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A discourse analysis of suicide ideation assessment among first year health professional students enrolled in a communications course

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ABSTRACT

Background: Suicide risk assessments require a complex set of skills around a sensitive matter which can be difficult for health care providers to perform. **Aim**: We explored whether and how first year students enrolled in a communication skills for health professionals course assessed for suicide during their final objective structured clinical examinations with a standardized patient who was exhibiting symptoms of depression. **Methods**: Discourse analysis methods informed by principles from conversation analysis were used to review 121 video-recorded and transcribed final exam interviews to identify patterns and variation in the language choices made to assess for suicidal ideation. **Results**: We found that 66 of the 121 (55%) final exam interviews included a suicide assessment. We noted key patterns and variation around *when* the assessments took place (while exploring depressive symptoms or as a topic shift), how they were *prefaced* (with ubiquity statements, normalization statements, or expressions of care and concern), and how the *question itself* was structured (with a negative preference structure, in a non-polar format, or ambiguously). **Conclusions**: Assessing for suicide is a delicate task for students learning to be health care providers. Utilizing normalization statements as well as statements of care and concern is a good approach to assess for suicide ideation.

KEYWORDS

Communication skills, objective structured clinical examination, standardized patients, suicide assessment

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Introduction

The Centers for Disease Control and Prevention in the United States reported that suicide was among the top nine leading causes of death for those between the ages of 10 and 64 in 2020 (Centers for Disease Control and Prevention, n.d.). This highlights a public health issue that requires professionals to collectively work to provide medical interventions and strategies to reduce the burden of depression and its potential outcome, suicide. Assessing for suicide is often incorporated into the curriculum of interprofessional health education communication skills courses and has been identified as a critical part of skills-based education (Hawgood et al., 2008). While some studies have illustrated different ways that assessing for suicide risk factors might be taught to health professionals (e.g. Norrish, 2009), to date, relatively little is known about whether and how student health professionals assess for risk of suicide.

In this study, we used discourse analysis methods informed by principles of conversation analysis to explore *whether* and, more importantly, *how,* first year medical, nursing, pharmacy and psychology students enrolled in a communication skills for health professionals course assessed for suicide during their final objective structured clinical examinations (OSCE) with a standardized patient (SP) who was exhibiting symptoms of depression. We analyzed not only whether or not the students in the course assessed for suicide (Mospan et al., 2017), but *how* they used particular language to do so. Recognizing the ways that student health professionals choose to assess for suicide (e.g. certain questioning techniques) can offer insights for improving both healthcare education and, ultimately, professional practice. Teaching students early in the curriculum the importance of this assessment and providing simulation opportunities and feedback should decrease students' anxiety about asking very personal questions. Guidance on specific language use to initiate the assessment should also increase their confidence in patient-centered communication skills that will, ideally, continue to develop as future healthcare providers.

Literature review

Patients often leave health provider visits with unaddressed concerns (Robinson & Heritage, 2016). To reduce this likelihood, patient-centered care is seen as the communicative ideal (Epstein et al., 2005). Significantly, most patients who attempt suicide are more likely to have interacted with a primary care doctor than a mental health specialist prior to their attempt (Lake, 2008; Luoma et al., 2002; Nock et al. 2022; Stene-Larsen & Reneflot, 2019). While comprehensive risk assessments are critical, doing so involves utilizing a complex set of skills around a sensitive matter. Carrying out these assessments can be difficult for health care providers (Miller, 2013; O'Reilly et al., 2016) who often lack confidence (Airey & Iqbal, 2020) or feel anxiety when doing so (Sands, 2004). Some providers have concerns that making an assessment may increase suicidal tendencies (Dazzi et al., 2014), though no evidence of this has been found (Law et al., 2015; Polihronis et al., 2020). Further, while there are guidelines for best practices, there is not yet a clear evidence-based standard in *how* to effectively assess for suicidal risk (Bernert et al., 2014).

