Suicide Assessment and Treatment Planning: A Strengths-Based Approach

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Free Resources: https://johnsommersflanagan.com

Preparation

- Welcome and thanks to Hal Lewis and Katie Wolverton for the invitation and for organizing!
- Emotionally challenging topic
- 30+ years ago – 2021 Networker article: https://www.psychotherapynetworker.org/article/myth-infallibility
- Please practice **proactive and positive coping**

PREPARATION II

Trigger Warnings

- I will be talking about suicide – I have had people need to leave
- I will be saying contrary things
- But, don't let my trigger warnings set you up to over-react☺

Now – A Strength Warning

Learning Process

- We are in-person!
  - I talk about a **strengths-based suicide approach** We watch a few videos, practice, and have some demonstrations
  - **You do your magic of imagining yourself taking what I say and making it work for you and your clients/patients**
  - You comment and interact **as you wish - learning/practice opportunities**
  - We all **cope well with** this challenging topic

Learning Objectives

1. List key differences between medical model and collaborative approaches to suicide assessment and treatment
2. Describe at least one way to integrate medical model and collaborative assessment and treatment approaches
3. Identify, implement, and discuss at least three specific assessment strategies you can use with clients/patients who have a history of sex offenses.
4. Identify, implement, and discuss specific suicide-focused interventions you can use with your clients/patients

Why a **Strengths-Based** Approach?

People who feel suicidal need to be seen, accepted, respected, and valued – not dismissed or reduced to a stereotype or told they should or shouldn't feel particular ways.

This is especially true for people with identities that have been historically and are currently marginalized. . . Including offenders.

Part I

Medical Model vs. Strengths-Based Principles

Inside the Box
The Traditional Medical Model

Basic Principles – Positivistic Philosophy

- Suicidal thoughts and behaviors **represent illness**; we need to intervene (90% estimate; **What's the "real" CDC estimate?**)
- We are **authority figures** who know more about patient health than they do
- The patient is a **suicidal person**
- We can **predict and prevent** suicide
- We use research-based **risk assessment** procedures and questionnaires to categorize risk as mild, moderate, severe, extreme
- We treat **mental disorders** that are linked to death by suicide

Common Standardized Questionnaires

- The Patient Health Questionnaire-9 (PHQ-9)
- The Columbia Suicide Severity Rating Scale (C-SSRS)
- The Ask Suicide-Screening Questions (ASQ)
- The diagnostic clinical interview (see JSF – 2024, chapter 10 – Suicide Assessment)

Questionnaire Advantages

- Gather information efficiently
- Standardization – reliability, validity, and norms
- Some patients are more open with a questionnaire
- Liability protection
- Prediction accuracy (maybe?)

Example: The PHQ-9

- Nine items from the DSM Major Depression diagnostic criteria
  - **Item #9**: “Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?” (David Jobes and the CAMS-care people just put a universal ghostbuster sign on the PHQ-9 as a suicide assessment tool)
  - **4-point Likert scale**: Not at all; several days; more than half the days; nearly every day

The Columbia (C-SSRS)

Two opening questions:

- Have you wished you were dead or wished you could go to sleep and not wake up? **[Passive suicidality]**

- Have you ~~**actually**~~ had any thoughts about killing yourself? **[Suicidal ideation]**

The Columbia – Next Three Questions

3. Have you been thinking about **how you** might do this?
4. Have you had these thoughts and had some **intention** of acting on them?
5. Have you started to work out or worked out the details of how to kill yourself? Did you **intend** to carry out this **plan**?

The Columbia – Always Ask

6. Have you done anything, started to do anything, or prepared to do anything to end your life?

Examples: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc.

If yes, was this within the past 3 months?

The Columbia – Limits and Problems

The question on the Columbia that has limited predictive value is #6 (the previous attempt/prep question). . .

Problems

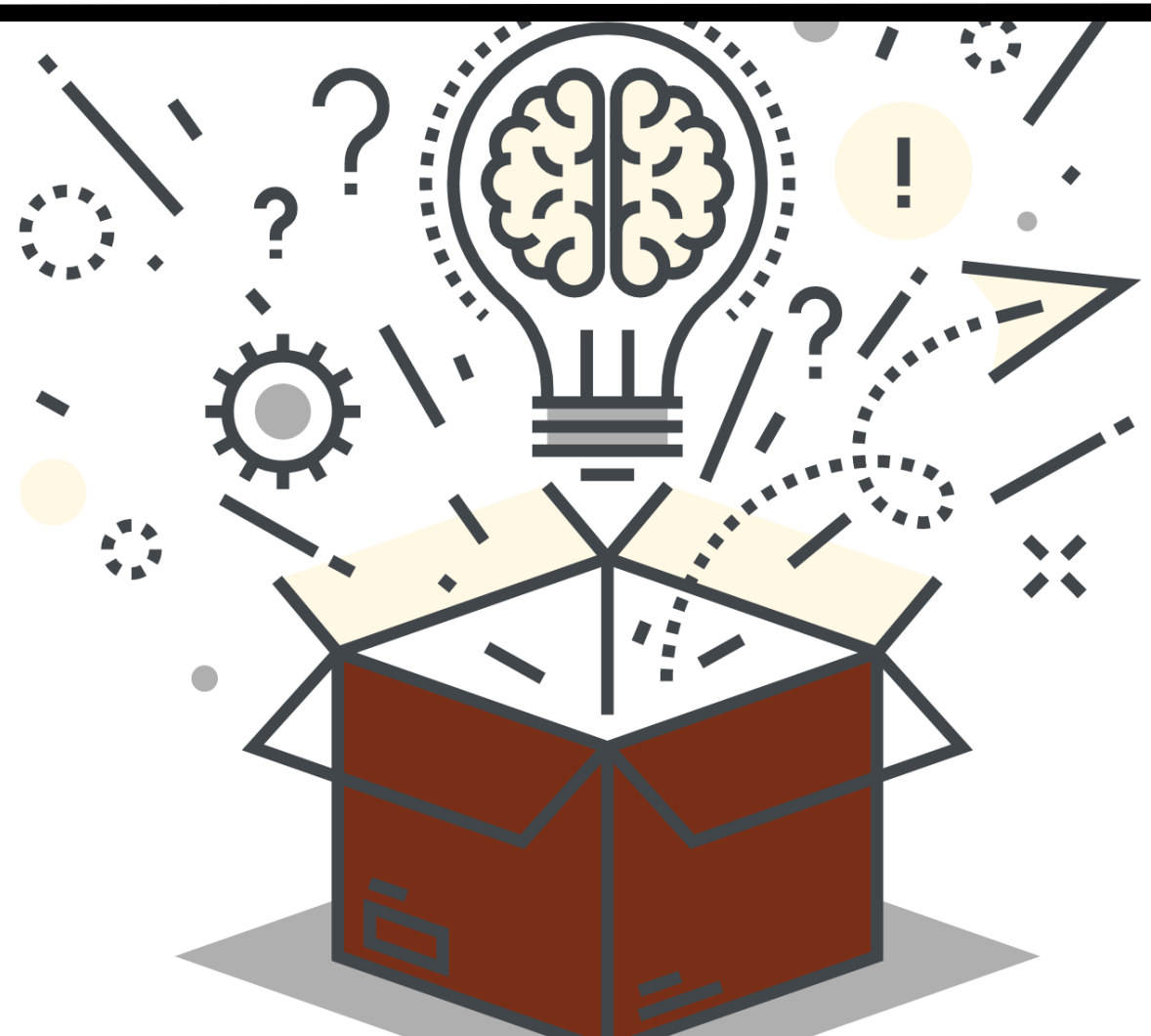
False positives – Passive SI, SI, intent, and suicide planning have low predictive value. Previous attempt* is likely better, but not good.

