A Conversation About… Deep Listening and Suicidal Suffering

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Content warning (00:00):

This podcast discusses content that may be distressing for some listeners. Please refer to the episode description for details about the topics covered.

Host (00:09):

Hi there. Welcome to Mental Health Professionals Network podcast series. MHPN's aim is to promote and celebrate interdisciplinary collaborative mental health care.

Nicholas Procter (00:27):

Hello and welcome to MHPN Presents a conversation about. My name is Nicholas Procter and I'm joined today by Conrad Newman. Welcome Conrad.

Conrad Newman (00:36):

Thank you very much, Nicholas. Good to be here.

Nicholas Procter (00:38):

Great to be here. And today we are coming to you from the land of the Kaurna people. We'd like to acknowledge Kaurna elder's past, present, and emerging, and certainly acknowledge the important contribution made by Aboriginal people to helping us understand suicide and how to respond with compassion. Today we're going to talk about the importance of deep listening in suicide crisis. Conrad and I have been committed for many years now to supporting people who are experiencing suicidal suffering. I have a disciplined background in mental health nursing and Conrad -

Conrad Newman (01:11):

I'm a psychiatrist at the end of my career.

Nicholas Procter (01:13):

And what we really have developed over this time is not just an interest in the topic and how we can conceptualise the topic, but I think a really great collegial relationship on how and when to move in new ways and to think about suicide. And we both travelled to the United States together to Colorado as part of the Aeschi group to talk about suicide and certainly the Aeschi philosophy and suicide. And we're building on our earlier podcast, the book club podcast. In today's meeting currently, Conrad is undertaking postgraduate studies in the field and I'm his thesis supervisor. But today's not about thesis supervision. It's about the topic of suicide.

Conrad Newman (01:55):

Yeah, exactly. And I think it'd be interesting to touch on just how long we've known each other, Nicholas. It would be about 15, 16 years. And I referenced this in the other podcast, I think you convened a group of people who were interested in suicide prevention at a coffee shop in Adelaide to basically talk about how do we do things differently because we weren't doing things terribly well. The suicide rate was high, satisfaction from people who'd attempted suicide and been seen in public facilities was not great. The satisfaction rate of their families was not great. So I think that's the origins of something that you have labelled, which I've really identified with, which is listening to listen and had its origins there.

Nicholas Procter (02:45):

I do remember that it was very good coffee.

Conrad Newman (02:47):

Yes -

Nicholas Procter (02:48):

And good coffee brings good conversation. And I think that was the early origins of a concept that became known as shared learning in clinical practise.

(02:58):

A series of symposiums run in South Australia, in metropolitan Adelaide, but also in regional parts of South Australia. And the whole idea about shared learning and clinical practise was to create a sharing culture, to be able to be generous with each other about what we know and how we're finding our way, what we've learned in that process and how we apply that at the point of care. So what sat behind each of those words I remember as a group was to be able to conceptualise how we share, create knowledge, and then apply it at the point of care.

Conrad Newman (03:32):

And the symposiums been going for 10 years, which is quite phenomenal and had fantastic feedback in terms of the content that was delivered. My other motivation for joining the group was I had taken a break from psychiatry and worked in IT in America for 10 years and came back and was the consultant psychiatrist for a closed ward, which is really jumping in the deep end, coming back into psychiatry. One of the things I was struck by was how we were dealing with suicide was no different to how it was 10 or 20 years earlier and a few other influences that really hit me at that time. There was a review between

2007 - 2009, so it's quite a long time ago now, but of eight men who had presented to an emergency department in Adelaide who went on to suicide shortly after their contact. What was interesting was a hundred percent of them were diagnosed with an adjustment disorder.

(04:36):

And I think we have this view that an adjustment disorder is less lethal than major depression, is less lethal than major depression from psychotic breaches, which I don't think is at all the case. And for all of those men, their supports, their family, their significant others, only three of the eight had any contact with their family. And I think listening to listening is not just about the patient in front of us, it's also listening to the family and the friends and the network of people around them. And of those eight, none of them received assertive follow up. And I think one of the things we now know is that men don't tend to come to services, we need to go to men. So that knowledge of what had happened really spurred my interest in the group as well.