The language that health providers use to elicit the patient's perspective of illness, including suicide assessments, can lead to better health outcomes or worsen health consequences (O'Reilly et al., 2016). Methods such as discourse analysis and conversation analysis examine language-in-use (i.e., language practices as they unfold moment by moment in situ) and have been used to conduct a close analysis of health care encounters (e.g., Maynard & Heritage, 2005). Discourse analysts have identified patterns of language-in-use in both naturally-occurring mundane talk (e.g., at home with family) and in institutional contexts (e.g., hospitals) (Lester & O'Reilly, 2019). These patterns have illustrated how language choices might result in particular conversational outcomes, such as whether the way a question is asked by a healthcare provider elicits additional patient concerns or not (Robinson & Heritage, 2016). In the healthcare setting particularly, studies using discourse analysis and conversation analysis have shown that the way providers frame questions can influence patients' willingness to disclose information in sensitive interactions such as palliative care counseling and suicide assessments (Pino et al., 2016; Mospan et al., 2017).

Notably, question and answer sequences are central to all clinical communication and have been well studied in clinical contexts (e.g., Heritage, 2010; Jenkins et al., 2015; Maynard, 1991; O'Reilly et al., 2016). Communication scholarship highlights that there are a range of question types, such as polar questions (i.e. "no other concerns, then?") and tag questions (i.e. "you haven't thought of hurting yourself, have you?") (Quirk et al., 1985). These questions often function in varying ways within a given interaction. In clinical contexts, questions have been found to set the agenda within a clinical interview (Heritage, 2010) and to play a role in delivering diagnoses (Maynard, 1991), among other functions. For example, formulating questions with negative-polarity (i.e. "no other concerns, then?") tends to lead towards patients saying "no" when asked if they have any unmet concerns, even though that may not reflect the reality of their situation. In contrast, asking if a patient has "something else" they'd like to discuss is more conducive towards eliciting unmet patient concerns. Heritage and Robinson (2011) found that asking questions with a positive polarity increased the patient's expressions of additional concerns from 53% to 90%.

While asking directly about suicidal ideation is considered best practice, exactly *how* to do this can be a challenge, as it can be difficult to know exactly what words to use (Sommers-Flanagan, 2018). Across 77 different psychiatrist visits, McCabe et al. (2017) found that physicians *always* used leading, closed-questions to ask about suicidal thoughts, 75% of which utilized a structure that set up a preference for a negative response (e.g. "no thoughts of harming yourself?"). These types of questions resulted in patients being more likely to say they were not suicidal. The use of questions that are not framed to elicit a "no" response can increase the likelihood that patients will be open about suicidal thoughts (Sommers-Flanagan & Shaw, 2017).

More broadly, it has been found that the effectiveness of a question asked in a clinical context is not simply about the type of question posed but also *how* it is used and the *way* it is asked (e.g., intonation) (Kiyimba et al., 2017).

Within the context of mental health clinical encounters, O'Reilly et al. (2016) found that mental health practitioners used two approaches when asking children and youth about self-harm and suicidal intent when they or their parents had not offered the information themselves. First, the incremental approach, a type of 'foot-in-the-door' technique, was used to gain agreement on a small request first which increased the likelihood of agreement to a

larger request. With this approach, health care providers first asked patients about their emotions and behaviors and eventually built to asking directly about any suicidal or self-harm intentions. The second approach involved externalizing and normalizing the assessment through the use of prefaces such as "*I have to ask* you if you've thought about hurting yourself". The use of ubiquity statements as a segue to collect sensitive patient information has been found to be preferred by patients. (Floyd et al., 1999). This approach is similar to the use of a normalizing frame, such as: "research shows that quite a few adults have thoughts about suicide, has this been true for you?" (Sommers-Flanagan & Shaw, 2017). Moreover, both externalizing and normalization strategies have been shown to reduce chances that patients will feel stigmatized or judged if they admit to self-harm or suicidal ideation. When patients do affirm suicidal thoughts, they have been found to distance themselves from the associated stigma (Ford et al., 2020). Moreover, many of these strategies are face-saving and function to preserve the positive image or identity of another speaker (Goffman, 1967). Face-saving strategies have been noted as being common when dealing with sensitive or delicate matters (Lester & Paulus, 2014), such as suicide.