False negatives – Suicide is frequently impulsive, often coupled (coal gas in UK), and not pre-meditated.

Machine Learning option – But we still have to interview

Outside the Box

Strengths-Based Principles and Suicide



Strengths-Based Principles – I

Embrace Shneidman's position: suicidal thoughts and behaviors are **neither an illness nor a sin.** **[not always easy]**

De-pathologize:

View suicide disclosures as a **natural communication of pain,** often from **life situations** and unmatched opportunity to offer compassionate help.

Strengths-Based Principles – 2

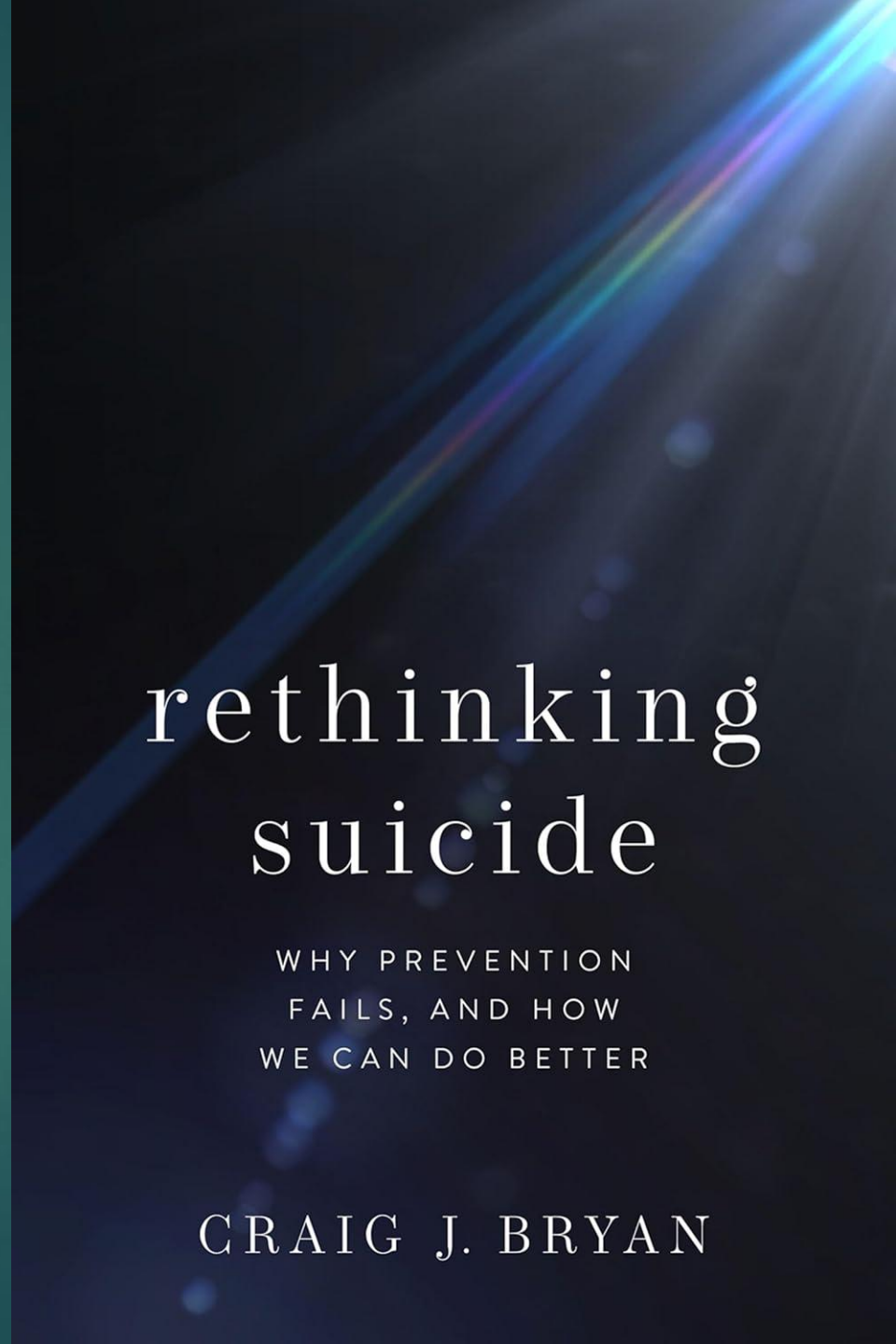
Recognize the limits of risk/protective factor assessment (because **mostly it doesn't work**; 50-year meta-analysis; cutting; cultural variability).

