STRENGTHS-BASED STRATEGIES FOR TALKING WITH YOUTH ABOUT SUICIDE

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For free resources:
https://johnsommersflanagan.com/

https://www.umt.edu/education/cape/

https://montanahappinessproject.com/

Gratitude

Gratitude

Thanks to Dr. Hana, Dr. Sonali, Dr. Alex, Dr. Chad, and Idaho State University for the invitation and for organizing

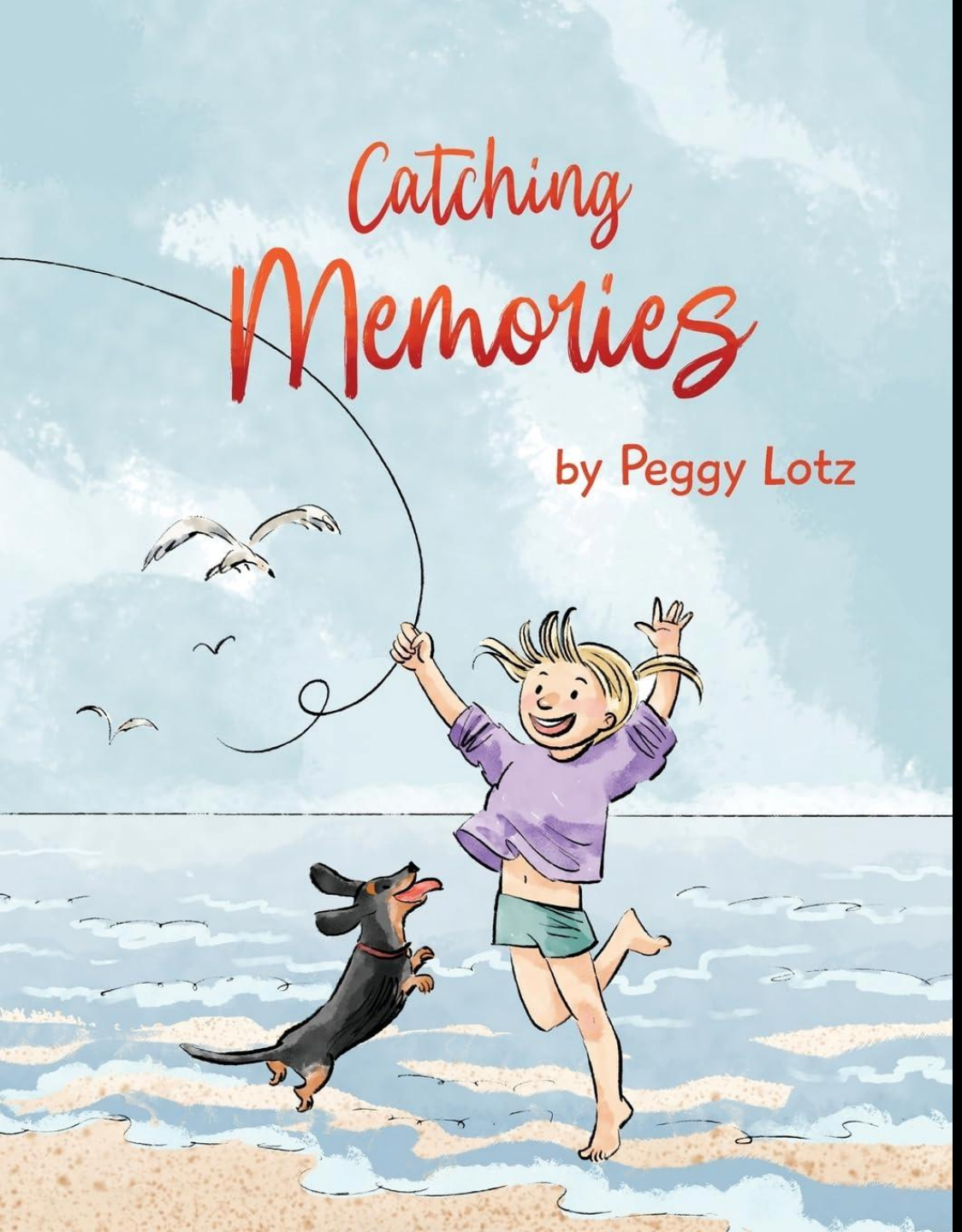
And . . . thanks to YOU

PREPARATION

- **Trigger warning – Why?**

We will talk about suicide assessment and interventions [and I will say contrary things]

- **Research indicates. . .**
- **Strength-warning. . .**



Remember . . .

- Trigger warnings **are suggestions** about what you might not be able to handle

- **Strength warnings** are suggestions about how learning new knowledge and gaining experiences **can make you STRONGER**

- What suggestions, direct and indirect, do we give youth about **depression, anxiety, trauma, and suicidal thoughts**?

The REAL Learning (Learner) Objectives

1. You come with YOUR knowledge, experience, and expectations – You come with YOUR WHY and PURPOSE
2. I offer ideas and we exchange experiences – along a bumpy and emotional road)
3. You take what fits for you and do what you need to do to remember to apply it to your life and work

Caveats: These are ideas. Nothing always works. Default to relationship connection.

