The importance of asking difficult questions

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Anthony is a Psychiatrist, Medical HR Expert, Coach, Technologist and Educationalist. He is one of the three original founders of the onthewards website. As the site's first Chief Technology Officer, Anthony was integral in getting us up and running and helped to steer the onthewards website through its first three iterations. Whilst Anthony is no longer formally involved with onthewards, he remains a strong supporter, having spoken at our inaugural conference otw18. Anthony holds leadership and training positions at both the University of Newcastle and Hunter New England Local Health District. He is also the Managing Director of AdvanceMed, a medical education and training company dedicated to helping doctors manage their medical careers.

This week marks Mental Health Week and instead of our usual Wednesday podcast, we've decided to post a blog about tackling some of the more difficult questions that arise when conducting a psychiatric interview by our Chief Technology Officer and psychiatrist, Anthony Llewellyn.

> *"For a number of reasons there are some topics or questions that we find less easy to ask of our patients. Perhaps it's just that we are not used to asking them, perhaps they seem too personal, perhaps they seem too awkward to ask or perhaps we are concerned about the emotional aftermath (for both the patient and ourselves) in asking."*

In this post I thought I would talk about three particular topics in psychiatry that medical students and junior doctors often struggle with in the psychiatric interview:

1. **Suicidal thoughts**
2. **Hallucinations**
3. **Abuse**

1. Suicidal thoughts

Around 1 in 20 adults probably experience suicidal thinking in any one year (1). Suicidal thinking and suicide as an outcome is of course a major factor in a number of the common psychiatric disorders that we encounter including: depression, bipolar, personality disorder, eating disorder and psychoses. So it's an important question to ask and generally recommended that it's asked of every patient presenting with mental health concerns.

The good news is that the majority of individuals who do experience suicidal thinking have no intention to act on these thoughts. However, this does not make the thoughts any less distressing.

When interviewing a patient the topic of suicide may come up as part of the normal course of the conversation.

How to ask difficult questions: suicidal thoughts

For example, when discussing their symptoms an individual who is suffering depression may volunteer suicidal thoughts. Such a patient might indicate that they have been having negative thoughts about themselves, to which a further probing question such as: “How bad do these negative thoughts become for you?” may elicit a response in the affirmative for suicidal thinking or may lead the patient to clarify that they have not been having suicidal thoughts.

I have, however, witnessed students and junior doctors in such circumstances attempt further and further probing questions in a diminishing effort to get the patient to bring up the topic of suicide themselves. At a certain point, you just need to ask and do so in a clear manner.

Generally, I raise the topic as a matter of routine in all patients:

“The next question I am going to ask you is one I ask of all patients that I see for the first time because its an important question to ask.”

PAUSE, and allow the patient time to prepare themselves for a potentially difficult question.

“Have you had any thoughts of hurting or harming yourself?

By making this question a routine one (i.e. one you ask a lot), you will become better at asking it in a natural and non-awkward way. Also, by indicating to the patient that it is a routine question, you are saying that you realise it might seem a bit of a weird and confronting question to some patients but that you are asking it because you are a professional and you care about their safety. In most cases this will increase the patient’s confidence in you as a professional.

2. Hallucinations

The presence of hallucinations is generally a worrying sign for psychiatrists. Guess what? Their presence generally worries patients and many will be hesitant to disclose them.

Classically we ask about the presence of auditory hallucinations or voices. Auditory hallucinations are false perceptions of sound sometimes described as the experience of internal words or noises that have no real origin in the outside world and are perceived to be separate from the person’s mental processes.

Auditory hallucinations

Auditory hallucinations are often experienced in psychosis as well as a range of other mental health conditions linked to a past traumatic experience. In some studies the prevalence of experiencing voices in the population has been estimated as high as 40% (2), with the majority of these individuals ***not*** having a mental illness.

Textbooks on symptomatology often lead readers to try to also determine the nature of auditory hallucinations with many questions to try to determine whether they are experienced inside of or outside of a person's head. However, there seems to be less evidence to support the fact that external voices are more indicative of a psychotic illness than internal voices.