We are **transparent** (e.g., hosp), **build trust** and **collaborate** to develop **individualized safety plans** and **decrease personal distress**. [This is our focus]

.

Predicting Suicide

- "The majority of patients who die by suicide screen negative for suicidal ideation. If you are a MH professional/agency who uses decision trees that designate negative screens as 'low risk,' you should consider discontinuing that practice. This is especially applicable to clinicians/agencies that use the C-SSRS's red/orange/yellow scoring system. The C-SSRS will 'miss' most patients who kill themselves." [False negatives]
  - **Craig Bryan, Ph.D., Feb 7, 2024** – LinkedIn post



Strengths-Based Principles – 3

While focusing on suicide (which is essential), **resist the temptation to over-focus** on suicide.

The patient is a whole person with **unique** strengths and resources: Show compassion for suicide pain. Also **pay attention to and draw out positives** (not naively; the best way is to **be with**). [7 dimensions]

Strengths-Based Principles – 4

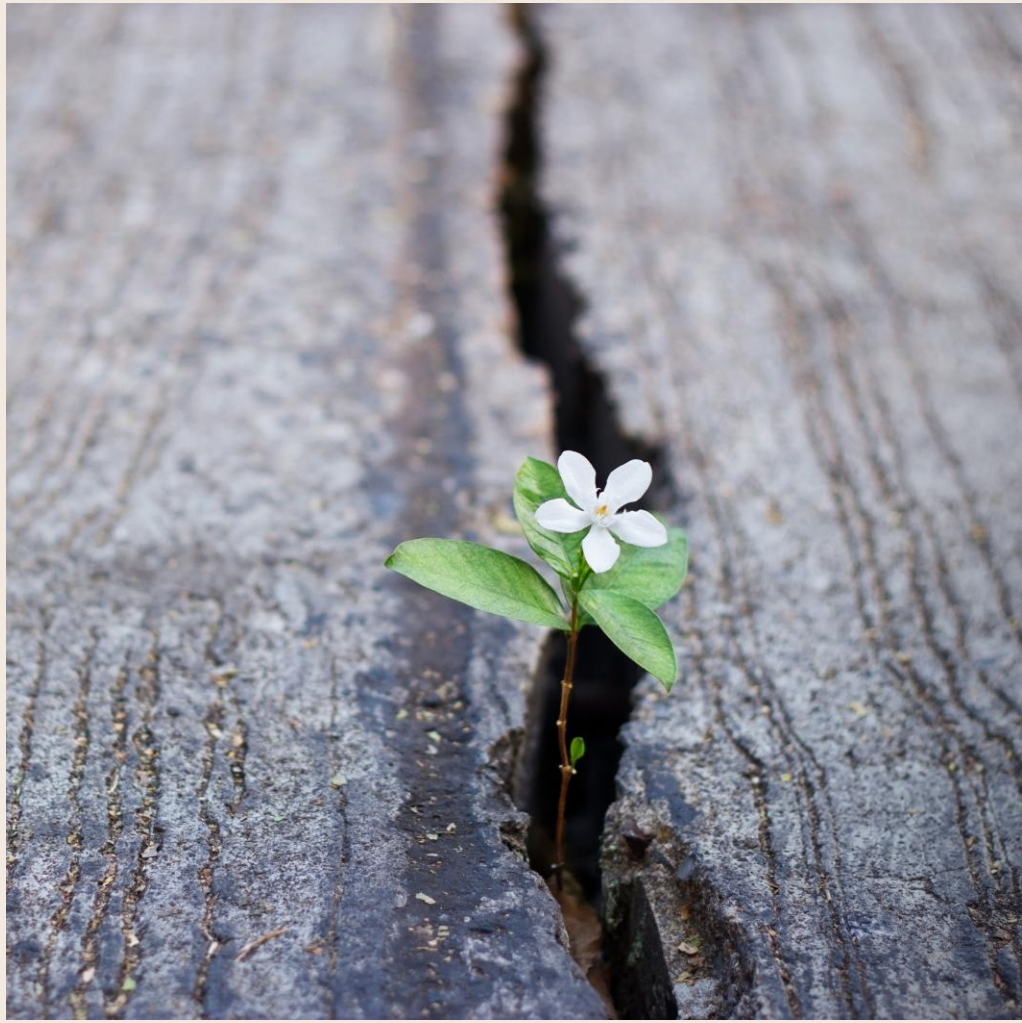
Use collaborative and therapeutic assessment:

- Start with empathy and compassion, **NORMALIZE,** and recognize that the problem may not be "in" the person [We acknowledge our legacy of pathologizing diversity]
- Balance your questioning: Don't just go through the PHQ-9. **Question #9** is a not REALLY a suicide question.