STRENGTHS-BASED PREVIEW: OUR ISSUES AND EXPLORING IDEATION

You're doing counseling. You need to ask about suicide.

Notice your (a) thoughts, (b) physical sensations, (c) emotions, and (d) behavioral impulses

Tommie, 18 y/o Yup'ik tribe – 14:14 to 15:15

https://players.brightcove.net/6241429 47001/r1evdKsni_default/index.html?vi deoId=5095441194001

Two SB "Prep" Concepts

We Need to Deal with Our Issues

- **What were YOUR issues** as you listened to Tommie?
- My friend Scott
- YOUR life experiences, religion, temperament, etc., will conspire to make assessment and treatment easier or more challenging.
- That's okay. **We can use our self-awareness to grow and change.**

We Need to Resist the Tunnel Vision Reaction

- When exploring ideation, **use a conversational style** to come alongside the emotion and cognition, and ask: **"What's happening when you're NOT thinking about suicide?"**
- Use other SB assessment approaches (much more later)
- **Post: What makes Tommie low or high risk?**

Suicidal Ideation is not an Illness, Mental Disorder, Sin (or even a good predictor of suicide)

Suicidal ideation is usually a response to a difficult life situation or intense personal distress (or both)

Youth who are suicidal are often smart, sensitive, and feel trapped, hopeless, or shame

Part I

Medical Model vs. Strengths-Based Principles

Inside the Box
The Traditional Medical Model

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?” **[This is NOT a “suicide” item.]**
  - (David Jobes and the CAMS-care people just put a universal ghostbuster sign on the PHQ-9)
  - **4-point Likert scale**: Not at all; several days; more than half the days; nearly every day

The Columbia (C-SSRS)

Two GOOD Opening Questions

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

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

Actually

- You shouldn't use the word "Actually"

The Columbia – Next Three GOOD Questions

3. Have you been thinking about **how you** might do this? **[Plan]**
4. Have you had these thoughts and had some **intention** of acting on them? **[Intent]**
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**? **[Both]**

The Columbia – Always Ask: The BEST Q

6. Have you done anything, started to do anything, or prepared to do anything to end your life? **[Attempt or prep]**

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 better, but not great.

False negatives – Suicide is frequently impulsive, and especially with rural youth, not pre-meditated.

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.**

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).

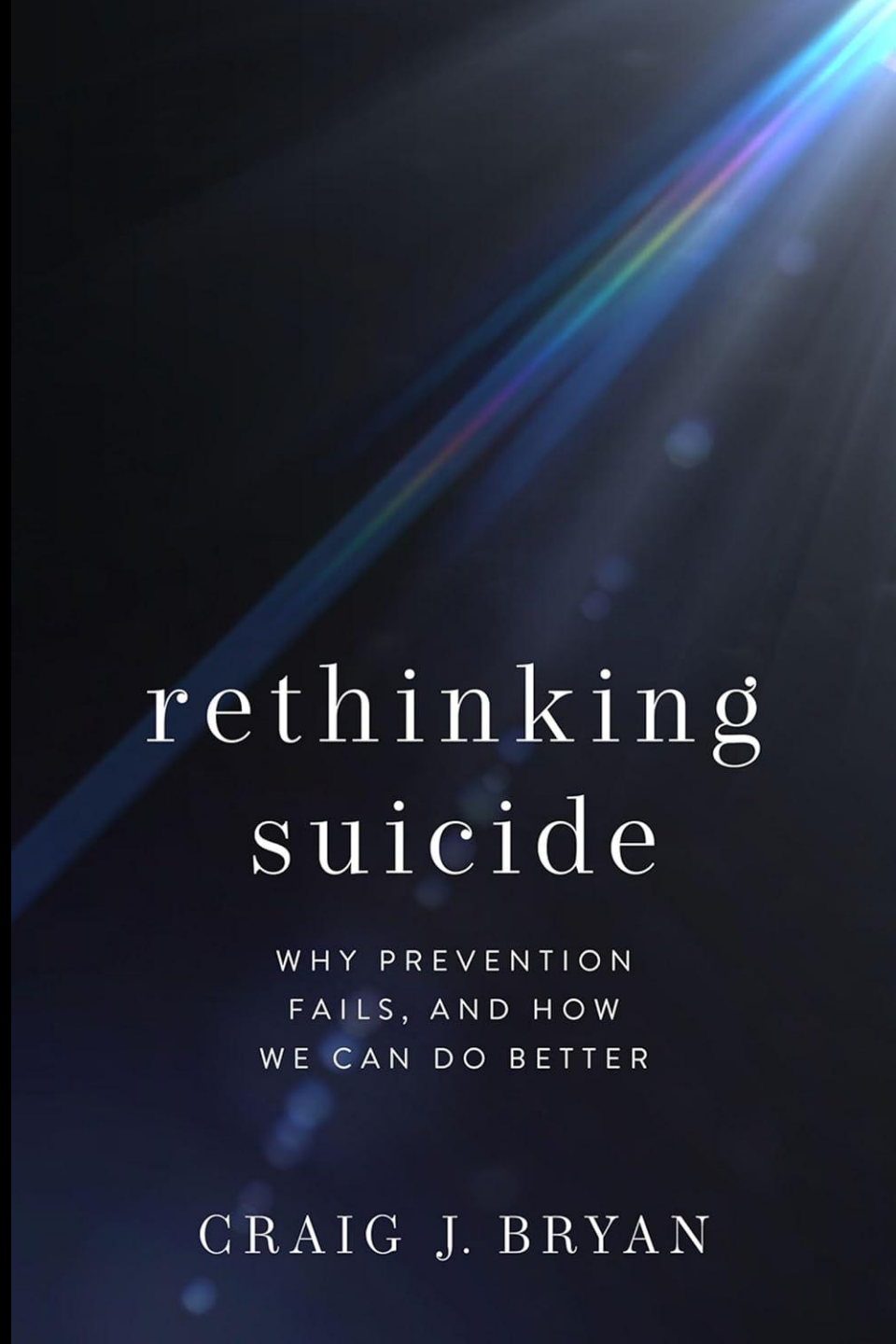
We are **transparent (e.g., hospitalization), **build trust** and **collaborate** to develop **individualized safety plans** and **decrease personal distress**.**