We can often first encounter the presence of auditory hallucinations by observation in psychiatry and this is where it can sometimes get a bit tricky. It may be obvious to us as interviewers that the patient is most probably experiencing voices (for example there is a reported history of the person talking to him/herself or they are clearly distracted by the presence of unseen stimuli during interview) but the patient themselves may be reluctant to disclose this information. This may be due to a genuine concern on behalf of the patient that disclosure could lead to unwanted consequences, such as being labelled "crazy" or "mad", given medication, or being locked up in hospital. Sometimes (generally less often) the voices may be telling the patient to not disclose.

Use a normalising approach to ask difficult questions

This kind of situation is one where a normalising approach can be quite useful. A normalising question is one that is prefaced by an indication that a positive response will not be taken by the interviewer as unusual. As mentioned, the presence of hallucinations in the population is quite common. For example, a normalising question to ask about auditory hallucinations in a person who is experiencing some psychotic symptoms might be:

"You've been telling me that you have been feeling a bit troubled lately and having trouble keeping track of your thoughts. You've also told me that certain people are worrying you. Have I got that right?"

Patient: *"Yes that's right."*

"OK. I've actually seen quite a few people with similar problems. People with these types of problems can often experience unusual things happening to them. Has this sort of thing happened to you?"

Patient: *"Such as?"*

"Well, people often describe hearing voices. Voices that other people don't seem to be able to hear."

Now I'm not promising that every person who is experiencing voices, particularly someone experiencing an acute psychosis will answer in the affirmative to such an approach. I can promise from experience that you will have more positive responses and that the false positive rate will be extremely low, but there will also be some cases where you may think it's a false negative.

Why is normalising an effective interview approach? Because it is saying to the individual that their problem is not isolated, that they are not alone. People as a general rule like to feel part of a group and associate with one.

When should you not use a normalising technique? When it's not true that it's normal. As noted, the evidence for hearing voices is quite common in psychiatry and medicine.

It can also be unhelpful to normalise a behaviour that is harmful to a person, for example in substance abuse whilst a statement such as

"it's quite normal for people with addiction to struggle to remain sober"

may well be true. It could probably be improved by adding the true statement of

"but it can often take a few attempts to get there and the important thing is to keep trying."

3. Abuse

The high prevalence of childhood and adult abuse in the population is undeniable. According to the World Health Organization 1 in 5 women and 1 in 13 men have been sexually abused as a child (3). More than 1 million women in Australia experienced some form of domestic violence in 2005 (4).

The link between abuse and mental illness is also clear, for example, a prospective study in the British Journal of Psychiatry showed that both women and men had an almost four-fold likelihood of developing a mental illness if they were sexually abused as a child (5).

Again I think it's important to ask question about abuse from your patients and establish it as part of a routine process of your developmental assessment or childhood history and personal history of a person.

In the past medical students and junior doctors may have been given conflicting advice about when and how to ask this question. Medical students may have been advised that it could be more appropriate for a more senior colleague to ask the question as they may be in a better position to help the person if the answer is yes.

"Others may disagree with me, but I think it is important to be able to ask this question and establish it as part of routine practice as early as possible. Patients tend to agree with this approach and overwhelmingly support routine inquiry about sexual abuse as they have reported a reluctance to initiate discussion of the subject" (6).

So how to ask the question?

Establishing it as part of routine practice and placing it within a normalising framework is a good approach. The American College of Obstetricians and Gynaecologists has a good consensus on this topic (7). They concur that making the question routine will make it a more natural question. They suggest a statement such as:

"About one woman in five was sexually abused as a child. Because these experiences can affect health, I ask all my patients about such experiences in childhood."

They also suggest that it is important to allow the patient to have control about disclosure to allow them to disclose only the information they are comfortable with in order to keep emotional defenses intact.

So in conclusion, there are difficult topics to raise in the psychiatry interview. These are topics which are emotionally difficult for both patient and doctor. However, making these questions routine and placing them within a normalising framework can ensure that we do ask them and do the best by our patients.

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