Strengths-Based Principles – 5

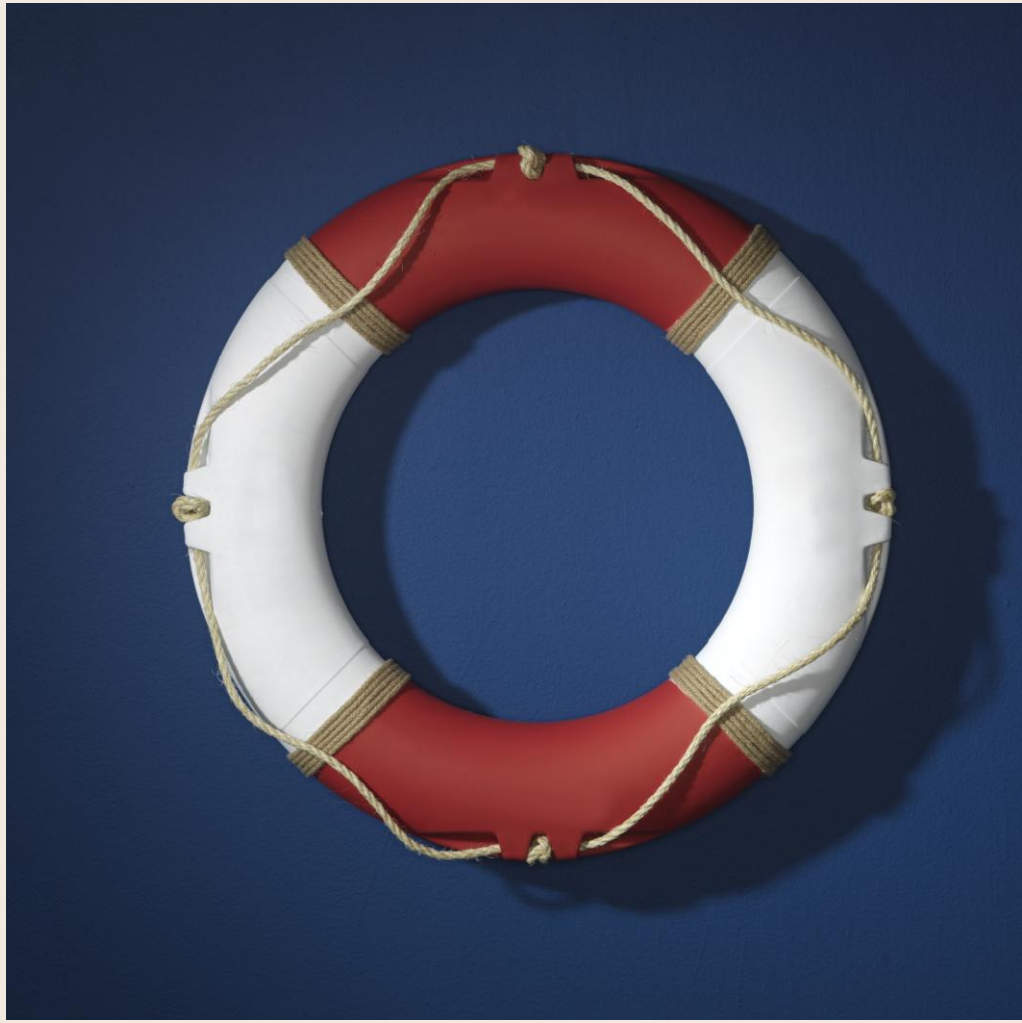
Implement specific intervention strategies that **target distress and suicidality.**

Remember – **Interventions can stimulate HOPE**



Strengths-Based Principles – 6

Despite embracing a strengths-based model. . . you may need to **be directive,** you may need to **initiate protective action**, and you may need to be the **voice of authority** and rational decision-making in the room.



Strengths-Based Principles – 7

Recognizing the immense stress we carry in this role, **we practice excellent self-care**, including evidence-based happiness activities (learn more at JSF)

- We **support each other**
- We acknowledge and talk about our own emotional challenges
- We use the skills we teach

Medical Model vs. Strengths-Based
[Let's embrace both]

A Positivistic Philosophy

- Suicidal thoughts and behaviors **represent illness**; we need to intervene
- We are **authority figures** who know more about patient health than they do
- The patient is a **suicidal person**
- We can **predict* and prevent** suicide
- We use **risk assessment** procedures and questionnaires
- We treat **mental disorders**

A Social Constructivist Philosophy

- Suicidal thoughts and behaviors are a **natural communication of pain**
- We **collaborate** on **individualized safety plans**
- The patient is a **whole person with strengths and resources**
- Suicide is mostly **unpredictable***
- We **individualize risk factors** and use **collaborative and therapeutic** assessment
- We treat patient **distress and suicidality**

Strengths-Based Tools for Suicide Assessment

Dealing with Your Issues

What are YOUR issues?

My friend Scott

Life experiences, religion, temperament, etc., will all conspire to make this assessment and treatment process easier or more challenging

Everyone Agrees: Always Ask Directly

Have you had thoughts about dying by suicide?

Say those words now. . .

[This does not “plant” the thought.]

Ask Directly II

You did that wrong. . .

That's okay . . . Your intent and authenticity is more important than "doing it right"

We can and will do better . . . and we will continue to do better

#1 Assessment Skill/Tool: Normalizing

- Ask **directly but prep first**
  - Prep – **Role Induction** – Use the word suicide with limits of confidentiality
  - Prep – I will ask you some questions that can be hard. For example, I'll ask about suicide. The reason I ask is because many people think about suicide. Thoughts about suicide are a sign of emotional pain in your life. If you tell me about suicidal thoughts, I won't immediately hospitalize you. We'll work to reduce your emotional pain.