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 youth 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

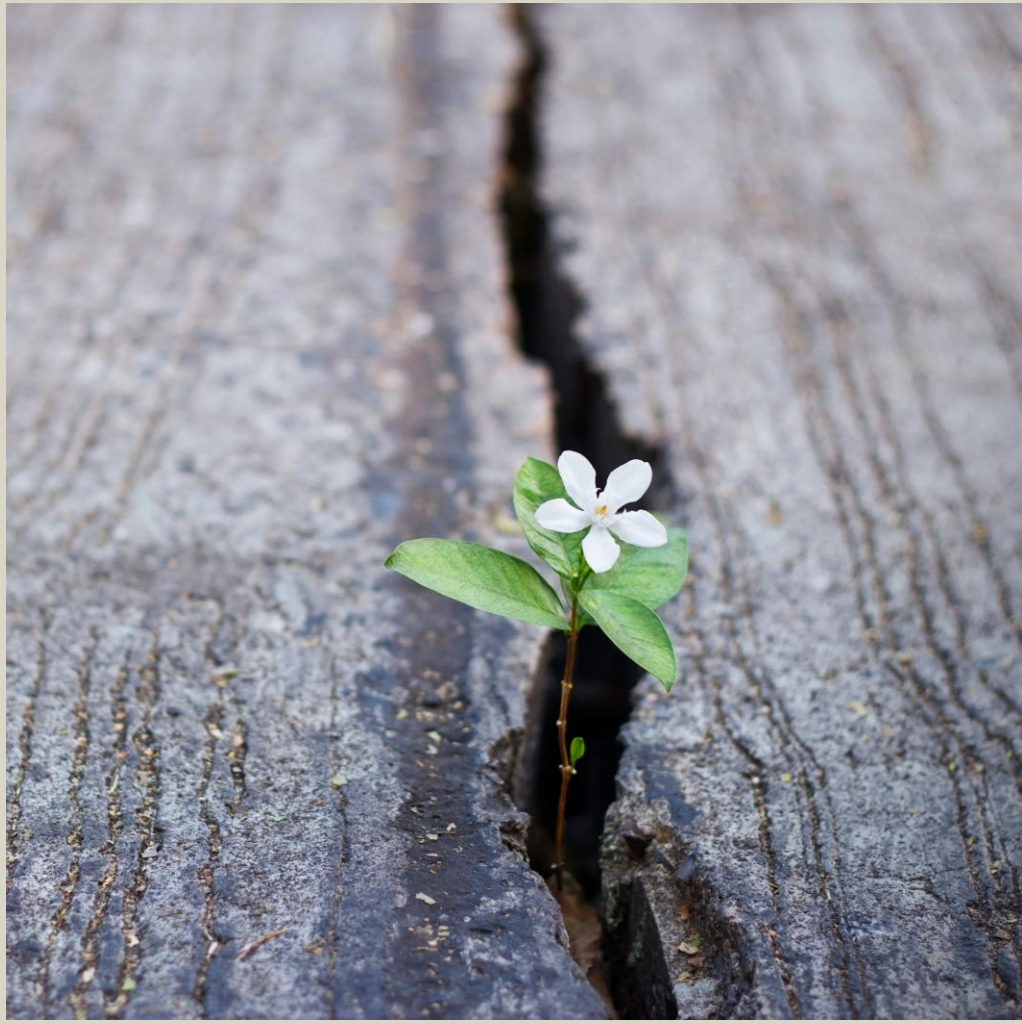
Use collaborative and therapeutic assessment:

- Start with empathy and compassion, **NORMALIZE,** and recognize that the problem may not be “in” the person [We acknowledge our legacy of pathologizing diversity]

