2026 CONFERENCE & EXPO APRIL 9–11 COLUMBUS, OH

Suicide Assessment and Treatment: A Strengths-Based Approach

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Intro and Gratitude

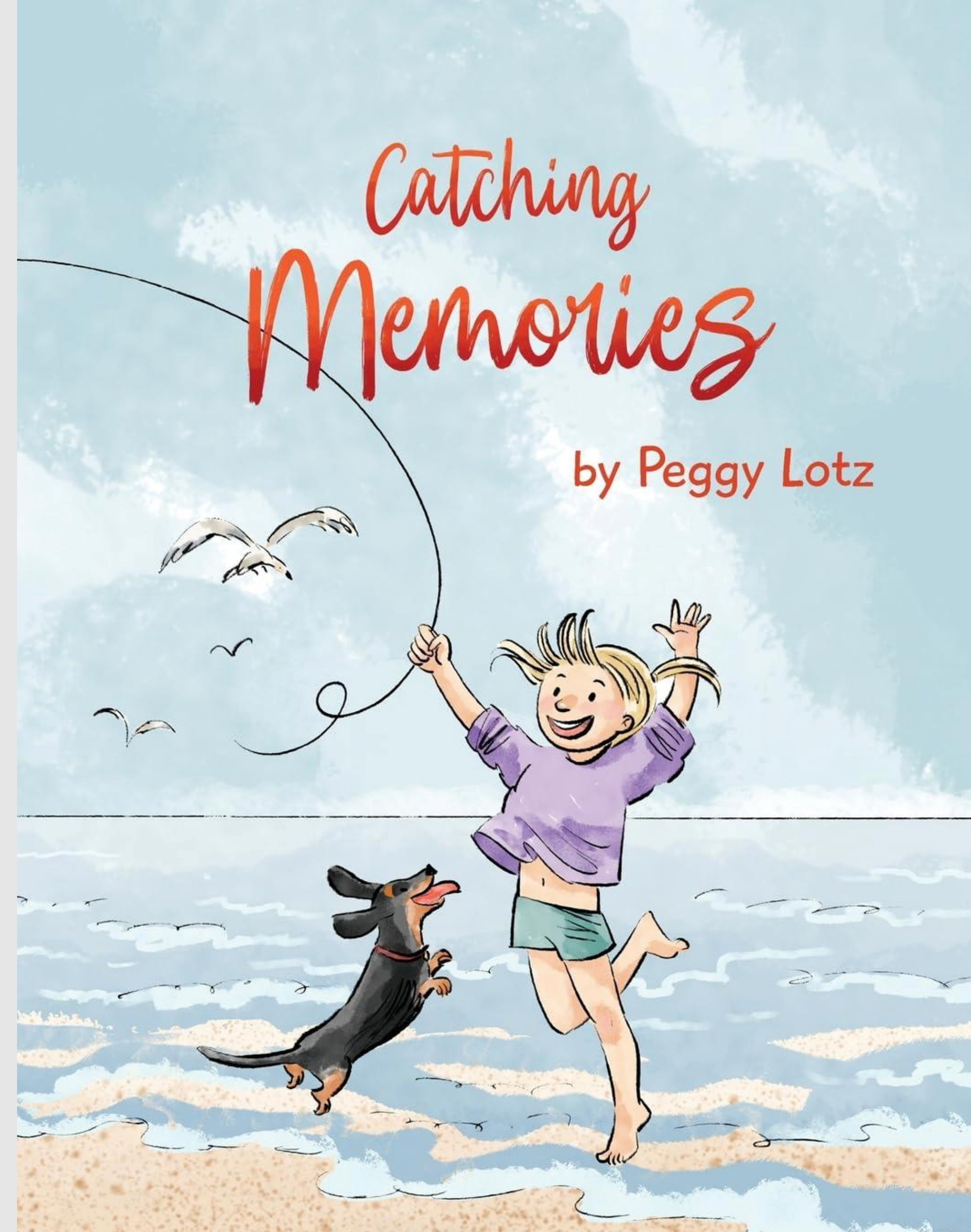
- Kim and John Intro + Survey [3 hours]
- Welcome and thanks to Crystal, ACA for the invitation and organizing!
- Thanks to the Center for the Advancement of Positive Education in the Phyllis J. Washington College of Education at the University of Montana:
- https://www.umt.edu/education/cape/

Preparation

- Trigger Warning and Why
- 30+ years ago – 2021 Networker article: https://www.psychotherapynetworker.org/article/myth-infallibility
- Research indicates. . .
- Strength warning!!
- Please practice **proactive and positive coping**

Remember . . .