Nicholas Procter (05:25):

That's really interesting because when I hear you speak, I think about two things, two types of listening I think of human connection, listening, being truly present, leaning in, listening in, working to a situation where the person in distress feels felt by the worker. So that dimension of leaning and listening and being truly present and connected. But you know, Conrad, when you speak, I also think about the system listening, the system responding the chain of care, the people who are involved in designing, delivering and evaluating the system, listening and leaning in and being truly present in the lives of people and their loved ones and their carers. They're two things that come to me when you make that point.

Conrad Newman (06:13):

It's interesting because my take on the system response in general is to put in more risk management procedures as a way of dealing with that rather than opening it up to listening and leaning in. As you said, more and more complicated risk assessment forms, risk assessment procedures. And we know, and I think we commented this in our last podcast, it's not so much about prediction because I don't think we can predict who will suicide. It's what can we do to try and mitigate the potential for suicide.

Nicholas Procter (06:45):

That's interesting because you're absolutely right. Risk stratification, so-called low, medium and high risk stratification to make decisions about what next and how next are completely out now. And there's a global consensus, there's a national consensus, completely out and don't provide any practical clinical utility. And that's linked of course to fluctuating states of suicidal distress, rapid intensification and intense moments of suicide related to stress and the onset and worsening of suicidal urges and a better understanding of the fine grain stuff around that, which has been very, very useful. But the other thing that I think of is when systems and services become risk procedural forms and ways of engaging becomes perfunctory and it is empty of person-centred, authentic connection and person-centred or authentic connection, literally connecting, human connection, is what I often hear as being the essential ingredient, the core ingredient for the prevention of suicide.

Conrad Newman (07:57):

I think it is very much so. And I think what that makes me think about is in South Australia there's been a fairly wide adoption of safety planning, which I think really comes out of your group and the shared

learning and clinical practise symposium as a simple but very effective way of trying to mitigate potential for suicide. But how it's done really differs. There are some centres where people are handed the safety plan sheet and told you have to fill this out before we can go home or before we can discharge you in contrast to centres where someone will sit down and work with the person to figure out what it means for them to try and keep themselves safe, when do they need to reach out to somebody else and when is it an emergency situation?

Nicholas Procter (08:56):

And that's about understanding the crisis narrative and having a conversation which kind of recounts to some extent the onset of distress, and what might be an effective way to be able to support the person or things that the person can do for themselves, things that make their situation safer, things that may distract them, things that may reinforce or reconnect with reasons for living right through to the removal of lethal means and emergency rescue and emergency care and people to talk to. And what we've been trying very hard to do with what I'd say would be good cooperation and engagement with SA Health, the ED physicians as well as nurses is try to explain that as not a form filling exercise, but an opportunity to make the most of an opportunity to be truly present and sit side by side. So yes, it's about the Aeschi type approaches, particularly the work of Stanley and Brown, the great work of Greg Brown and the late Barbara Stanley and the way in which they contributed to Aeschi and I credit you for introducing those people to me through the Aeschi process. You certainly did do that. And then how we document that, how we make that possible and visible and practical and applied and where possible involving family members and loved ones that may be part of that process.

Conrad Newman (10:18):

Very much so. I agree with you completely. It's an entry point to a dialogue rather than just a form. And I think the extension of it, and I'm yet to see too many safety plans that have added this extension, but it's where you get the family involved and the person says, when I do X, I would like my significant others to do Y. So for example, when I start withdrawing to my bedroom, I'm not answering phone calls, I'm missing days at work. What would I like them to do because the warning signs that I'm becoming unwell or becoming suicidal.

Nicholas Procter (10:55):

And just thinking about the words entry point to a dialogue. So when you enter something, you shift positions, you are entering into a situation or a possibility which may bring fresh ways of knowing and knowing how and when to move with new possibilities. But importantly about the dialogue, about the conversation, about what's right for the person that's developmentally, appropriately, age appropriate, gender appropriate, culturally appropriate. And even just thinking about that, thinking about those dimensions. Some of my work has been, as you know, in the refugee space, and I've had a lot of engagement over the last 15 years with people of refugee background, not just in Australia but elsewhere. I've had 10 trips to Nauru where many people have been held and still are remaining on the island. And it's something that's been really clear to me in suicidal crisis and certainly trying to understand and respond to suicidal suffering for people of refugee background, who've had trauma experiences to enter into that conceptualization of distress.