Strengths-Based Principles – 5

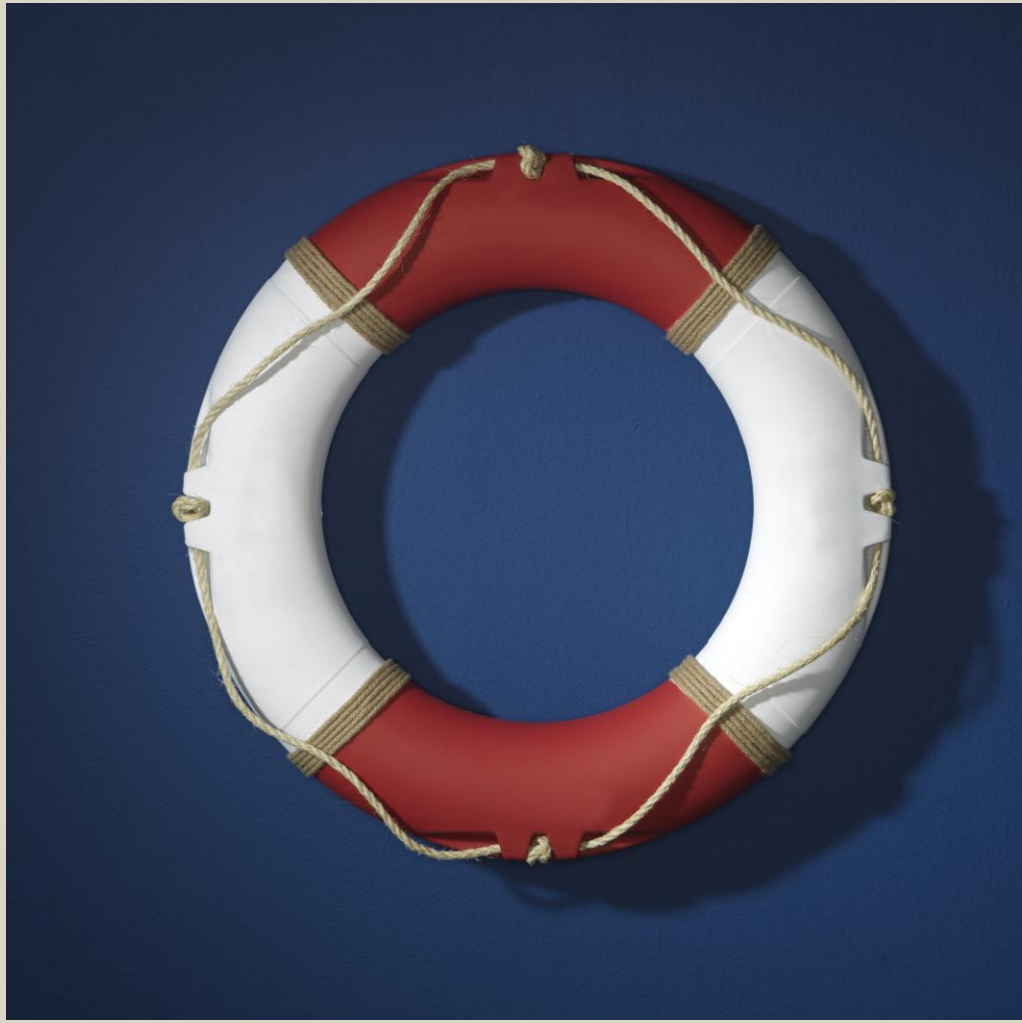
Implement specific intervention strategies that **target distress and suicidality.**

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 **[Positive affect now!]**

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**

Part 2

Strengths-Based Tools for Suicide Assessment

#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

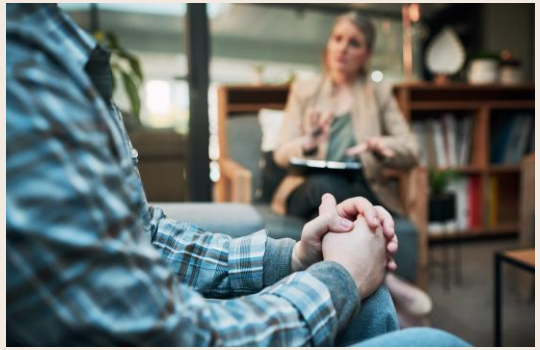
- Ask **directly AND normalize** the asking
  - I've read that up to **50% of teenagers** have thought about suicide. Is that true for you? [Construction workers]
  - People who are **oppressed and negatively judged by society may** think about suicide from time to time. Have you had thoughts about suicide?
  - 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 student or client 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?**

Exploring Ideation Therapeutically

- Remember 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”
  - Your cases?