Methods

We collected data from a communication skills course designed to teach first year medical, nursing, pharmacy and graduate level psychology students how to engage in patient-centered interviewing to gain the patient perspective of illness. In fall of 2019, the course was taught in a hybrid format with learners completing asynchronous instructional modules, taking an online quiz, and conducting multiple in-person interviews with SPs as part of a small group with instructor feedback. Instruction emphasized an incremental exploration of depressive feelings which logically progressed toward two evidence-based components of suicide assessment: the use of a ubiquitous opener to help externalize and normalize the inquiry followed by a direct question about suicidal thoughts. ("Anytime I talk with a patient who seems down, I make it a point to ask…have you thought about committing suicide or hurting yourself?"). Following the online module, faculty were encouraged to have all learners practice assessing suicide ideation through a depression case in a small group setting followed by debriefing, to ensure learners were confident going into a final OSCE. Objectives for the final were to actively listen for the patient's perspective of illness, facilitate patient expression of thoughts and/or concerns, and reach common ground regarding next steps in their care.

This paper reports findings from a larger study that received Institutional Review Board approval. 149 out of 201 students consented to have their eight-minute video-recorded final OSCEs treated as data. Videos were downloaded for analysis after grades were submitted and transcribed verbatim using Trint and edited for accuracy by the research team. The entire final exam interview was transcribed. For the purpose of this paper, we focused our analysis only on the suicide assessment portion of the interview. Some exams were not able to be analyzed due to poor sound quality resulting in a data corpus of 121 exams. Eighteen different SPs served as interviewees for these OSCEs.

To analyze our data, we utilized a discourse analysis approach (Wood & Kroger, 2000) that was *informed* by some of the principles of conversation analysis (e.g., attending to the sequentiality of the interaction). More specifically, we drew upon an approach to discourse

analysis that was sensitized by the following overarching, analytic questions (Potter, 2004; Wood & Kroger, 2000):

- What is accomplished (i.e., social action or activity) in and through the language use?
- How is the language structured to make this social action (e.g. suicide assessment) possible?
- What conversational features or discursive strategies are used to make a particular social action (suicide assessment) possible?

Moreover, we sought to pay attention to what the student providers' utterances *achieved* in the context of the interactional sequence.

While our analysis was informed by the substantive literature, we conceptualized it as inductive and iterative and carried it out across multiple stages. First, we used a modified version of Jefferson's (2004) method of transcription (see Appendix A) to support a closer analysis of not just *what* was said but *how*. For example, in addition to taking note of words included within a question posed by a provider, we also took note of *how* the question was delivered (i.e., intonation). As such, our transcription system transformed a question such as, "What brings you here today, to "What (.) brings you here today↑". This attention to the micro-features of the interaction allowed us to attend to the potential function(s) of a given question as situated within the sequence in which it was produced. Each transcript was reviewed for accuracy by at least two members of the research team in iterative rounds and reviewed by the first author, with any issues mediated during team meetings. Second, we labelled the sequences or segments of the interaction where the student providers conducted a suicide assessment. Third, the research team read the transcripts in their entirety, focusing specifically on the suicide assessment sequences. The team members identified patterns and variations in the particular language choices that were used to enact the suicide assessment. Specifically, the research team maintained memos that recorded the interpretations of what was accomplished as a result of each conversational feature or language choice. In addition, the research team labeled the transcripts, tracking the various conversational features that were used in patterned ways. Fourth, drawing upon the principles of conversation analysis, we made note of and tracked (via memoing and coding the data) the sequential relationships within the interactions, generating tentative explanations about the interactional functions of the conversational features used. Fifth, drawing on previous literature as well as instructional material from the course, the research team made note of the interactional outcomes of particular conversational features. Throughout, we used ATLAS.ti qualitative data analysis software (Windows 8**)**, to manage and organize our research process. Finally, throughout, we assumed that the findings we produced were one of many interpretations, aligning closely with social constructionist understandings of language-in-use (Lester & O'Reilly, 2019).

Results

We found that 66 of the 121 (55%) final exam interviews included a suicide assessment. Five interviews included two assessments. These findings were consistent with Mospan et al. (2017) who found that 55% of learners (enrolled in the same course a few years earlier) included a suicide assessment. We found key patterns and variation around *when* sequentially

the suicide assessments took place, how they were *prefaced*, and how the *question itself* was structured.

Location of the assessments

Suicide assessments were launched in two ways: 1) during a sequence in which the student and SP were already exploring symptoms of depression (consistent with the incremental approach), or 2) as part of a shift away from a topic that was *not* already exploring symptoms of depression. See Table 1.