- Trigger warnings **are suggestions** about what you might not be able to handle
- **Strength warnings** are suggestions about how learning and gaining experiences **make you STRONGER**
- What suggestions, direct and indirect, do we give clients about **depression, anxiety, trauma, and suicidal thoughts**?



REAL Learner Objectives

- You come with **YOUR** knowledge, experience, and expectations – You come with **YOUR WHY** and **PURPOSE**
- We offer **ideas** and exchange **experiences**
- You take **what fits for you** and apply it to your life and work
- **Caveats**: These are ideas. Nothing always works.
- Default = **relationship connection.**

Part 1: Strengths-Based Principles

Why a Strengths-Based Approach?

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

- This is **especially true** for people with identities that are historically and currently marginalized (**WHY?)**

Strengths-Based SA and Intervention Principles

Suicidal thoughts and behaviors are neither illness nor sin

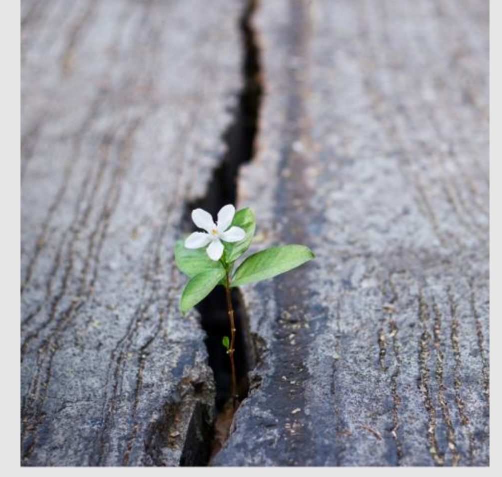
Depathologize!

Recognize the limits of risk/protective factor assessment

Collaborate!

Resist the temptation to overfocus on suicide

See strengths!



Implement interventions that target distress and suicidality

Grow HOPE!

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** to develop **individualized safety plans**
- The patient is a **whole person**
- 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 [8:20] 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 personal questions**. 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 or think about hospitalization. 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 our 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)

3-minute practice

#2 **Assessment Skill: Evaluate Ideation**

Ask directly and then **evaluate ideation**

Disclosure is good news (it's a sign of trust; say "thank you")!

- Trigger – What triggers your SI? What's happening when. . .SI
- Frequency – How often?
- Intensity – All you can think? Or background? Whole brain?
- Duration – How long usually?

Termination – What's going on when no SI?

You need to ask about suicide: **Tommie, 18 y/o Yup’ik tribe** – 14:00 to 15:15

https://players.brightcove.net/624142947001/r1evdKsni_default/index.html?videoId=5095441194001

Exploring Ideation **Therapeutically**

Assessment should be therapeutic

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?
The Plan: Craig Bryan says "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?
Previous Attempts: Stay with Client Stories

- **Previous attempts** – Listen, reflect, ask “How did you recover and get here?” or “What helped?”

- Keep 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 emotions and meaning associated with surviving a previous attempt

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

- "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

That One Thing (2/3)

Possible “irrational” responses:

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

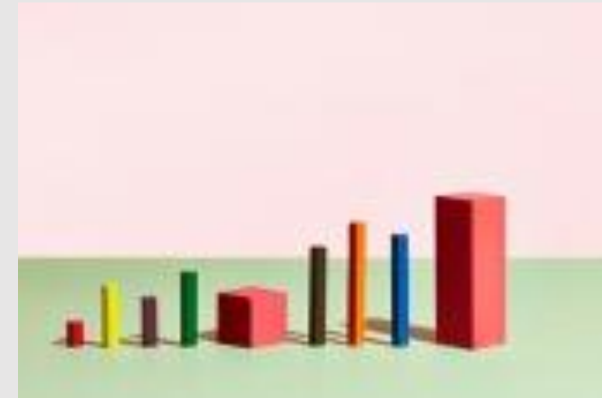
What treatment targets are linked to these responses?
Turn and practice now . . . with yourself 😁 or each other

That One Thing (3/3)

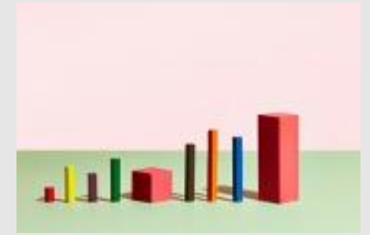
- “If we could somehow **magically change** just one thing in your life that would eliminate your suicidal risk all together, what would that be?” (Jobes, 2023, p. 63)
- This question **points you** and the client toward a treatment focus
- It also may **reveal** irrational expectations

#4 Assessment Skill: **Mood Scaling [8:50] with Suicide Floor**

- This is John's 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?