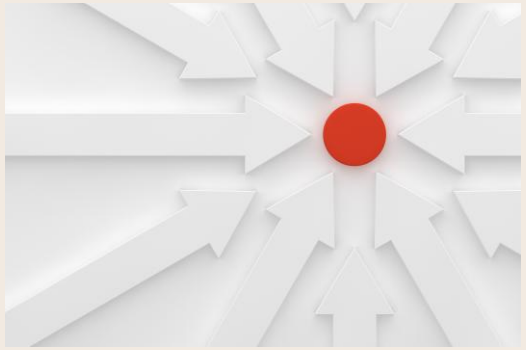
Where Might Evaluating Ideation Lead?
Craig Bryan: “Find the Narrative”

- **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
Stay with the Narrative (the stories)

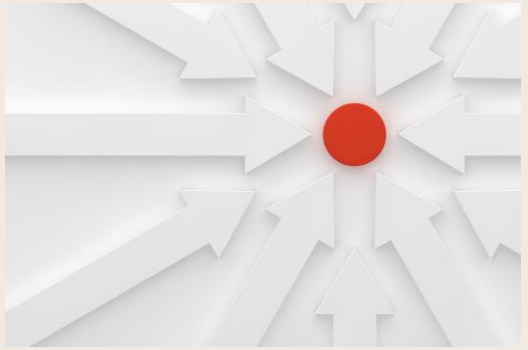
- **Previous attempts** – Listen, reflect, ask “How did you recover and get here?” or “What helped?”
- Keep some structure, but let this flow and reassure your client that your goal is to be helpful and promote safety, not to hospitalize
- Notice, track, and reflect the emotions and the meaning associated 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 client 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 treatment targets are linked to these responses?

Turn and practice now . . . with yourself 😁

#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?

MOOD SCALING REFLECTIONS

- **Advantages:** More relational; we learn what improves mood and mood-lowering situations.
- **Disadvantages:** Time and lack of standardized norms.
- How might you use it (**variations**)?
- 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: Have you been thinking about **how you want to live**?

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: Would you work out, with me, a plan to keep yourself safe and 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 feels challenging?
- Where do you need or want practice?

Flood the Zone

PJW_CAPE

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PART 3: STRENGTHS-BASED SUICIDE INTERVENTIONS

A Treatment-Planning Model

Suicide Intervention 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]