Table 1. *Location of the assessment in the interview*

Location	Number of final exam interviews where this occurred
When exploring depressive symptoms	39
As a topic shift	32

In the first approach, the assessment occurred *incrementally,* during or after the student and patient were discussing a family history of depressive behavior and/or the patient's decision to reject antidepressant medications, as illustrated in Extract 1.

	Extract 1.	
1	Provider:	So (.) um (.) just (.) I would like t-just >get a little bit more of an< understanding
2		about how you're feeling so um could you just explain a little bit more about what
3		um (.) lack of energy: feeling bl:ue um all that kind of all all those things how how
4		that affects you and your life like uh=
5	Patient:	=oh I just(.) i just feel do::wn um (.) tired (.) um have trouble ↑concentrating um
6		(.) and I have trouble sleepin you know↓ 'ust I'm j'st >I'm just not excited< about
7		anything
8	Provider:	well I ask um all of the (.) patients that I see that are >feeling down< and kind of
9		uh (.) um feeling down and (.) lethargic or um (.) just um tired all the time um
10		have you ever had any thoughts of maybe hurting yourself (.) or↑ (2)
11	Patient:	no no nothing ((shakes head back and forth)) like t'at it's
12		'ust I'm just tired all the time

The sensitivity of the interactional task is marked by the student provider's notable number of mini-pauses and prefaces of "um" throughout this extract. After the student provider invites the patient to share more of their feelings, specifically related to lack of energy and feeling blue (lines 1-4) (which could be symptoms of depression), the patient reveals that they have felt "down" (line 5). The student provider then repeats the phrase "feeling down" and "tired", first used by the SP, to transition to the assessment in line 10 ("have you ever had any thoughts of maybe hurting yourself or"). Repetition has been shown to play an important role in health assessment interviews (Vickers et al., 2016). When a speaker repeats another speaker's language, it functions to create mutual understanding, and is commonly used when dealing with sensitive topics (Brown & Levinson, 1978). In our data, this particular approach may have functioned to make the connection between symptoms of depression and the need to assess for suicidal risk visible to the patient.

In contrast, at other times, the students assessed for suicide as part of a topic shift that was not directly connected to exploring symptoms of depression, as illustrated in Extract 2.

	Extract 2	
1	Provider:	all right do you have a good support system with all of this too,
2	Patient:	well I attend church regularly=
3	Provider:	=okay
4	Patient:	m' wife's really a good support person.
5	Provider:	that's good (1) okay well=
6	Patient:	=she's the re'son I'm back over here
7	Provider:	oh yeah ((shakes head up and down)) I understand she knows best sometimes
8		um so can I ask you have you thought about hurting yourself or anythings (.)
9		with this new bout of depression=↑
10	Patient:	=I'haven't thought about hurting myself or anybody else or made a plan or none
11		of that stuff
12	Provider:	okay just wanted to double check [so no]
13	Patient:	[I understand]
14	Provider:	thoughts of suicide

In lines 1-7, the student provider and patient are engaged in a topic that is exploring existing and *positive* aspects of the patient's support system (e.g. "m' wife's a really good support person") rather than symptoms of depression. In line 8, the provider somewhat abruptly, within the same turn, shifts the topic to suicide assessment ("um so can I ask you have you thought about hurting yourself or anythings (.) with this new bout of depression↑"). This shift is not prefaced by anything that might otherwise prepare the patient for this question, such as a natural link between exploring symptoms of depression and assessing for suicide risk. While the SP readily answers this question as part of the OSCE final, such an abrupt topic shift may disorient a patient and obscure the connection between depression and suicide. This could cause "trouble" in the interview. Notably, given the institutional context (i.e., OSCE final exam), we noted throughout our analysis how the SP often responded in ways that were quite different from what is known from the literature around naturalistic clinical interactions. That is, in the literature base involving *actual* patients, we would expect, for instance, sudden topic shifts to potentially disorient a patient and lead to trouble in the clinical interview. However, this was not the case in our data, where the SP often made evident in their responses that they had an institutional task to complete, and, that was to participate as an actor in the context of the student provider's exam.

Prefacing strategies

The student providers used three strategies to preface the suicide assessment: ubiquity statements, normalization strategies, and statements of care and concern. See Table 2.