(12:01):

And I remember one of the great mentors that has opened up these possibilities literally opened up these dialogues, Konrad Michele, who we discussed in our most recent podcast together. He made this point that outside observers can always make a judgement, make a statement about somebody's

distress, but it's only when you enter into the conceptualization of distress, be truly present, create psychological safety, lean in, listen in, and be truly present, that things can be opened up. And I know that he does that in his work and he certainly does that in rethinking suicide, his book that we spoke about last time we were together.

Conrad Newman (12:43):

And very much inherent in his work. And I think where we're shifting is it's not launching into an assessment by how old are you, where do you live? Who's at home with you? It's giving the person 20 minutes to say to them, what is it that happened that led to this point where you attempted suicide?

Nicholas Procter (13:04):

And what are the relationships, opening up the possibilities to hear about the relationships that the person is describing to be really the drivers of distress or linked to drivers of distress and trying to understand that. Now, Conrad, about your research work that you're doing right now, what are some of the things that have come through to you? What have you learned?

Conrad Newman (13:23):

The basic premise of the research is listening to telephone calls to a 24 hour a day mental health triage line by men or people who are concerned about men, where all of the men went on to die by suicide. So it's a really deep dive into what people say and do in interactions with people on the phone who are suicidal. I think it differs to other approaches like ethnographic approaches where you're watching, which I think changes people's behaviour. These are recordings from a triage service that are kept for 25 years and were available for review. What's been interesting is of the recordings I've listened to, there are several themes that come through. One of the first ones would be what I'd call a lack of compassion. Another one would be a certain level of burnout by the call takers. I think also what is really striking is I guess you would call it almost hostility to towards the caller.

(14:40):

One of the comments that has stuck with me is a call taker telling the caller to grow up, not a useful comment to make for someone who's in suicidal distress. And the recognition of the suicidal distress hasn't been great as well. So one young man that is one of the longer cases in my research work, called twice very distressed both times and there was no follow-up arranged for him. So he was left with his distress without any further support, having lost his wife, lost his children, his job was at risk. So in terms of meeting the person and coming up with a plan with them, a collaborative plan for how they could, number one, try to keep themselves safe, and number two, access further support has been lacking.

Nicholas Procter (15:42):

What do you make of that? What do you think is the backstory to how things got to this?

Conrad Newman (15:49):

I think there's a few factors. I think number one, it is a very difficult job. I think to answer crisis calls all day would be very depleting. I think from what I can gather is a lack of training and the selection of the workers, the workers who man a triage phone line like that should be amongst the most skilled practitioners from a psychotherapeutic point of view, but also from a recognition of mental illness point of view, and from a knowing how to link people with services.

Nicholas Procter (16:23):

And in your research, do you begin to make recommendations above and beyond that you're starting to think about what's needed in the system, what's needed in services, what's needed specifically around education or training?

Conrad Newman (16:40):

Yeah, I think it is very specific education and it's very specific suicide focused education. David Jobes, who's also one of the founders of the Aeschi Group, has a great model that he talks about where traditionally we look at are you depressed? Are you sleeping, are you eating? Can you concentrate? Whereas his model kind of switches that and says suicide is the number one focus for the interaction and how do you target and try to mitigate that?

Nicholas Procter (17:13):

It's interesting you mentioned Jobes as one of his quotes that has always resonated with me, and it kind of goes along the lines of the client is the expert in their experience and the clinician rallies around that perspective. People's psychological pain, their hopelessness, and what he's really trying to do when working with people who experience suicidal thoughts is make the most of the opportunity to discuss the drivers of distress. But also link services, supports, ways forward, solutions where they can be found side by side. He tries to do that in a side by side way. And I think this relates to what we discussed earlier. It's almost as if we need to invest and make visible in the interaction, those soft skills, those soft skills of listening, being truly present, giving people space, holding space, deep listening, listening to listen and to do that side by side and to know how to hold space. When you do do that and without judgement but be truly present, many times my experience has been when I've held space with people, the quality of the interaction becomes richer and deeper. And the relationship of hearing and my hearing, the relationship of hearing is also their relationship of hearing themselves. So what they are saying, they hear and make meaning out of that, or meaning making.

Conrad Newman (18:47):

Very much so. It's also trying to instil hope in a situation where a lot of people will make you feel that the situation is hopeless by their view of what's going on in their life and trying to mobilise reasons for living no matter what they might be. And I hear all kinds of different reasons for living through my family, my job, my pet dog, trying to key into that so that there's an anchor point to life.