00:01:38:15

1. Emotional Dimension

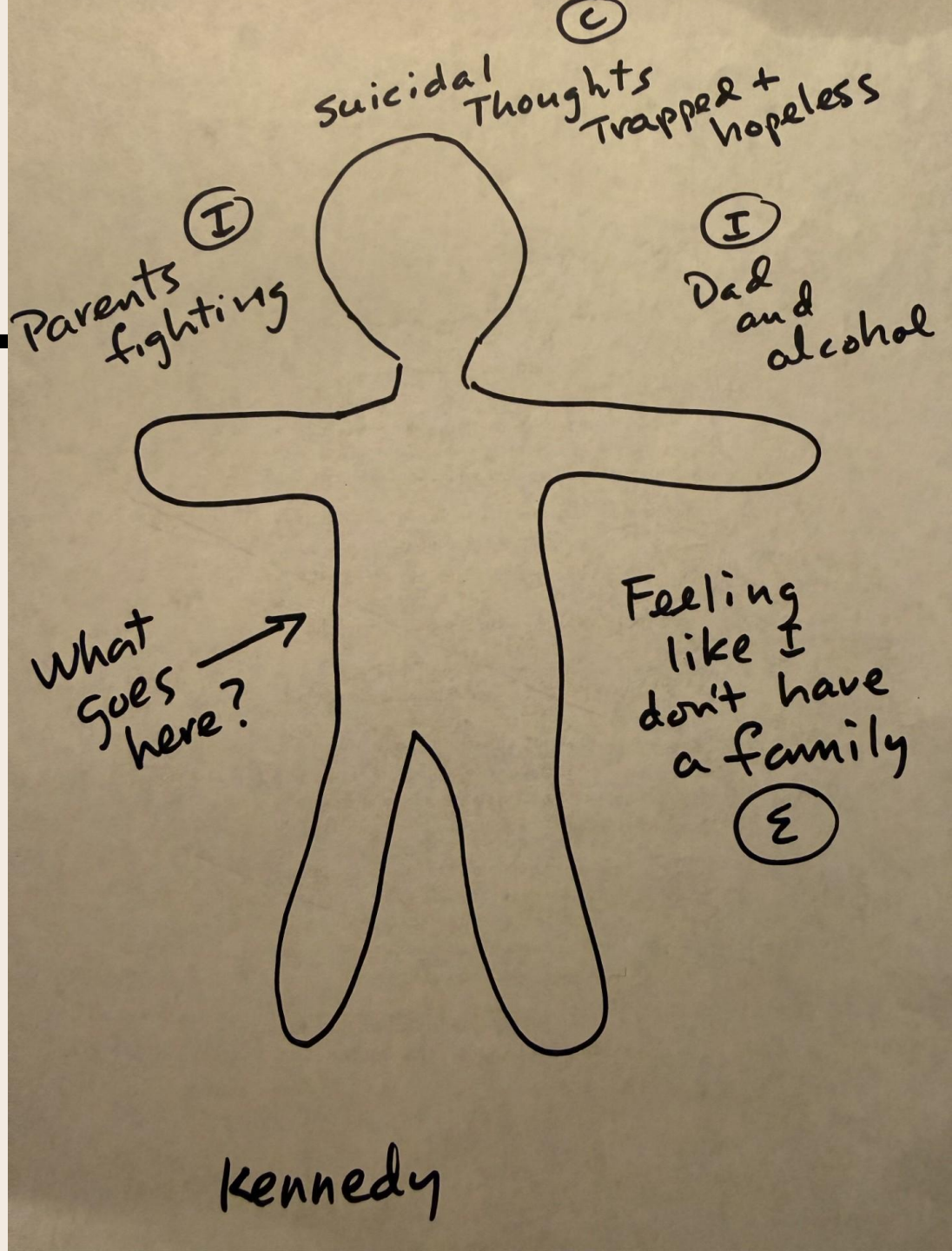
Main Treatment Planning Targets

1. Excruciating Distress [Psychache]
2. Affect dysregulation
3. Acute or chronic shame, guilt, sadness, or anger **(*something wrong* with the self;** 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 diagnoses) and PAIN **outside the person**

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



Emotional: Dysregulation and Regulation

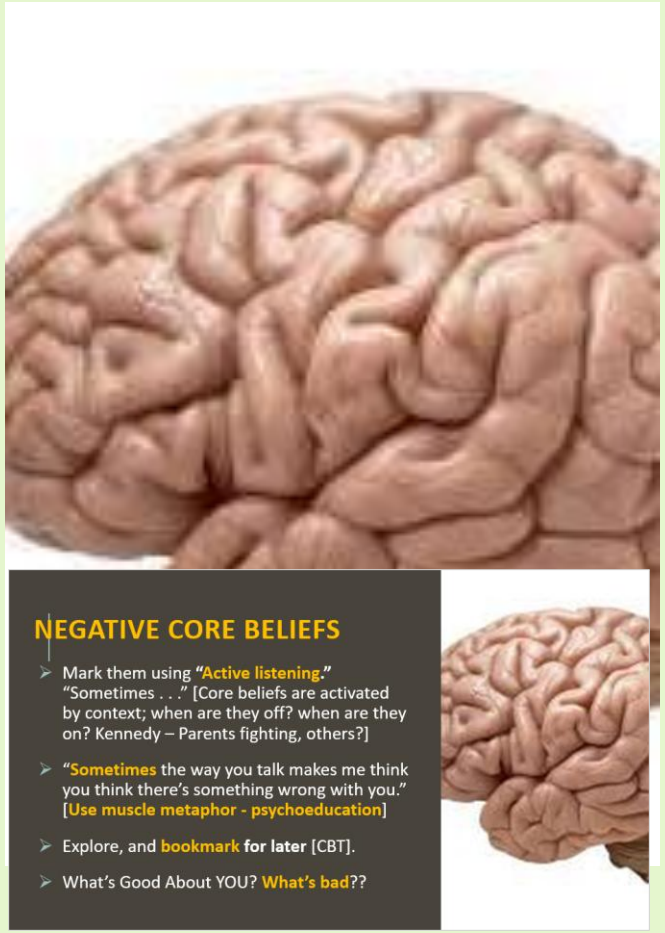
We want Kennedy to learn some emotional regulation tools

DBT (Linehan): Mindfulness+

Distress tolerance: Just breathe + Cold water splash

Youth will have idiosyncratic regulation methods. . .and we want to move them beyond smoking a particular herb

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 [don't get distracted by the shiny thing]
- Colter – Need my mom [or dad] – IEP story
- Final story [Later]

NEGATIVE CORE BELIEFS

- Mark them using **“Active listening.”** “Sometimes . . .” [Core beliefs are activated by context; when are they off? when are they on? Kennedy – Parents fighting, others?]
- “**Sometimes** the way you talk makes me think you think there’s something wrong with you.” [**Use muscle metaphor - psychoeducation**]
- Explore, and **bookmark for later** [CBT].
- What’s Good About YOU? **What’s bad**??