Table 2. *Prefacing*

Prefacing	Number of final exam interviews where this occurred
Ubiquity statements	37
Normalizing statements	3
Expressions of care and concern	8

Ubiquity statements framed the risk assessment as something routinely asked to all patients. They are one way to provide an externalizing frame; that is, posing the question as something that is required by an authority ("I have to ask") or as one that is asked to everyone no matter the specific symptoms (O'Reilly et al., 2016). These kinds of statements can prepare the patient and the student provider for possibly uncomfortable questions by positioning them as matter-of-fact. This can be particularly useful when handling a delicate matter such as suicide (Sommers-Flanagan, 2018). Extract 3 is an example.

	Extract 3	
1	Patient:	I just(.) i just feel do::wn um (.) tired (.) um have trouble ↑concentrating
2		um (.) and I have trouble sleepinIs you know↓ 'ust I'm j'st >I'm just not
3		excited< about anything
4	Provider:	well I ask um all of the (.) patients that I see that are
5		>feeling down< and kind of uh (.) um feeling down and (.)
6		lethargic or um (.) just um tired all the time um have you
7		ever had any thoughts of maybe hurting yourself (.) or↑ (2)
8	Patient:	no no nothing ((shakes head back and forth)) like t'at it's
9		'ust I'm just tired all the time

As in Extract 1, the notable number of mini-pauses and prefaces of "um" throughout this extract reflect the sensitivity of the topic. The ubiquity statement preface appears in line 4 ("well I ask um all of the (.) patients that I see that are >feeling down<" . . .) which simultaneously distances the student provider from the assessment while also connecting it to the symptoms of depression. By leading with the ubiquity statement, it positions the assessment as something that the provider asks everyone with that particular symptom. O'Reilly et al. (2016) noted that externalizing the reason for asking, such as "I ask um all of the (.) patients that I see . . .", allows for a provider to distance themselves from implying any judgement toward the patient. However, we noted that while this strategy may make the *provider* more comfortable, and is readily responded to by the SP in this example, it may send a message of suicide being a 'taboo' topic, resulting in the patient denying any such feelings. The use of the ubiquity statement "I have to ask" suggests a question asked out of obligation rather than sincere concern.

While not frequently used, we noted that normalizing statements were notably distinct from ubiquity statements. Instead of positioning the assessment as something the student provider "always does" or even "must do", it is positioned in closer alignment with the exploration of depressive symptoms, specifically. These types of statements may be more likely to open the conversation and reduce the possibility that the question is taken up by the patient as a judgement or indictment. Extract 4 is an example.

	Extract 4	
1	Provider:	. . .>I don't want this to come across < wrong or anything like that but people
2		that (.) do have thoughts of depression some people think about harming
3		themselves and I just wanna make sure that you have not made a plan or
4		thought about harming yourself or anybody else,
5	Patient:	no I guess'(.) I'm not (.) um feeling that

Prefacing the question with ">I don't want this to come across wrong<" (line 1) makes visible the difficult nature of this interaction – the student provider is concerned about how the patient will react to the question. In line 2, the provider specifically references "people that (.) do have thoughts of depression" (emphasis on the word "do") to normalize the assessment. Such a preface functions to alert the patient that a delicate matter is about to be introduced but, in contrast with a ubiquity statement, what comes next ("people that (.) do have thoughts of depression some people think about harming themselves") functions to normalizethat people who experience depression, specifically, may think about suicide. This preface ideally will function to encourage the patient to share any suicidal thoughts they may have (Shea, 2017).

Finally, we also noted a few cases where statements of care and concern were used to preface the suicide assessment, as illustrated in Extract 5.

	Extract 5	
1	Provider:	and um I always like to check with patients who (.) um (.) >show signs of
2		depression< or (.) acknowledge that they have depression↓ (.) uh cause patient
3		safety and you know I care about you it's my number one priority and I was (.)
4		wondering <if you have ever tried> to commit ↑suic::ide or if you have a pl::::an
5		or anything like tha::::at,
6	Patient:	No::::o huh uh no

In this case, a normalization statement in lines 1-2 ("um I always like to check with patients who (.) um (.) >show signs of depression<") is followed by an expression of care and concern in line 3 ("you know I care about you it's my number one priority"). Prefacing it with both a normalizing statement and a statement of care and concern may function even more successfully to encourage patients to disclose any such thoughts, depending on the institutional context.

