ENGAGEMENT

COMMUNICATION

> *It's not what our message does to the listener, but what the listener does with our message that determines our success as communicators. (Mackay, 1998, p. 25)*

Engaging effectively with someone who may be at risk of suicidal behaviour is fundamental to suicide prevention. It involves listening respectfully to what a person is saying. And it involves focusing with a commitment to understanding what the associated feelings and meanings are for that person at that particular time. In our interactions with potentially suicidal people, it is important to validate their emotions and experience, to provide reassurance and never to ignore or discount their distress.

(See also the video interview with 'Sarah' for a consumer perspective on the importance of respectful engagement and the Foundation Booklet.)

Engaging effectively should also encompass engaging with other service providers in order to understand their ways of working and the constraints and opportunities they bring to collaborative health care. Skilled engagement is not exclusively held in the domain of the professional. Many people involved in care and/or support require and indeed may already have these skills.

Engaging effectively does not necessarily occur simply because the worker is well intentioned. Rather, it involves the ability to attentively 'tune in' to the inner world of another person and to become aware of some of the complex and sometimes contradictory feelings and meanings that are in play. These complexities are likely to be at the forefront of someone's experience if they currently have suicidal thoughts and/or plans.

Engaging in this way requires high level skills, as well as the ability to follow and monitor the ways in which people's life circumstances and emotional states change. Individuals hold multiple positions in both their inner and external worlds and these are not fixed or static – they are in continual process.

Being psychologically 'with' someone as they externalise what is actually going on for them at a particular time, is a key to effective engagement.

This way of attending to someone can be an extremely positive therapeutic intervention in itself. The experience of being genuinely 'heard' without someone imposing their views on what is being said, can bring enormous relief to people when their equilibrium and mental health is compromised by strong negative and/or confusing emotions. It is useful to remember that assessment, treatment and management are not mutually exclusive concepts.

This phenomenon is evidenced in social justice processes, such as the Inquiry into the Stolen Generations (HREOC, 1997). During this Inquiry, Indigenous people were invited for the first time, to tell their stories of removal from their families, in their own way. For many, it represented an important point in a journey of healing. The significance of this experience – of feeling heard and believed – is also cited by adults who are attending counselling as a result of childhood sexual abuse (see Breckenridge *et al*., 2005). In both examples, people have described the relief that comes with disclosing distress to someone who is empathic. The impact of this quality of connection with another human being, especially if a person has not had the opportunity to speak in this way before, can literally be life saving.

In the examples offered above, there is a prior understanding that disclosure is likely to occur. In contrast, a person in a primary health care role may find themselves interacting at any time, without notice, with someone who is distressed enough to be at risk of suicidal behaviour. In addition, such a person may not reveal their feelings and may even attempt to mask them.

It is vital therefore, that a person in a primary health care role maintains a high level of awareness about the potential for suicidality and has the skill to engage effectively with people who may be at risk. It is also important to keep in mind the highly changeable nature of people's emotional states and life circumstances.

One of the purposes of engaging in the ways that have been discussed is to establish an authentic, collaborative and supportive relationship or interaction with another person. This is valuable in itself. However an important outcome of this quality of engagement is that it also facilitates the externalisation of feelings and meanings.

It is invaluable when someone is supported to share and explore their feelings – and the ways in which they are constructing meanings about them. The person has the opportunity to look at and explore what is going on for them – rather than simply being overwhelmed. And, the listener has the opportunity to assist the person in noticing other features or ways of seeing.

This work is vital and can be learnt and improved with practice, but it is not simple. It is important therefore to look at some of the barriers to achieving effective engagement.

DIFFERENT FRAMEWORKS

A message (even if it is repeated) does not ensure that the person has understood what you meant to convey. A General Practitioner, for example, may say to a patient that there is no point in prescribing an antibiotic because the infection is not bacterial. However, what the patient may hear, is that he/she is not really sick enough (or important enough) to warrant any medicine. The different meanings that each person has about sickness, wellbeing and appropriate attention, come in this case, from entirely different frameworks.

The communication confusion in this example is that the connection between bacterial infection and antibiotic is not shared between both parties. Similarly, the phrase no point could have a different meaning to the person who hears the message. To the patient, it could mean that the GP thought that there was no point in consulting about this issue because it was too trivial.

The example is not intended as a message to General Practitioners about the question of antibiotic use, but rather, as an example of people making meaning from what is immediately relevant to themselves – their own thinking, beliefs, interests and circumstances.