Nicholas Procter (19:20):

Conrad, what do you make of situations where somebody says, I don't have any reasons for living.

Conrad Newman (19:27):

It very much sways me in terms of what the management should be. So when people have multiple reasons for dying where they have no reasons for living, where they have intense emotional pain, where they have intense stress, where they have intense self-hate, where they rate their own suicide risk as high, which as a side point is all captured in the suicide status form that David Jobes has produced. I am then thinking more about being able to keep that person safe for a period of time until those things shift. And they do shift because people's suicidality fluctuates. Not that it won't return, but it gives you a window of opportunity to try and put in place some strategies to try and help the person endure the suicidal state rather than die from the suicidal state.

Nicholas Procter (20:27):

And it's interesting when you speak, I reflect on how today, for example, we've talked about compassionate listening and caring and leaning in listening, in being truly present, working to a situation where the person feels felt. But we've also talked about where that's not happening and how that's absent from clinical practise and professional practise. And so the question I have in my mind is how do we as a society or how do we as a healthcare system, service provider, organisation, get these things to stick? How do we win the hearts and minds of people so that they know how and when to move in new ways that reflect the things that many of us in the field of suicidology argue are essential and argue are key elements of a considered compassionate person-centred response to stick in practise?

Conrad Newman (21:27):

I think it's tough, but I think it's doable. And the things that come to mind are having champions in lots of areas that actually champion a different approach and model it to people. Education obviously is important, but I also think there's something in someone staying in the same position for 10 or 15 years without being rotated out of that might not be the best way of maintaining their compassion. That I think that it's demanding work that phone triage people do. It's demanding work that ED staff on psychiatric wards, giving them the opportunity to do something different for a period of time to refresh, I think would have a lot of value.

Nicholas Procter (22:17):

A few years ago now, I was introduced to the concept of affective learning, emotional learning, and it has its origins in primary education, but it's also applied in workforce settings and workforce education and being emotionally moved to understand and learn from that understanding and have a reflective practise dimension to that.

(22:40):

And I found in more recent times, so I'm flash forwarding now to more recent times that people who share lived experience of suicide can be our teachers. They can teach us how to get through the darkest periods, how to survive alone at times, what it feels like when the interaction is perfunctory or impersonal, detached in its nature, what that truly means, how that left them feeling, what the experience was and how they needed to rebuild to survive and to get through. I've been really impressed sometimes with the willingness and the generosity of people to share those stories and share them with a good heart as a good faith transaction for a better society, a better world for people who experience suicide and experience suicidal suffering. I've been moved by that in recent times and I wonder whether that is a place that we need to shine a light more on.

Conrad Newman (23:42):

I think we certainly do. One of the things that has struck me though is when I've spoken about the possibility of doing that in different services, there's been a lot of anxiety about introducing people with lived experience of suicide into the dialogue with people who are suicidal. And I think it's a misplaced anxiety. I think it's such a powerful thing and people give so much validity to people who've been through an experience and survived it compared to what they might get in terms of medical advice.

Nicholas Procter (24:17):

That's a very interesting observation. What do you make of that?

Conrad Newman (24:20):

I'm not quite sure. I'm not quite sure where the anxiety comes from. Partly it might be anxiety about what impact it's going to have on the peer worker, but I think that can be mitigated through good supervision and support. But other than that, I'm not sure.

Nicholas Procter (24:35):

So Conrad, one of the things that I'm thinking of now is listening. There's a consensus and a strong agreement about listening. We're on a big unity ticket on listening. But is there more to the story? Are there other things that come into conscious play that are in the real world of clinical practise?

Conrad Newman (24:53):

One of the other situations that I think you being the people that are listening to the podcast will encounter is the person that you're seeing who has written a suicide note, say goodbye to the people that they care about. And yet when you talk to them, they say it was all a mistake and they really just need to go home. And I think in those situations, what I tend to do, and this is influenced by the work of M David Rudd, another Suicidologist who is part of the Aeschi group, and what he says is, I hear what you're telling me, but in this instance, I'm inclined to go on your behaviour rather than on the words that you're telling me. So that's just a minor point in that it's not always just listening to what the person says, it's their behaviour and what you reflect on in terms of their intent.

Nicholas Procter (25:58):

Are there tensions in that? Are there tensions for a clinician who has the authority to implement those orders? And what are those tensions? Are there tensions? What are those tensions?