Questioning strategies

Student providers asked about suicidal ideation in several ways: directly asking with a preferred negative response, directly asking with a non-polar question, and indirectly asking in an ambiguous way. We also noted variation in word choices used for the suicide assessment. Table 3 illustrates the frequency and type of question formulations used across the data.

Table 3. *Questioning strategies*

Questioning strategies	**Number of final exam interviews where this occurred**
Asking directly: non-leading (non-polarizing) structure	59
Asking directly: negative (polarized) preference structure	7
Asking indirectly/ambiguously	5
Asking directly using the word "suicide" or "kill yourself"	19
Asking directly using the words "hurt" or "harm" yourself	31
Asking directly using the words "hurt" or "harm" yourself or others	19

Student providers most frequently structured the assessment as a direct question. There were two variations of this: 1) a non-leading, non-polarized question; or 2) a question structured to "prefer" a negative response (Sacks & Schegloff, 1979). Sacks (1992) originally introduced the notion of preference structure when discussing invitations, wherein the preferred response is that of acceptance. Notably, some question formulations are structured in a way to "prefer" a particular response. In our dataset, questions were most often non-polar, as in Extract 6.

	Extract 6	
1	Patient:	no:↑ that's the weird thing I mean nothing has happened um everything is (.)
2		perfectly okay
3	Provider:	have you ever thought about >hurting yourself< (0.5) or committing suicide↓
4	Patient:	no

The question in line 3, "have you ever thought" does not prefer a negative or positively structured response, leaving interactional space for the patient to respond in a range of ways. In contrast, Extract 7 is an example of a negative-response (polarized) preference structure.

	Extract 7	
1	Provider:	so I'm gonna summarize again↑ you're just feeling down (.) um you haven't been
2		sleeping well you said uh your marriage is goo:d, your kids are good you're a
3		librarian you don't feel like work is any type of stressor=
4	Patient:	=not at all
5	Provider:	and you don't want to take any of your prescription uh medicine just because you
6		don't want that um (.) kinda that feeling from the medicine um you've had no
7		suicidal thoughts, (.2) is that correct?
8	Patient:	that's correct

In lines 6-7, the student provider conducts the assessment by asking: "you've had no suicidal thoughts, (.2) is that correct?". The structure, by including a tag question, *prefers* the response in line 8: "that's correct" which is a negative response to the assessment. This question type will require patients to work harder if they *have* had suicidal thoughts because dispreferred responses must be accounted for.

In a handful of interviews, students used an indirect approach to assess for suicide risk, as in Extract 8.

	Extract 8	
1	Provider:	OK (.) u::m all right so >I'm just going to summarize< (.) kinda briefly what we
2		talked about you're still not sleepin we::ll you don't really wanna take this
3		medication you wanna try something else (.) um...you are you know you're
4		dealing with depression, but you (.) feel pretty OK >I mean it's making you
5		ti::red<, but you feel mentally (.) OK is that ↑accurate do you feel like you're
6		in a good mental state↑
7	Patient:	ha (.) uh tired messes up your mental state I guess I guess
8	Provider:	you guess, (1) okay do you feel safe goin home by yourself↑ (0.2)
9	Patient:	oh yeah↑
10	Provider:	↑okay I'm just making sur:e

As the interview nears closure (the 2 minute warning occurs just after this extract), the student provider moves to provide a summary of the interview. She starts with the presenting

symptom (the inability to sleep) and the unwillingness to take the prescribed anti-depressant (lines 2-3 “you don't really wanna take this medication you wanna try something else (.)”). The student provider notes that while the patient knows they are dealing with depression they are also claiming to “feel mentally (.) OK”. They then ask the SP to confirm this (“is that ↑ accurate do you feel like you’re in a good mental state ↑”) after which the patient responds with less certainty, noting that the fatigue “messes up your mental state I guess I guess” (line 7). This functions to prompt the student provider in line 8 to ask “do you feel safe goin home by yourself↑”. Asking whether a patient is “fine to go home” is ambiguous and may not lead to open disclosure about thoughts of suicide. The patient’s response “oh yeah” comes after a brief delay rather than immediately which could point to “trouble” with the ambiguity of the previous question. The indirect method is not an ideal approach to assess for suicide ideation due to the risk that the patient may fail to understand the intent of the question. Subsequently, students using this technique may not follow-up with any other question to clarify the meaning behind what was asked.

