of communication including non-verbal components in terms of their contribution to assessing risk of violence in a forensic setting. The authors suggested there may be insufficient emphasis placed upon the non-verbal component.

This issue was also highlighted by Archinard et al (2000), who analysed the facial expressions of patients who had attempted suicide and those of the professionals who assessed them for suicide risk. Their conclusions revealed that non-verbal communication could provide useful information pertaining to the overall mood and suicidal intent of the person even if they do not verbally disclose their intentions. There is an argument for the therapist paying more attention to their own non-verbal reactions, as these could potentially ‘get in the way’ of effective communication.

### TABLE 1. GROUPS AT INCREASED RISK OF SUICIDE

- People who have deliberately self-harmed in the past
- People who misuse alcohol
- People who misuse drugs
- Those with a family history of suicide
- Those with a serious physical illness/disability
- Prisoners
- Offenders serving noncustodial sentences
- People who are unemployed
- People who are divorced
- People on low incomes

### REFERENCES


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It has been suggested that non-verbal communication constitutes the majority of interpersonal interaction in the health care setting (Dickson et al, 1997; Hargie et al, 1994; Ley, 1988; and Ellis and Beattie, 1986). Non-verbal communication is entirely more difficult to control than its verbal counterparts and the former is usually more of an accurate indicator of someone’s state of mind than the latter.

It is therefore essential that health practitioners have their psychological radar switched on and tuned in not only to the verbal but also the non-verbal behaviour of their patients when interviewing and assessing overall suicide risk.

We receive continuous verbal and non-verbal messages, information and feedback from our patients during interview and therapeutic contact. Practitioners find it easy to imagine that this continuous stream of information is subconsciously received and evidenced in the form of a gut feeling. However, in the context of suicide risk assessment, non-verbal elements are often ignored. We believe this to be potentially dangerous for both health practitioners and patients alike.

Practitioners may be entirely selective in their search for information that underpins subsequent clinical judgement. The ultimate question is therefore: ‘Are health practitioners happy to continue to evidence their clinical decisions simply on the basis of what their patients say?’

Frederick Perls, the founding father of gestalt therapy – a widely applied model of counselling – consistently maintains that what clients say during initial contact with counsellors and those in the helping professions more often than not transpires to be lies (Corey, 1996). He postulates that in order to facilitate the accurate assessment of a client’s life circumstances and overall outlook on life during initial contact, counsellors and skilled helpers should largely ignore the verbal elements of a client’s story and focus heavily on the non-verbal components of the storytelling (Patterson, 1996).

For a more accurate suicide risk assessment to be possible, the various risk assessment tools currently in operation should be augmented by a structure that facilitates the capture and analysis of significant non-verbal behaviours including eye contact, feet shuffling, shoulder shrugging, eye rubbing and fist clenching. Given that non-verbal communication may potentially play a significant role in suicide risk assessment, the clinical ramifications for mental health nurses and other allied professionals are substantial. Additional training in relation to the essence and meaning of non-verbal communication, for example with reference to proxemics, kinesics and chronemics, is therefore essential.

Furthermore, additional knowledge in these fields would require fundamental change in current suicide risk assessment strategies. Many health professionals shoulder the burden of suicide risk assessment alone.

The one-to-one assessment interview coupled with the need to simultaneously record information conspire to limit opportunities to pay attention to patients’ non-verbal communication and behaviour. In some realms of mental health practice such as family therapy and crisis response work, more than one practitioner is present during an assessment interview – a model that would facilitate the accurate collection and interpretation of this hidden information.

The useful by-products of working in this way are increased peer support for the practitioner and a more objective and accurate assessment as well as a built-in opportunity for reflective practice. Working with another practitioner to assess a patient can feel very exposing for any worker but the potential for learning for both parties is obvious.

The inclusion and measurement of information about client non-verbal behaviour will further increase the likelihood of accurate and thorough suicide risk assessment and this will be the subject of our postgraduate study at the University of Ulster. We plan to develop an adjunct to existing suicide risk assessment tools, which can be used by health professionals of all disciplines operating within the challenging arena of suicide and self-harm.

Conclusion

Mental health nurses set great stock in the notion that they are trained observers. Indeed, observing and being sensitive to client behaviour would be seen as essential in most fields of health care.

We are not suggesting that practitioners are incapable of detecting the non-verbal components of their clients’ behaviour. However, it may be that within an increasingly litigious practice arena they are selecting a preference for concrete, recordable, defensible information. Attempted suicide is a complex, multifaceted behaviour, and a number of related factors have the potential to confound patients, carers and practitioners alike.

There is compelling evidence that a significant number of those who successfully commit suicide are in contact with a professional close to the time of their suicide. The National Confidential Enquiry into Suicide by People with Mental Illness (Appleby, 2001) posits an overall figure for Northern Ireland of 45 per cent. Despite this, their intent is clearly not being picked up. Of these completed suicides, 90 per cent were perceived as being of low or no immediate risk of harming themselves at their final contact. Could it be that as professionals we are asking all the right questions but not seeing the whole of the answer?