Language is not neutral or value free and so there is plenty of room for different interpretations of what is said. In addition, people are not blank slates waiting to receive information. Any information that a person receives is processed and filtered through complex frameworks that are built by multiple experiences over a lifetime – and which are often resistant to change.

Effective communicators are able to relate to another person's framework of meaning rather than only operating from their own. In fact, even the recognition that another person HAS a different way of interpreting events and interactions, is often missed entirely.

The following example highlights a difference of framework. We interviewed Angela, a young South Australian mother of two young children (including a sick baby), about her suicidal behaviour and experiences of accessing support services. In her description of an interaction with her GP it seemed that the GP thought that concrete activities might be helpful in dealing with depression. The GP had responded positively, for instance, when Angela had made a start on some housework and had also complimented Angela on some new clothes that she was wearing. Angela interpreted these messages in the following way:

> *….For a start I don't think she understood me. I thought to myself, 'you probably never washed or ironed a thing in your life. You've probably got a cleaning lady'. And why was my worth as a mother being measured [in how I looked], I was actually rewarded because I went to David Jones and bought some new clothes… she thought that was important! As if that and keeping up with the housework [is important] when I was trying to cope with a baby who might die. (Angela, Adelaide, 2005)*

This example powerfully demonstrates that the way in which messages are interpreted (by the receiver) is as crucial in the communication process as the meaning intended by the sender.

It is also important to understand that not only do people have different frameworks of meaning, experience and interpretation, but that they will defend these strongly. It can feel very threatening if the scaffolding on which our personal framework rests is destabilized.

The response to having personal frameworks challenged is readily evident in any observation of two people having an argument. Usually, neither is able to engage with the other point of view because the need to defend their own becomes so pressing. It indicates that in some circumstances, people are unable to absorb information or differing views, no matter how articulately the information is expressed.

ENGAGING WITH OTHERS

For all of the reasons outlined above, engaging effectively with a person requires interactions to be relevant to their needs, interests and circumstances. And in order to have any sense of what these are, it is necessary to find ways of relating authentically with them. As Diane, who had attempted suicide put it:

> *The relationship that I had with my psychiatrist - in terms of feeling - to be honest, some days it felt like a lifeline. The only thing that stopped me going under was the thought that he would actually listen to me. (Diane, Adelaide, 2005)*

It is important to have a focus on the process of building a relationship with someone (even if it is a brief one) as well as focusing on goals and outcomes for them. In a primary health care context the common ground may usefully become 'working on the problem together.' And, working in appropriately staged steps, rather than attempting to achieve major goals all at once, is often the most helpful approach.

A person who is feeling destabilized by intensely felt inner states, such as depression or anxiety, may not readily disclose this to another person. There are many possible reasons, for example:

- Believing that 'one ought' to be able to handle life's pressures and that it is a sign of weakness to admit to vulnerability
- Fear of being judged, labeled, and/or exposed to unknown treatments and responses
- Difficulty in finding words to describe overwhelming emotional states
- Holding no expectation that it is possible to feel differently
- Not trusting anyone enough to speak about such 'private' things
- Not wanting to be a 'time waster'
- Assuming that no one cares anyway
- No one ever asks!

Given these possible scenarios, it is important that people in a primary health care role are able to create opportunities for people to talk about what is going on for them, how they are feeling and what meanings they construct about their life – things like:

- Life events – what has been happening
- Feelings experienced – what feelings they have
- Explanations and meanings – How (or why) they think that things are occurring as they are in their lives.

Some potentially suicidal people may be quite difficult to engage with, or you may even find it impossible. Their reluctance to engage may signal their high risk status and may indicate that you will need to have another plan in place for responding to them. If you are having trouble engaging with someone try some of the following strategies:

- Tell them you are concerned that they are at risk
- Ask if they would like you to contact someone as a support
- Ask if they would prefer continuing the discussion with someone else (e.g. someone of a different gender or culture)
- Ask if there is anyone they have seen in the past who was helpful, and what that person did for them

The video by Dr Tori Wade also covers engagement during the management and referral of people at risk of suicide.

CHARACTERISTICS OF EFFECTIVE ENGAGEMENT

AWARENESS

The first skill of engagement is to be aware when a person may be troubled and at risk. It involves the ability to intuit when it might be helpful to enquire further. Intuition is not typically named as a therapeutic tool in a primary health care context, yet the issue of suicidality requires abilities (such as empathy) which are difficult to discuss using a scientific paradigm alone. Given that suicidality is not a bio-medical illness in itself, it is necessary to be able think beyond a bio-medical framework in responding to it effectively.

