Help-negation among telephone crisis support workers: Impact on personal wellbeing and worker performance

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Presentation abstract

Telephone crisis supporters (TCSs) provide front line mental health support to callers in crisis. TCSs often support callers with suicidal thoughts, depression and anxiety, and the caller’s experience of the call will influence whether they will seek help from a crisis support service in the future. Despite their important role, little information on TCSs’ mental health and help-seeking behaviour exists – a structured literature search returned only 2 studies.

This paper presents the results of the first study in a national research program that is aiming to inform the future training, preparation, supervision, and support of frontline health professionals who are working in telehealth crisis sector, both within Australia and around the world.

This study answered three research questions:
Do TCSs’ experience symptoms of suicidal ideation, depression and anxiety?
Do TCSs intend to seek help for these symptoms?
Do service provision intentions vary for TCSs experiencing different levels of symptoms?

Results provide compelling evidence that exposure to callers in crisis is an occupational hazard for all telehealth professionals in the sector, including medical professionals. The first study of the research program suggests that help-negation (reluctance to seek help as distress levels increase) occurs commonly among telehealth professionals who are exposed to suicidal, depressed and anxious callers. The results also suggest that this common occupational hazard significantly impacts both the personal wellbeing and professional use of recommended intervention skills by telehealth professionals with callers.

Implications for TCS training, preparation, supervision, and support are discussed.
Premise

Suicide prevention requires effective risk reduction *at the same time as* active wellbeing promotion and optimal crisis intervention.
Proven service model + Optimal helper performance → Optimal crisis intervention
Optimal helper performance

- Knowledge of and adherence to optimal helper skills
- Working understanding of caller distress experience, expression, development of symptoms
- Resilience to occupational hazards
Greatest occupational hazard: *Personal impact of the distress of others*

- Personal distress is related to **poorer skills performance** among doctors and other health professionals.

- Personal distress is related to **lower levels of personal help-seeking and wellbeing (help-negation)** in general community samples.

Greatest risk to optimal crisis intervention is **disconnection from professional skills and personal wellbeing**.
Question

Is personal distress related to poorer telephone support skills performance and lower levels of personal help-seeking among telephone crisis supporters?
Aim

Answer three research questions:

1) Do Telephone Crisis Supporters experience symptoms of suicidal ideation, depression and anxiety?

2) Do TCSs intend to seek help for elevated symptoms?

3) Do TCSs experiencing different levels of symptoms still intend to follow recommended Lifeline support skills?
Method

• A representative sample of 124 Lifeline TCSs completed an online survey

• TCSs reported their current level of suicidal ideation, depression and anxiety symptoms, plus intention to seek help for these symptoms

• TCSs reported their intention to use recommended telephone crisis support skills: significant suicidal ideation, serious depressive episode, and acute general anxiety
Results

Research Question 1: Do TCSs experience symptoms of suicidal ideation, depression and anxiety?

- Most participants were in the normal range on all measures of psychological distress (suicidal ideation, depression, anxiety)

- But, even low level symptoms can impair normal function

- As a group, participants were
  - unable to manage their day-to-day activities approximately 1 day during the past month \( (M = 1.13, SD = .81) \)
  - had to cut down on day-to-day activities on an additional 3 days during the past month \( (M = 2.93, SD = 5.39) \)
Research Question 2: Do TCSs intend to seek help for symptoms?

• OVERALL, participating TCSs reported they were
  – Likely to seek help from a professional for personal symptoms of suicidal ideation, depression and anxiety
  – Unlikely to seek help from telehealth or personal help-sources
  – Unlikely to not seek some form of help

HOWEVER...
When compared as two groups with different symptom levels:

Compared to TCSs with low level symptoms, TCSs with higher levels of suicidal ideation, depression and anxiety symptoms were

- **Unlikely** to seek help from professional, telehealth and personal help-sources (ORs = .74 - .99)

- **Likely** to not seek help from anyone (ORs = 1.19 - 1.25)
Research Question 3: Do TCSs experiencing different levels of symptoms still intend to follow recommended Lifeline support skills?

- OVERALL, TCSs were likely to use the recommended skills with suicidal, depressed and anxious callers.

- However, when compared as two groups by symptom level:
  - TCSs with higher levels of suicidal ideation and anxiety symptoms were unlikely to use recommended skills with suicidal, depressed or anxious callers (ORs = .78 - .94).
Conclusions

• While TCSs are generally *Likely* to seek professional help for symptoms of personal psychological distress, and to use recommended skills with callers, help-negation (reluctance to seek help as distress levels increase) occurs among TCSs exposed to suicidal, depressed and anxious callers.

Help-negation impacts TCSs’ *personal wellbeing* and their *skills with callers*
What is help-negation?