Finally, as can be seen in the extracts in this section, student providers varied in what words they used to ask about suicide. In the course, students were encouraged to use direct, unambiguous language when conducting suicide assessments, but most did not do so. In only 18 of the interviews did providers use the word “suicide” or “kill yourself”. The most frequently chosen description was “harm/hurt yourself”, with fewer choosing the phrase “harm/hurt yourself or others” during the assessment. Still others, such as in Extract 8, did not use any of these words. These word choices may have implications for the outcome of the assessment, which we discuss in the next section.

Similar to other studies of clinical contexts involving sensitive interactions, our findings highlight the range of ways that student providers do the delicate work of conducting suicide assessments.

Discussion

More patients who die by suicide will communicate with their primary care provider than with a mental health specialist (Lake, 2008; Nock et al., 2022; Stene-Larsen & Reneflot, 2019). This makes it critical for students to learn how to effectively assess for suicidal risk. This study documents the ways in which student providers chose to make these assessments in preparation for their work as health care professionals. Findings can be used for curricular improvement.

Previous research showed that both an externalizing approach (such as ubiquity and normalization statements) and an incremental approach (situating the assessment in a discussion of emotions and behaviors) can be useful (O’Reilly et al., 2016). In the current study, roughly half of the students who assessed for suicide did so by using a method consistent with an incremental approach by first exploring the symptoms of depression prior to asking about suicide. However, the other half treated the assessment as a topic shift. Miller (2013) noted this disruption in the flow of the interview as a potential problem that arises from “prescribed questions” (such as teaching students to always assess patients with depression for suicidal risk) stating that such questions may “violate the flow of talk” (p. 38) if they do not happen incrementally. When introduced at the wrong time, an assessment “may constitute abrupt,

and unaccounted for, changes of subject (i.e. appear *out of place)*" (Miller, 2013, p. 39). This is indeed how nearly half of the assessments in this study were situated rather than as the incremental, logical progression from a discussion of depression as the students were taught to use in the course. This illustrates the challenge in preparing future health professionals to navigate a delicate matter such as suicide ideation. The disorganized assessments from the students could also have been a result of performance anxiety since the final OSCE score contributed to a significant portion of their final grade.

In the course, students were encouraged to use ubiquity statements when broaching difficult topics such as suicide assessments. While many did use such statements as prefaces, we noted that they need to be more closely tied to symptoms of depression. Providing an externalizing frame (O'Reilly et al., 2016) without the tie to depression may function to distance the provider from the patient if it is taken up as an obligation or requirement rather than as an expression of genuine concern. The provider's goal may be to distance themselves from making a judgement, but the patient may take up the message that suicide is a 'taboo' topic, resulting in the patient denying any such feelings. Normalization statements, while also an externalizing frame, may be preferable to ubiquity statements as they position suicidal ideation as frequently occurring with depression. Normalization statements may be more likely to encourage disclosure by reducing the stigma and alleviate feelings of isolation (Shea, 2017).

As suicide assessment is a sensitive task, prefacing it with a statement of care and concern may function to encourage the patient to disclose suicidal ideation. O'Reilly et al. (2016) noted that by using the externalizing/normalizing strategy combined with couching it in care and concern can help manage what can inherently be a delicate topic. Sommers-Flanagan (2018) also recommended directly expressing empathy, showing patience while waiting for a response, and validating disclosed emotions by using the patient's own language as key ways of engaging in conversations around suicide.

In the course, students were encouraged to use direct questions that used the word "suicide" or "kill yourself" to be as unambiguous as possible. Most did use non-polarized direct questions, which is encouraging, especially since Ford et al. (2020) found that clinicians were more likely to assess with questions that preferred a 'no' response. However, in only 18 of the interviews did students in our study unambiguously use the word "suicide" or "kill yourself". Ford et al. (2020) also noted that physicians used "self-harm" as the umbrella term to include suicide, which demonstrated a lack of specificity.