OPENNESS

The second skill is the ability to be open to another's inner world and available to navigate some aspects of it with them. It is an important skill to begin seeing the world through the eyes of another and to (metaphorically) enter into the ways in which they are thinking. When this occurs the health worker is able to assist the person to explore and voice the feelings they have and the meanings that they are making. It is in this process that the health worker may facilitate the discovery of alternative options and

ways of thinking. Being 'open' requires attentiveness to the clues or signals that someone is communicating (consciously or not). This may involve verbal signals, e.g. I sometimes think they'd be better off without me, and/or it might involve other signals such as non-verbal behaviours that indicate emotional distress.

RESPONSIVENESS

The third basic skill of engagement is to pick up these signals appropriately. Again, this requires a judgement about the meanings of such signals and how to respond to them. It is usually good practice to ask the person rather than to make assumptions.

For example, if someone does talk about people being better off without me (or something similar) it could be a key intervention to ask open questions such as: What sorts of thoughts are worrying you at the moment? It shows that you have heard and that you are open and available for further discussion. It also invites the person to further reveal some of their feelings and experiences if they need to. By engaging initially in this way, the worker can achieve several positive outcomes, including:

- Communicating concern for the person's wellbeing
- Inviting information that is relevant to the person's life
- Allowing the person to define what is important to convey (rather than simply responding to the primary health care worker's support options)
- If the person does disclose distress, information is available to inform assessment of risk (and appropriate support options) as well as contextualising the direct question (if appropriate): *Are you having suicidal thoughts?*

RESPECT

Showing respect is central to effective engagement with another person. Although this may seem an obvious point, it is interesting to note that some people do not access services because they find the responses that they receive alienating. This may be especially true for people, who already feel marginalised – for example, homeless people, or people whose first language is not English.

Being respectful however, does **not** imply that everything that a person says is 'OK', or that it should be endorsed. Such a response, especially if a person is describing their suicidal thoughts or plans, would clearly be inappropriate and unhelpful. Neither does it mean compromising one's own values. What is important is to be open to what is 'real' for someone else and to be sensitive and open to the significance of this for them.

If for example, someone is 'hearing voices,' it is important to try to understand that person's reality in relation to these voices. Being shocked, afraid or critical is not helpful. It is not supportive to give glib advice, or to argue. Arguing with the irrational thoughts can create a context where the person defends their thoughts, and in so doing makes them seem more important. Finding ways to acknowledge the significance of these thoughts, at the same as supporting the person to notice other thoughts, feelings and experiences, is usually more helpful than trying to talk people out of their negative thoughts.

A respectful interaction with a suicidal person involves doing some simple things well – for example, seeking permission to give their details to another worker or to make contact with a family member who has insight about their circumstances or history. It is also important to engage the person in choices about their support, their preferences and wishes. Even if someone is highly troubled or confused they are still likely to be aware of whether they are being treated with respect and dignity in relation to their choices.

LISTENING

The fourth and most important skill in engaging effectively is the ability to listen well. When a person experiences genuine encouragement to explore aspects of their inner world and has found ways to externalise important features of it by talking, this can be a very positive and reassuring therapeutic intervention.

Listening well however, does not simply mean not interrupting or being polite. People follow such conventions regularly but may not be listening well. There are many reasons for this, one of which is the way in which particular triggers influence people. For example, slowly consider the following words:

- Medication
- Grief
- Cutting
- Drama queen
- Funeral
- Attention Seeking
- Relationship

It is quite possible that as these words come to mind, they 'trigger' small trajectories of thought. This occurs continually when someone is speaking – their words or descriptions evoke thoughts and connections that take the listener along their own thought pathways.

Another barrier to listening well is that thoughts occur much more rapidly than the spoken word. Therefore, when a person is speaking, the listener's thoughts are often running ahead of what is being said. When this happens the listener is thinking more about what they are going to say next, than they are about what is being said. It is difficult to be genuinely 'with' another person when this occurs.

And if the conversation is of a potentially serious nature, as with suicidality, it is possible that the listener isn't able to 'take on board' the issues that the other person is talking about. As was mentioned earlier, it can be very threatening to have our own framework or world view disrupted by a completely different framework.

It could be the case, for example, that a person who is frequently self harming by cutting or burning themselves is feeling desperate and may even be practising or rehearsing for suicide, because they cannot see any future or way of stopping the pain that they constantly experience. A health worker on the other hand, may be unable to respond effectively because their own framework or the unwritten framework in the workplace, regards such behaviour as time wasting or 'only' attention seeking.