#1 Assessment Skill/Tool: Normalizing

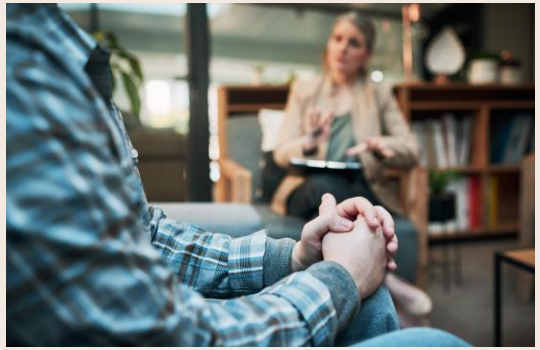
- Ask **directly AND normalize** the asking
  - I've read that up to **50% of teenagers** have thought about suicide. Is that true for you? [Construction workers]
  - People who viewed **negatively by society** **may** think about suicide from time to time. Have you had thoughts about suicide?
  - Normalize the asking: **"I ask everyone I see."**

#1 Practice: Use Normalizing Language

It can be difficult to find the right words in the moment. Practice. You don't need to use my words; it's better to use your words, words authentic to you and that fit your setting and population. [veterans, LGBTQ+ youth, sex offenders]

Reflection: Think of a patient now, and, **for practice,** imagine what you would say to convey the normalizing message (Jillian story)

#2 Assessment Skill: Evaluate Ideation



Ask directly and then **evaluate ideation**

Disclosure is good news (it's a sign of trust)!

- Trigger – What triggers your SI?
- Frequency – How often?
- Intensity – All you can think? Or background?
- Duration – How long usually?
- **Termination – What's going on when no SI?**

Demo – Exploring Ideation

- You're doing counseling
- You need to ask about suicide
  - **Tommie, 18 y/o Yup'ik tribe** – 14:14 to 15:15
- https://players.brightcove.net/624142947001/r1evdKsni_default/index.html?videoId=5095441194001

Exploring Ideation Therapeutically

- Tommie Singing and poetry [**self-expression**]
- Other examples:
  - Sean – “Biking and playing basketball”
  - Chase – “Being with someone (or somewhere) that validates who I am”
  - Cory – “Doing something meaningful with my niece or for my tribe”

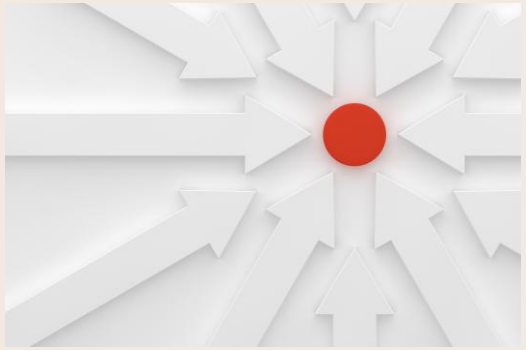
Where Might Evaluating Ideation Lead?

- **Plan** – S-L-A-P the plan
  - Specificity of the plan
  - Lethality of the plan
  - Availability of the plan
  - Proximity of social support/intervention

Where Might Evaluating Ideation Lead? II

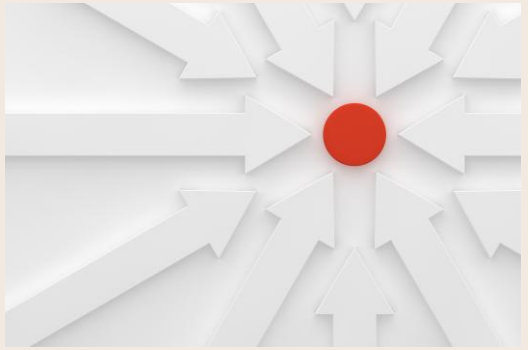
- **Previous attempts** – Listen, reflect, ask “How did you recover and get here?” or “What helped?”
- Keep some structure, but let this flow and reassure your patient that your goal is to be helpful and promote safety, not to hospitalize
- Notice, track, and reflect the emotions and the meaning associated with surviving a previous attempt

#3 Assessment Skill: That One Thing (1/2)



- “If we could somehow **magically change** just one thing in your life that would eliminate your suicidal risk all together, what would that be?” (Jobes, 2023, p. 63)
- This question **points you** and the patient toward a treatment focus
- It also may **reveal** irrational expectations

#3 Assessment Skill: That One Thing (2/2)



Possible “irrational” responses:

- “My mother would be alive”
- “I wouldn’t have been sexually abused as a child”
- “There would be no more hate”

What are the treatment targets linked to these responses?

#4 Assessment Skill: Mood Scaling with a Suicide Floor

- This is my favorite **5-minute interview** strategy
- Demo or **video**
- May I ask some questions about **your mood?**

#4 Practice: Mood Scaling

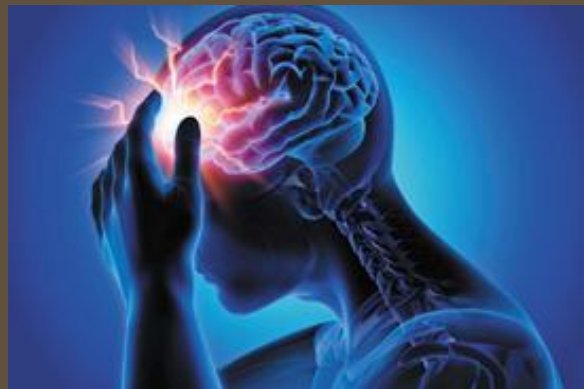
1. Rate your mood, using a zero to 10 scale. Zero is the worst mood possible. Zero means you're totally depressed and so you're just going to kill yourself. A 10 is your best possible mood. A 10 would mean you're as happy as you could be, maybe dancing or singing or doing whatever you do when you're extremely happy. Using zero to 10, what rating would you give your mood right now?
2. What's happening now that makes you give your mood that rating?
3. What's the worst or lowest mood rating you've ever had? What was happening to make you feel so down?
4. For you, what would be a normal mood rating on a normal day?
5. What's the best mood rating you've ever had? What was happening that helped you have such a high mood rating?

Optional Video

MOOD SCALING – REFLECTIONS

Discussion points:

1. **Advantages**: More relational; we learn what improves mood and mood-lowering situations.
2. **Disadvantages**: Time and lack of standardized norms.
3. How might you use it (**variations**)?
4. Other reactions?



Integration of Medical Model and Strengths-Based: The Minimal

- **Frame the Questionnaire Process**
  - I'm going to ask you nine questions from this questionnaire. These are important questions. I hope you'll answer them honestly.
  - I want to know much more about you than what's on this questionnaire. When we're finished with the questionnaire, we can talk about other things important to you.