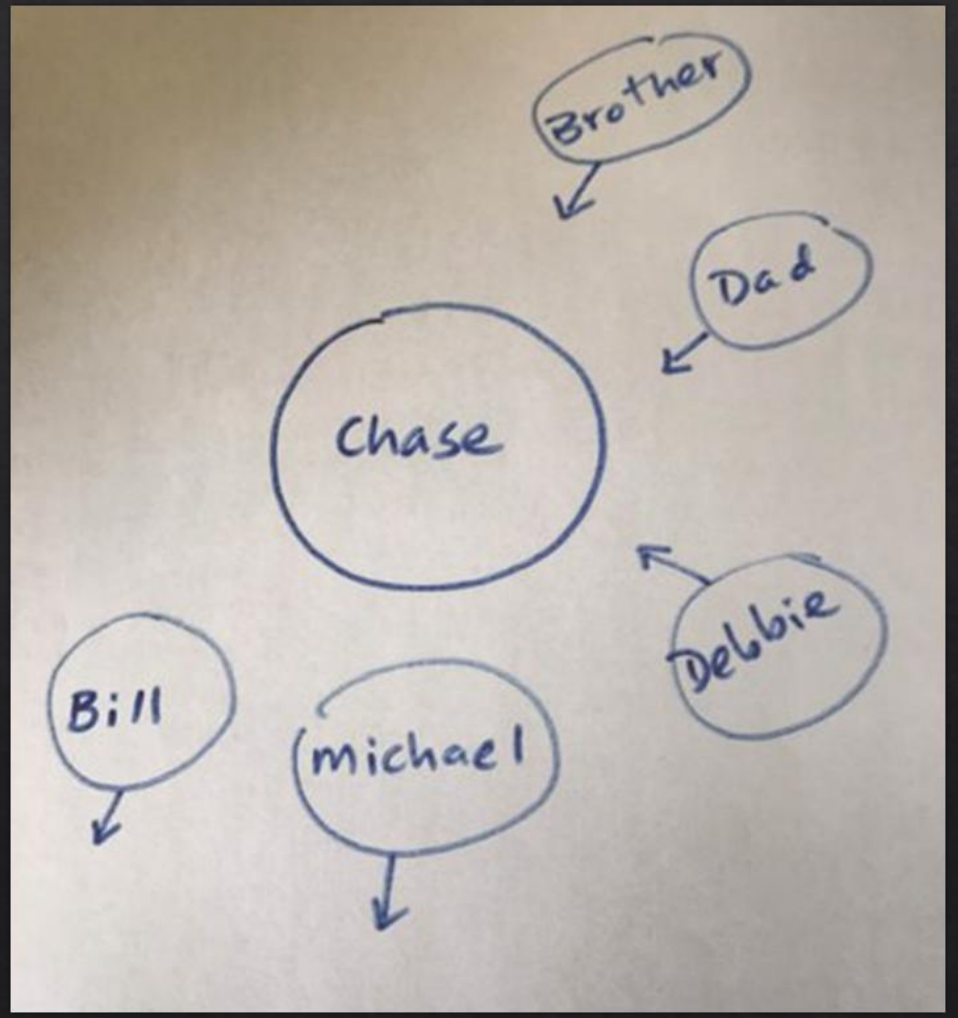
3. Interpersonal [Social]

Main Treatment Planning Targets

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

Drawing the Social Universe

- Volunteer
- Create another drawing
- Who's the most supportive person in your life?
- Who's the least supportive person?
- Who are you around the most?
- Who do you want to be around more?



SOCIAL UNIVERSE SKILL

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

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

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 Kennedy: https://johnsommersflanagan.com/2021/03/30/how-to-do-suicide-safety-planning-a-case-example/

7. Contextual Dimension

Main Treatment Planning Targets:

1. Poverty (April 2020 example; resources)
2. Neighborhood violence (safety)
3. Racism—perceived systemic oppression (affirmation/acceptance)

Also: urban, rural, school, government, society, culture, situational triggers, toxic environments, unemployment, high pressure employment, MH resources, bootstrap values

“ The Rural Context

Greater isolation

Increased alcohol use

Firearms availability

Fewer MH resources

Where to find connection?