Similarly, if someone is describing the experience of living with a violent and abusive partner, it is quite common for the listener to ask without thinking: 'Why don't you leave him?' This may be the obvious solution for the listener, who may well be unable to contemplate any other option. However, for the person describing this situation, such a response may be counter productive.

It may convey the message that they are mad and/or inadequate to put up with it. Or, that they must enjoy the abuse. However, there are other possible explanations. Perhaps the person loves the violent partner but wants the violence to stop. Perhaps she cannot see a safe way to leave, or perhaps she is frightened for the safety of her children. Maybe she needs more time and support to work through what the options are, or maybe she will be rejected by her family if her marriage is seen to fail. The point is that it is not possible to know, or be able to be helpful, unless we are able to listen.

GOOD LISTENING REQUIRES:

1. Giving attention rather than being distracted with other matters.

2. Encouraging further elaboration with open ended questions e.g. *Can you describe how that feels? Or, can you tell me some more about that?*

3. Being respectful of another person's lived experience (seeing events through the lens of the other person rather than your own).

4. Communicating clearly when you are moving to another mode, e.g. *It has been very useful for me to know what's been happening lately. I'd like to finish dressing these wounds now and then perhaps we can discuss ….*

5. Demonstrating that you have listened attentively by consulting with the other person about whether your responses and strategies for support are compatible with what you've heard.

The importance of these skills is highlighted in the following comment from Angela about recovering from a suicide attempt:

> *Nobody wanted to talk to me about it. The nurses,… because when you're in hospital your nurse that you're allocated to is supposed to have about a 10-15 minute little chit chat to you every day. It just didn't happen. I know I was sleeping a lot because I was sleeping from the wearing off of my taking too many tablets. But nobody wanted to talk to me about it. … Nobody wanted to know what the voices said to me. (Angela, Adelaide, 2005)*

BUILDING A THERAPEUTIC RELATIONSHIP

The Management of Mental Disorders Treatment Protocol Project (1997) offers the following suggestions for the development of a therapeutic relationship:

- Maintain the **attitude** that the individual is a person of goodness, dignity and strength, who is worthy of courtesy, respect, acceptance and expenditure of time.

- Maintain the **belief** that the person will benefit from the relationship. Even if the individual cannot be 'cured', a joint therapeutic effort may at least lead to improvement of functioning, enjoyment or physical health.

- Remember that the relationship may take **time** to develop and that the importance of the relationship may not be acknowledged by the individual.

- Improvement may be exceedingly slow and there is often a need to accept 'where the individuals are at,' even though the clinician may feel that the individual should be doing something to improve their lot.

- **Listen** to the individual and his or her family in an understanding manner, without feeling the need to 'label' or explain everything that has been said.

- Use people's **names**.

- Make **eye contact**.

- Do not talk about the individual or family in their presence as if they were not there.

- Do not use technical language without explaining it.

- Ensure the family understands what has been said by taking responsibility for the explanation. For example, say, *Have I explained that clearly?* Rather than, *Do you understand what I've said?*

- Do not patronise or 'talk down' to an individual, or family members.

- Leave space for individuals to talk and express any problems being experienced. Do not crowd the individual by asking too many unimportant questions.

- **Watch and listen for clues,** such as body posture, what is left out of conversations, or spoken clues, such as *I'm mostly OK* (which may be a purposeful hint that there is a problem that the individual would like to talk about).

- **Reassure** the individual that nothing said will be laughed at or used in judgement.

- **If the individual is angry** acknowledge the anger e.g. *I can understand that you're feeling quite angry.* But do not take the anger personally. Give the individual time alone to calm down if necessary.

- **If the individual is seductive** do not be seductive in return. Instead try: ignoring the behaviour; having a chaperone; leaving the door open; clarifying the relationship. Do not be rejecting or rude.

- **If the individual is demanding,** clinicians need to make sure they: state clearly what they will and will not do; are empathic about the individual's feelings, provide alternatives to choose from so that the individual feels some sense of control over what is happening.

- **If the individual is inquisitive** and wants to know about the clinician personally: tell the individual that there is only a short amount of time and that the time is needed to deal with his or her problem (p.28).

Primary health care workers are in a key position to identify people who are at risk of suicide and to prevent suicide. It is vital that they focus on and practise skills of engagement in order to achieve both of these outcomes successfully.

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