More Integration

Sample Columbia Questions

Have you been thinking about **how you** might do this?

Add: What thoughts do you have that make you feel like you don't want to die? (or how to prevent this suicide from happening)

Have you had these thoughts and had some **intention** of acting on them?

Add: Have you had thoughts and then decided not to act on them? What made you not act?

Have you started to work out or worked out the details of how to kill yourself? Did you **intend** to carry out this **plan**?

Add: Just to be balanced, we should work out a detailed and easy to enact plan to save yourself.

And More Integration

Combine Two Approaches

Example: Use a questionnaire and. . .

Add the Mood Scaling with a Suicide Floor to start generating ideas for treatment

For Additional Assessment Info

The comprehensive suicide assessment interview (RIPSCIP) https://johnsommersflanagan.com/2016/02/06/r-i-p-sc-i-p-an-acronym-for-remembering-the-essential-components-of-a-suicide-assessment-interview/

Need a PHQ-9 or C-SSRS alternative? David Jobes recommends the ASQ Toolkit.pdf: https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

Assessment Reflections

- What felt challenging?
- Where do you need or want practice?

PART 3: STRENGTHS-BASED SUICIDE INTERVENTIONS

A Treatment-Planning Model

Individually Sensitive Suicide Intervention and Management Strategies

Seven Organizing Life Dimensions

1. **Emotional** [Core: Excruciating distress]
2. **Cognitive** or Mental [Mental constriction, “nothing helps”]
3. **Interpersonal** [Social disconnection or perceived burden]
4. **Physical/Biomedical** [Agitated, impulsive, ill, and drugs]
5. **Spiritual/Cultural** [Meaninglessness or disconnection]
6. **Behavioral** [Suicide plan/intent, lethal means, desensitization]
7. **Contextual** [Sociological, political, oppression, poverty, and other environmental stressors]

1. Emotional Dimension

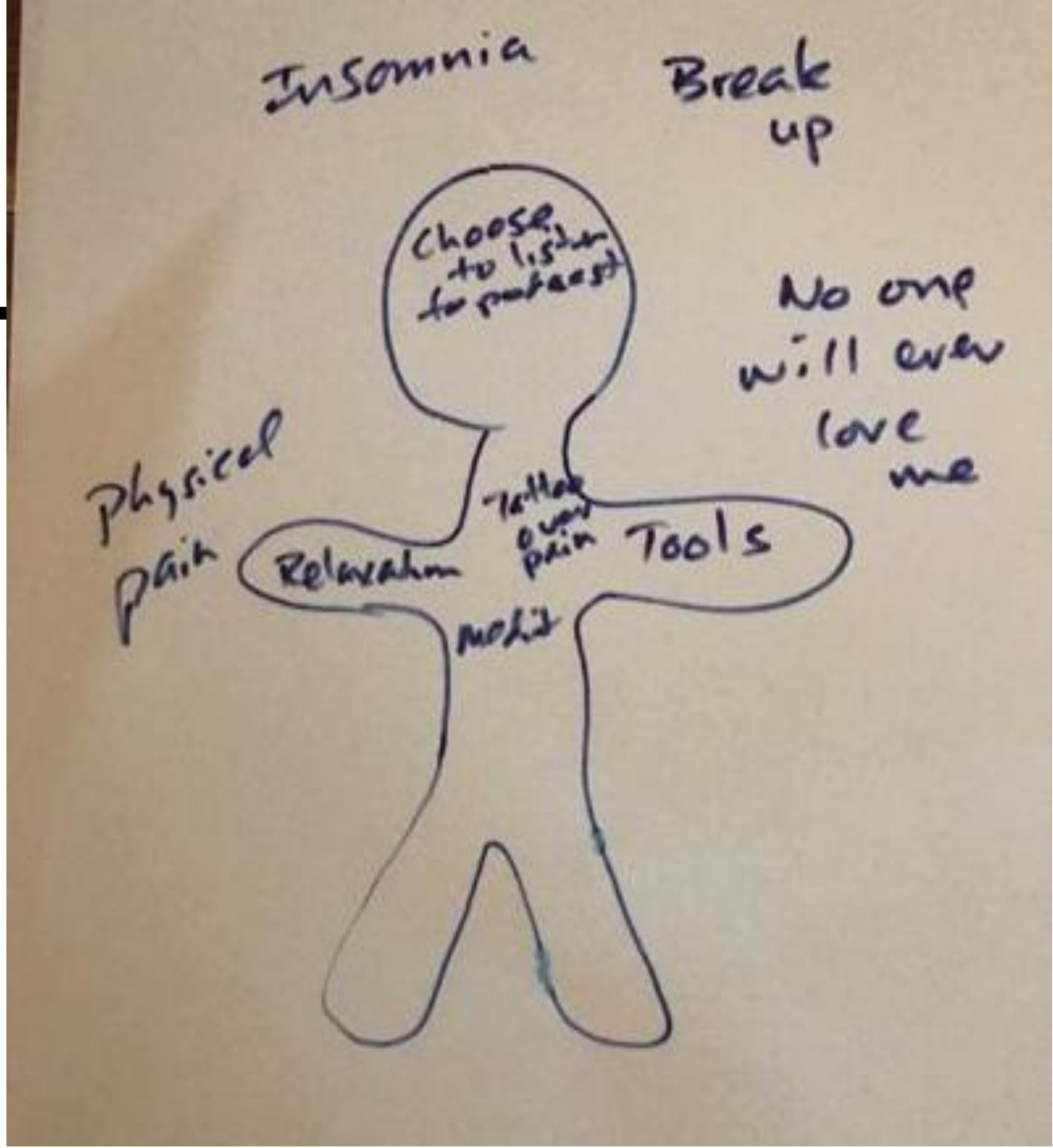
Main Treatment Planning Targets

1. Excruciating Distress [Psychache]
2. Affect dysregulation
3. Acute or chronic shame, guilt, sadness, or anger
   (for oppressed individuals and groups, we can conceptualize this as internalized oppression and re-externalize it)