Practice implications

While faculty have been encouraged to have all students participate in suicide ideation assessment with a SP, there is no online module of the course dedicated to this. Creating such a module in addition to a facilitator and SP guide may help improve instruction around when and how assessments should occur (e.g., Cegala & Broz, 2002) to ensure consistency across the small groups. Course improvements should aim to increase the frequency of suicidal risk assessments during the final OSCEs. Coaching the SPs to respond differently based on the location of the suicide assessment can encourage students to align the assessment with the exploration of the symptoms rather than as a topic shift. SPs should be coached to respond

differently depending on which of the prefaces and questioning strategies are used. Instruction should emphasize use of normalization prefaces rather than ubiquity statements alongside expressions of care and concern. Asking about suicide risk directly, with a non-polarized question structure that includes the words “suicide” rather than “harm” should also be encouraged, with SPs coached to respond differently based on these choices. A possible sequence based on these findings is outlined in Table 4.

Table 4. *Possible sequence to teach students how to assess for suicide ideation*

Strategy	Function	Example
Normalization statement after exploring depressive symptoms	Mitigate threat/delicate nature of the task	It’s totally normal when you’re feeling down to consider self-harm or um something like that.
Expression of care and concern	Display empathy and build trust	I’m glad you came in to see us.
Direct question	Eliminate ambiguity	Have you ever thought of committing suicide?
Expressions of care and concern	Display empathy and build trust	I’m glad we talked about this….I like to talk about this with my patients when they are having these feelings

Modeling the suggested sequence in a video along with describing the function of each turn can give better direction and clarity to students. Sequencing these micro-skills (how to ask a direct question) as part of a macro-training process could be a viable model of teaching the complex interviewing skills needed when assessing for suicide risk (Shea & Barney, 2015). Through a process of serial role-playing with specific feedback at each stage, students can progress from individual micro-skills to more complex interviewing. This approach could be used instead of embedding the instruction on suicide assessment in a larger module on identifying emotions, as is currently the case.

Conclusion

Assessing for suicide is a delicate task for both patients and health care providers, both of whom may be reluctant to engage around the topic. This study provides insights into the details of interaction through an analysis of language choices made by students learning how to effectively assess SPs for suicide risk. Utilizing normalization statements as well as statements of care and concern to assess suicide ideation while exploring depressive symptoms can be positioned as a best practice for students. Like any qualitative study, we do not here claim generalizability of our findings, but naturalistic generalizations by the reader are encouraged. That is, findings from our institutional context may apply to similar educational settings in which sensitive topics (e.g. suicide and self-harm) are being explored by student providers in the health professions.

Before seeking mental healthcare specialists and counseling, most depressed patients initially communicate with their primary care provider. Thus, it is critical for the primary care providers to possess exceptional communication skills to recognize the viewpoint of patients who

mostly are reluctant to reveal their suicidal ideation. These skills must be taught within the curriculum for future healthcare professionals. In this study, we gained a better understanding of which patterns are likely to be effective for eliciting standardized (and ultimately, actual) patients' thoughts towards suicide intention. Out of the eight variations of assessing for suicide, the 'generalizing,' 'normalizing,' and 'asking directly' in the context of exploring depressive symptoms approaches seem likely to be the most effective in eliciting the patients' perspective towards depression. Even though our data is limited to SPs, the different communication strategies we identified add to the current knowledge base for when and how to assess for suicide.

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Declaration of interests statement

The authors have no potential competing interests.

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Appendix A

Appendix A: *Jefferson Transcription Symbols (Jefferson, 2004)*[1]

Symbol	Definition
=	Indicates no hearable gap or pause between the end and start of the next turn
(.)	Hearable brief interval, typically between 0.08 and 0.2 seconds
(1.5)	Time between end of a word and the beginning of next
Word	Underlining indicates emphasis
Wo::rd	Indicates a prolonged vowel or consonant
↑	Indicates upward shift in pitch
↓	Indicates downward shift in pitch
,	Indicates slight rising intonation
.	Indicates final falling intonation
°°word°°	Indicates whispering
Hhh	Indicates outbreath
~ word ~	Indicates a shaky voice
(( ))	Indicates comments or descriptions included by analysts
< >	Indicates that the pace of the speech has slowed
> <	Indicates that the pace of the speech has sped up

1) There are a range of other transcription symbols that are part of Jefferson's method. For the purposes of our analysis, we used a modified approach, attending to those symbols that were analytically most relevant.

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