Conrad Newman (26:00):

I think in fact, there are always tensions when you are assessing somebody who's suicidal. The tension between do they need to be in hospital or can they be treated in the community? What supports do they have that can bolster them through this? What do we need to do to alleviate their pain or sleeplessness? And are there things that are going to be happening in the near-term future that are going to increase their risk?

Nicholas Procter (26:30):

So if we're a practitioner, what I think of when you speak about that is I think about the life of a practitioner and the thinking space of the practitioner to be able to hold these tensions, but also to bring a wide angle lens to the physical and mental health dimensions of the story, but at the same time know how and when to bring a zoom lens into the relationship to try and understand what's happening in the space between the worker and the person in distress or the person who's presented. But also a zoom lens on what was it that is in the story for how things got to this, and being able to understand that. So what does that say to me? It says to me that as a practitioner working in health and human services, mental health services in particular, being reflective and being nimble and being able to nuance in a way that maintains connection but also takes into consideration the system-wide processes, what's going on in the wider system and the wider world. And that includes social determinants of suicide right through to other determinants or drivers.

(27:41):

And that's a lot, and that's a new way of conceptualising suicidal suffering. It's a new way of thinking about training and development needs. It's a new way of helping families better understand what's happened and what is happening with their loved one. There's a great deal in that landscape if we do it well. It's a landscape that can bring hope and people are understood. It brings hope through people responding and being in tune with drivers, but the wider determinants. But it also gives you something to work with that's community as well as other places or solutions or supports or ways forward that are embedded in community, but also embedded in other practises, other specialist areas.

Conrad Newman (28:25):

I think very much so, but I think where clinicians are up against incredible difficulty at the moment, is just the changing landscape in Australia in terms of the haves and the have nots. And never before in my practise, even in my private practise, have I seen so many people who are homeless or facing homelessness, family disruption, unemployment. And it's hard to mitigate against those factors. You need a whole of government response.

Nicholas Procter (28:55):

It is so true. And Conrad, the other day, I walked from my office to a meeting and I had, in the CBD, and I walked 700 steps. So I looked at my step counter, I walked 700 steps and I passed seven people sleeping rough or asking for money on the street, sleeping in doorways. And I thought, I have never seen that before, but that has just occurred. So I think that is so true, and the socioeconomic determinants and social forces and social dimensions of doing it tough are so visible now. And you're right. That's what clinicians, frontline workers health and human service workers and non-government sector volunteers, lived experience workers are all responding to, understanding and responding to right now. And there's not a medical solution to that, but it has potentially dramatic and if not catastrophic in some cases, consequences. So there's a big story there, a big body of work in social policy and human service, policy, housing, a whole range of things.

Conrad Newman (30:10):

Before we finish off, there's one other person I wanted to mention who's Christopher Shea, who's been influential in Queensland and the Gold Coast in their efforts to redo how they approach the suicidal person. And for people who are listening who are thinking, I'd like to sharpen my skills in assessing the suicidal person. He has a book, he also has an online training programme, which I found particularly useful in terms of sharpening my skills for dealing with a suicidal person.

Nicholas Procter (30:45):

Conrad, those points that you just made, the way that you made them tells me that there's a conversation still to be had. We've got more discussion, more conversations, and I'm certainly looking forward to that.

(30:56):

So thanks for joining us on this episode of MHPN Presents A Conversation about, you've been listening to me, Nicholas Procter and -

Conrad Newman (31:04):

Conrad Newman.

Nicholas Procter (31:05):

We hope you've got something out of this conversation where we've discussed key things around suicide, Aeschi. Some of the references and resources, will make those available. If you want to learn more about Conrad or me or Aeschi, or if you want access to the resources to which we've referred, go to this episode's landing page and follow the hyperlinks. MHPN values your feedback. On the landing page, you'll also find a link to a feedback survey. Please do fill it out. Your comments are important to us. Let us know whether you found this episode helpful and or provide comments and suggestions about how MHPN might better meet your listening needs. Thank you for your commitment and engagement with interdisciplinary person-centred mental health care. And don't forget to provide us with some of your ideas via the feedback form on what you'd like to hear more about in the field of suicidology. Stay tuned for the next MHPN Presents podcast, which will be released on Wednesday fortnight. Thank you very much.

Host (32:12):

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