Emotional: Separate Pain From Self

Label problems (even emotions) and PAIN **outside the person**

Put strengths, strategies, and skills **inside the person**



Emotional: Dysregulation and Regulation

DBT (Linehan): Mindfulness+

Distress tolerance: Just Breathe+

Three-step emotional change trick: https://wordpress.com/post/johnsommersflanagan.com/2101

2. Cognitive Dimension

Main Treatment Planning Targets:

1. Problem-Solving Impairment
2. Hopelessness
3. Negative Core Beliefs

Alternatives to Suicide

- Shneidman Story – An intervention for mental constriction
- Kay story
- Final story [Later]

Negative Core Beliefs

- Mark them using **“Active listening.”**
  “Sometimes . . .” [Core beliefs are activated]
- “Sometimes the way you talk makes me think you think there’s something wrong with you.”
- Explore, and **bookmark for later** [CBT].
- What’s Good About YOU? What’s bad??

Evidence-Based Happiness

- **Witness Something Inspiring**

- During lunch, or break, or tomorrow, or all weekend, make a point every day to watch for something that's just a little bit inspiring.

Interpersonal [Social]

Main Treatment Planning Targets:

1. **Unwanted Social Disconnection* [aka thwarted belongingness; Joiner]**
2. Social Skill Deficits
3. Feeling Like a Social Burden

The Chase Video (7 min)

Cognitive Interventions

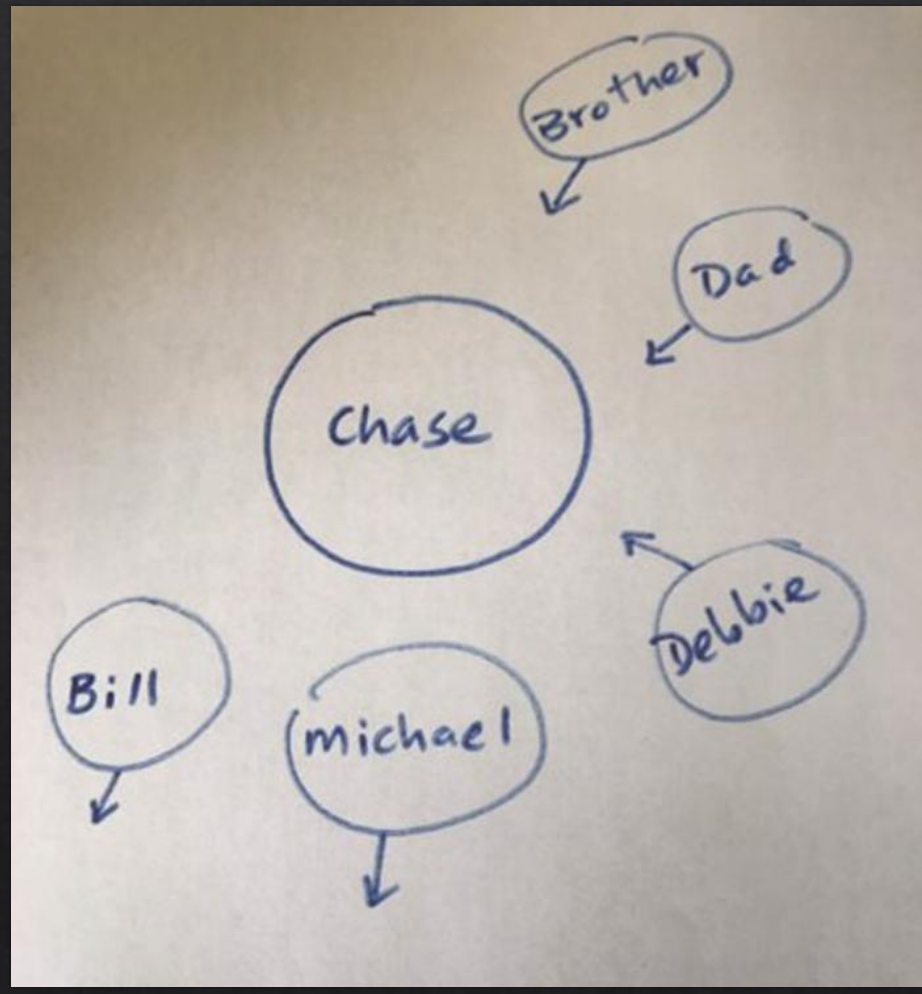
- Interpersonal interpretation of a longstanding pattern
- Building hope from the bottom up

Social Intervention

- Chase's social universe

Hope from the Bottom Up

- Who gives you validation?
- “No one gives me validation.”
- Who is the most toxic person in your life?
- “Bill”
- Who’s the next most toxic?
- Michael
- Who’s neutral?
- Debbie



Social Universe Skill

How might you use this **social universe assessment** therapeutically?

Building hope (continuum) from **the bottom up**

SOCIAL CONNECTION

Getting connected can be with you, in-person, or online.

Finding relatable people who generate hope is important.

This is Victor Armstrong who gives encouraging and insightful messages on Twitter (X).

4. Physical Dimension

Main Treatment Planning Targets:

1. Arousal-Agitation
2. Trauma, insomnia, nightmares
3. Physical symptoms of depression

Cory and Trauma and Culture

- 1:48:01 – 1:54:48

- Cory is a 28-year-old member of the Lakota-Sioux tribe and Iraqi war veteran

Cory Debrief – Chat Time

- What do we know about Cory in the emotional, cognitive, interpersonal, and other dimensions?
- How can we work with Cory on emotions?
- What will goal-setting look like with Cory?
- What are your thoughts on his risk level?