A **common process** that **occurs in the face of distress** – TCSs are **not immune or unusual** when they develop distress and negate help.
Help-negation is defined as:

The process of help withdrawal or avoidance among those currently experiencing clinical and subclinical levels of different forms of psychological distress

Wilson et al EIP 2011
Understanding the **determinants** of the **help-negation** process provides a **potent opportunity** to target training strategies that facilitate **TCS wellbeing** *and* optimal call outcomes.
Results case-controlled comparison of help-negation across the past 10 years among young adults in the community
**SUMMARY**: Logistic regression using increasing intensity of suicidal ideation to predict intention to seek help for suicidal thoughts

<table>
<thead>
<tr>
<th>INTENTION</th>
<th>2000</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends and family</td>
<td>no***</td>
<td>no***</td>
</tr>
<tr>
<td>Mental health professional / Telephone crisis line</td>
<td>no***</td>
<td>no**</td>
</tr>
<tr>
<td>Not seek help from anyone</td>
<td>yes***</td>
<td>yes***</td>
</tr>
</tbody>
</table>

***Odds Ratios (adjusted for age) within 95% Confidence Intervals and significant at p<.001, **p<.01

Wilson Caputi et al 2012a
A similar pattern of reluctance to seek help has been also found for symptoms of stress, anxiety, depression

(Wilson Caputi et al 2012b)

Where does this lead us?
Predicting TCSs personal help-seeking and service provision: Is it about problem labelling and TCS confidence?
Aim

Answer two research questions:

1) Is TCS personal help-seeking and Lifeline skills application a function of inaccurate problem labeling?

1) Is TCS personal help-seeking and Lifeline skills application a function of low confidence?
Method

• Same sample of 124 Lifeline TCSs and same online survey as in Study 1

• Participants reported intentions to use recommended telephone crisis support skills: significant suicidal ideation, serious depressive episode, and acute general anxiety

• TCSs were asked to label each problem-type and report their confidence for working with each problem
Results

Research Question 1: Is TCS personal help-seeking and Lifeline skills application a function of inaccurate problem labeling?

— Most TCSs were able to accurately label hypothetical callers’ symptoms as suicide (56.1%), depression (76.5%) and anxiety (79.5%)

— A significant minority opted not to label the caller’s problem, noting that this was not their role as a TCS

— TCSs ability to accurately label suicidal ideation, depression and anxiety was not associated significantly with personal help-seeking intentions for suicidal ideation ($p = .692$), depression ($p = .260$), anxiety ($p = .234$)

However...
• In general, TCSs who could accurately label depression were significantly more likely to use recommended Lifeline skills \((p = .025)\).

• TCSs who accurately labelled depression were significantly more likely to use recommended Lifeline skills for suicide calls than those who labelled depression inaccurately \((M = 3.87 \text{ vs } M = 3.74; \ p = .007)\).

• Ability to accurately label depression did not associate significantly with intentions to use recommended skills for general mental health calls \((p = .058)\).
**Research Question 2:** Is TCS personal help-seeking and Lifeline skills application a function of low confidence?

- About half of TCSs felt confident to seek help for personal symptoms of suicidal ideation (51.6%), depression (56.5%) and anxiety (54.8%)

- TCSs reported greater confidence to seek help for personal symptoms of anxiety \((M = 3.35)\) than for depression \((M = 3.30)\) or suicidal ideation symptoms \((M = 3.16)\)

Adjusting for confidence made no difference to the help-negation or service provision results
Summary: results across studies in community and TCS samples

• **Expanding results:** Cognitive, affective and social processes involved in help-negation after critical suicidal thoughts (Wilson C, Svenson A, Caputi P; Oral Presentation NSPC 2013)

• **Help-negation**
  - Help-negation occurs with **low intensity** symptoms of common mental disorders (stress, anxiety, depression) and suicidal thinking
  - Help-negation process is **relatively stable** across time
  - Help-negation is **stronger** for friends and family than mental health professionals
  - Patterns of help-negation are **slightly different** for arousal symptoms vs depression and suicidal ideation
  - Help-negation and skills application is **not a function of purely psychological processes** (e.g., knowledge, attitudes, beliefs or confidence)
Biological and neurological underpinnings are implicated (+ social and psychological factors)

- Expanded in NSAC 2013 Poster Presentation: Preventing help-negation for suicidal ideation: Implications for social network size and frequency of social interaction (Svenson A, Wilson C, Caputi P)
• TCS performance:
  
  – Personal anxiety, depression and suicidality are an occupational hazard of the TCS role
  
  – Elevated but low level symptoms impair personal function and wellbeing as well as recommended Lifeline skill application
  
  – Accurate problem labeling facilitates recommended skill application
  
  – Only half of TCSs could or would accurately label anxiety, depression or suicidal ideation
  
  Where does this leave us?
Study 3
Taneile Kitchingman (PhD Clin Psyc research)
Coralie Wilson
Peter Caputi
Alan Woodward
Ian Wilson

Which call types have the greatest risk for evoking TCS distress and help-negation?

(watch this space)
Study 4
Tara Hunt (Hons research)
Coralie Wilson
Peter Caputi
Alan Woodward
Grahame Gould
Taneile Kitchingman

Which skills optimise call outcomes and protect TCSs against developing psychological distress?

-Expanded in NSPC 2013 Poster Presentation: The role of assertiveness on TCS well-being and service provision
Recap

Suicide prevention requires effective risk reduction at the same time as active wellbeing promotion and optimal crisis intervention.
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Optimal helper performance

- Knowledge of and adherence to optimal helper skills
- Resilience to occupational hazards
- Working understanding of caller distress experience, expression, development of symptoms
Questions?

Thanks for your attention

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