Intervene on substances

Firearm safety

Access without stigma

In Closing

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

Free Resources

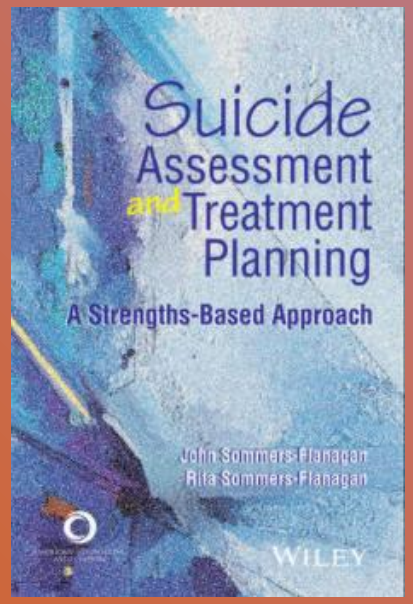
https://montanahappinessproject.com/

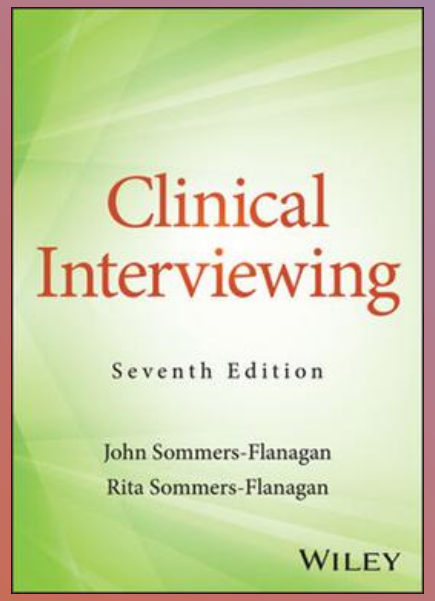
https://johnsommersflanagan.com/

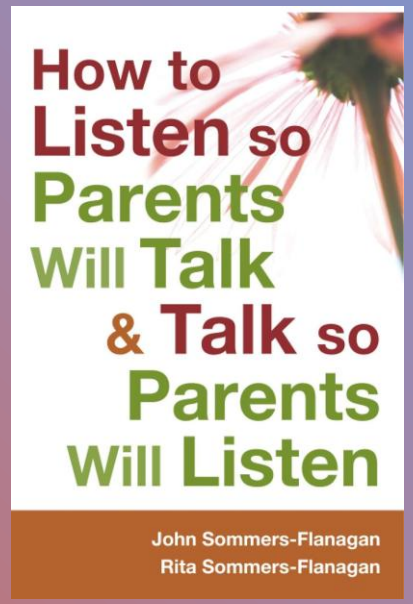
https://www.umt.edu/education/cape/

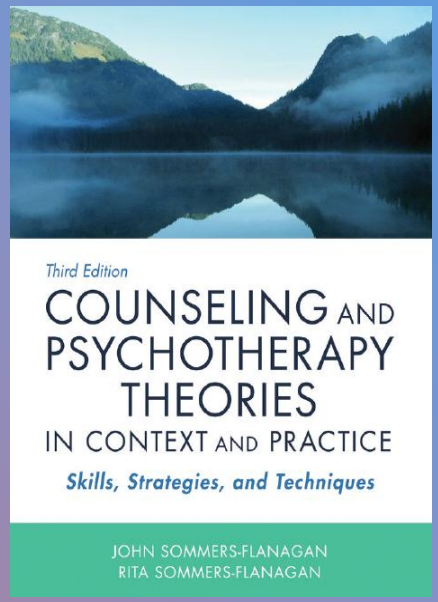
BOOKS BY…

JOHN AND RITA SOMMERS-FLANAGAN

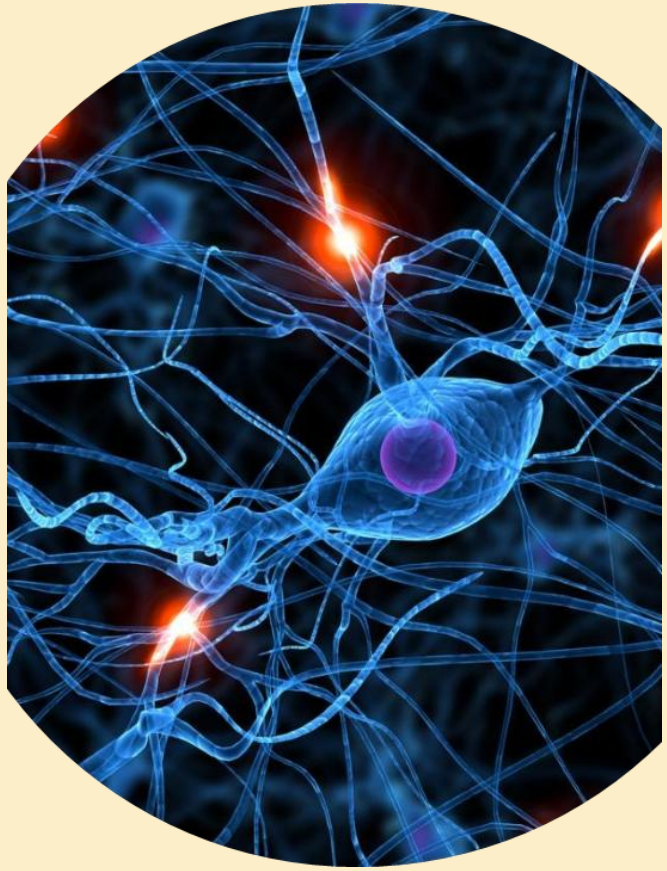








4. Physical Dimension



Main Treatment Planning Targets:

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

TRAUMA, INSOMNIA, NIGHTMARES

TF-CBT, EMDR, CPT . . .

CBT-I

Imagery Rehearsal Therapy (IRT)

WHAT IS IRT?

Imagery rehearsal therapy (IRT) is a cognitive-behavioral treatment for reducing number and intensity of nightmares

Empirically supported treatment

Commonly used in persons with PTSD who experience chronic nightmares

Relatively simple and short-term

Does not require clients to relive trauma event

FOUR STEP APPROACH

DEMO?

1. **RECALL** NARRATIVE OR CENTRAL ELEMENTS OF THE NIGHTMARE.
2. **REWRITE** THE NIGHTMARE. “CHANGE IT ANYWAY YOU WISH.”
3. **REHEARSE** THE NEW DREAM FOR AT LEAST 5-20 MINUTES EACH DAY AT TIME OF CLIENT CHOOSING AND BEFORE FALLING ASLEEP INVOKE INTENTION.
4. **REPEAT** AND CONTINUE TO PRACTICE WITH 1 TO 2 NEW DREAMS A WEEK.

Cultural and Spiritual

Main Treatment Planning Targets

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