Trauma, Insomnia, Nightmares

- TF-CBT, EMDR . . .
- CBT-I
- Imagery Rehearsal Therapy (IRT)
- Single session nightmare (insomnia) cure

Case Formulation and Planning - Cory

Problems or Chief Distress

- **PTSD and Alcohol Abuse**: War trauma; intergenerational trauma; alcohol use for numbing
- **Emotional**: Shame, anger, nightmares
- **Cognitive**: Mental constriction
- **Interpersonal**: Social disengagement
- **Cultural/Spiritual**: Tribal disconnection
- **Behavioral**: Destructive impulses [no intent + reasons for living]

Interventions [to Move Toward Goals]

- **Cognitive**: Collectivist goal-setting [in-session]
- **Emotional**: Reframe talking about emotions as a strength he can share [this will take time]; use IRT
- **Interpersonal**: Weekly contact with niece via telephone. Build community at UM
- **Cultural/Spiritual**: Brainstorm and enact tribal connections
- **Behavioral**: Addictions counseling; collaborative safety plan

Collaborative Goals

- **Cognitive**: Stay focused on collectivist goals
- **Emotional**: Increase positive affect; engage in trauma work*; practice culturally accepted shame/anger expression
- **Interpersonal**: Increase meaningful local and tribal community interactions
- **Cultural/Spiritual** : Re-establish sense of social/community identity
- **Behavioral**: Enact safety plan as needed

Cultural and Spiritual

Main Treatment Planning Targets:

1. Cultural/Spiritual Disconnection
2. Meaninglessness
3. Shame (Emotional)

Possible Video Clip

- A case of Passive SI
- Jeanne is 67-year-old and bereaved Xs 2
- Jeanne Clip – 1:19:20 – 1:23:08

Observations on Jeanne

- Spirituality/Religion
- What helps?

Gratitude Demo [Option]

- Gratitude can be an interpersonal or a spiritual intervention

- Pair-up and debrief

Behavioral

Main Treatment Planning Targets:

1.Suicide Desensitization

2.Lethal Means

3.Suicide Intent and Planning*

Safety Planning (with Kennedy?)

- How Can I Make My Environment Safe?**
- My Unique Warning Signs
- My internal Coping Strategies
- People and Settings that Provide Support and Distraction
- Who Can I Ask for Help?
- Professionals or Agencies I Can Contact for Support
- How I Can Make My Environment Even Safer?

Safety Planning II

- Follow the Stanley and Brown SPI protocol – or whatever your agency is using
- When you safety plan, be explicitly collaborative and compassionate
- To watch a safety planning example of JSF with a 15-year-old: https://johnsommersflanagan.com/2021/03/30/how-to-do-suicide-safety-planning-a-case-example/

In Closing

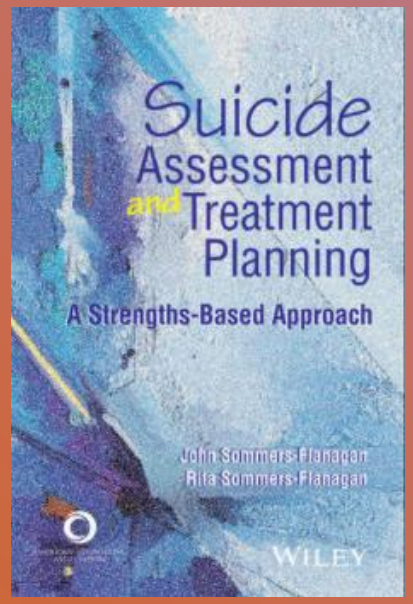
- What do you want to remember?
- What can implement soon?
- **Thanks for being you . . .**
- Monitor and take care of yourself and your colleagues

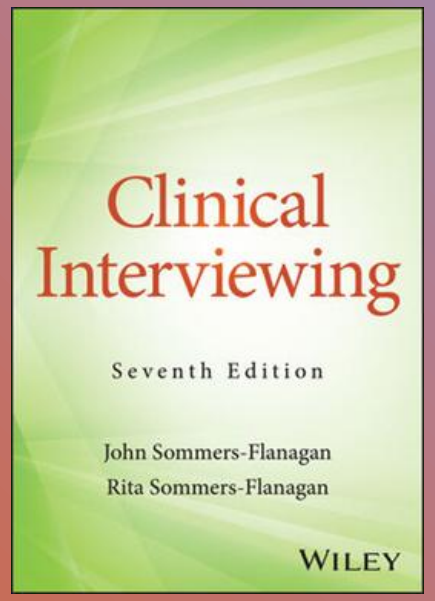
Conclusion: Reminders

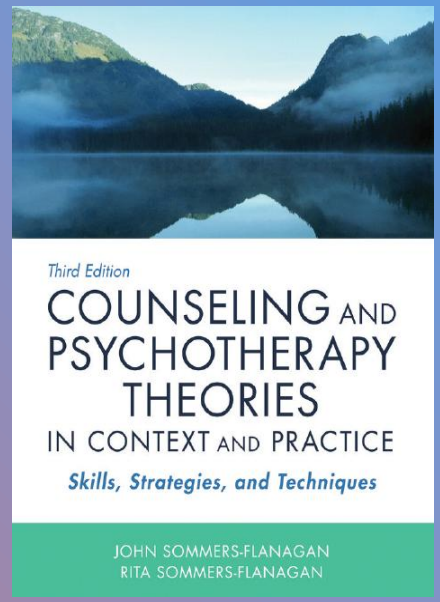
- The mind is a terrible place to go . . . Alone
- Which is why we should keep on talking—directly to each other and to other friends, family, and community—about suicide and suicide prevention.
- Info at: johnsommersflanagan.com

BOOKS BY…

JOHN AND RITA SOMMERS-FLANAGAN







Free Resources

https://montanahappinessproject.com/

https://johnsommersflanagan.com/