Integrating Medical and Strengths-Based Models: 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.

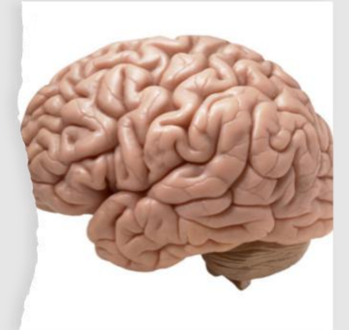
- I want to know much more about you than what's on this questionnaire. When we're finished with the questionnaire, we can talk about other things important to you.

More Integration

Sample Columbia Questions:

- Have you wished you were dead or wished you could go to sleep and not wake up?

  Add: Have you **wished** you were more **alive and engaged with life**?



- 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 with me on a plan to keep yourself safe and save yourself.

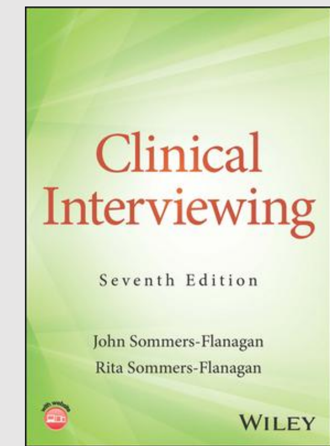
And More Integration

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: Notice. . . [9:20: Break]

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

Part 3: Strengths-Based Suicide Interventions

A Treatment Planning Model [9:30]

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]

A Treatment Planning Model
Seven Organizing Life Dimensions
An Erikson's Developmental Stages Lens

Stage	Basic Conflict	Important Events	Key Questions to be answered
Adolescence (12 to 18ish)	Identity vs. Role Confusion	Social Relationships/ Identity	Who am I and where am I going?
Young Adult (19 to 35ish)	Intimacy vs. Isolation	Intimate Relationships	Am I loved and wanted?
Adult (35ish to 65ish)	Generativity vs. Stagnation	Work and Parenthood	Will I provide something of real value?
Older Adult (65ish to death)	Ego Identity vs. Despair	Reflection on life	Have I lived a full life?

A Treatment Planning Model
Seven Organizing Life Dimensions
Using an Erikson's Developmental Stages Lens (1/3)

Three Principles for Developmental Strengths-Based Assessment

1. The Developmental Question Changes Across the Lifespan

- **Each Erikson stage defines what it means to be "okay" — and what it means to "fail".**
- **The Seven Dimensions apply across all stages**
  - A 16-year old's suicidal crisis is often about identity and belonging.
  - A 32-year old's is often about intimacy and loss of connection.
  - A 55-year old's is often about stagnation and legacy.
  - A 72-year old's is often about integrity and burden.

Using an Erikson’s Developmental Stages Lens (2/3)

2. Lethality Risk Is Not Equal Across Age

- Adolescents attempt more and die less (1 in 200 attempts fatal; impulsive, brief window for intervention).
- Older adults attempt less and die far more (1 in 4 attempts fatal; deliberate, under-detected).
- This means the clinical urgency of any expressed plan is highest — not lowest — for older clients.
  *We systematically underestimate this population.

A Treatment Planning Model
Seven Organizing Life Dimensions

Using an Erikson's Developmental Stages Lens (3/3)

3. Strengths are often Stage-Specific

- Hope and future-orientation are the most powerful protective factors for adolescents.
- Relational stability and meaning-making anchor emerging adults.
- Purpose, mattering, and generative engagement protect middle adults.
- Meaning in life and narrative coherence are protective factors for older adults. -Askingabout generic "strengths" may miss the target.

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)**

Emotional Dimension

Erikson's Stages: Developmental Vulnerabilities and Focus

Adolescence – **identity** vs role confusion: Tinelle (12, she/her; identifies as queer and White) parents divorced last year and now attending new school. "…everyone knows I'm a loser from a loser family."

Older Adult- **integrity** vs. despair: Gerald (74, he/him; identifies as straight and White) feeling deep sadness. His wife died 6 months ago, fishing buddy died last year. "I miss my old life – my wife, my parents, my friends; they are all gone."

Case – Kennedy – Opening

Kennedy is a 15-year-old referred by her parents for depression/suicide ideation [Simulation]

Watch for:

- Opening statements and focus
- Collaboration?
- First mention of suicide
- The “gun” mention
- Individualized distress and risk
- What makes Kennedy suicidal?

00:01:38:15

Case – Kennedy – Opening

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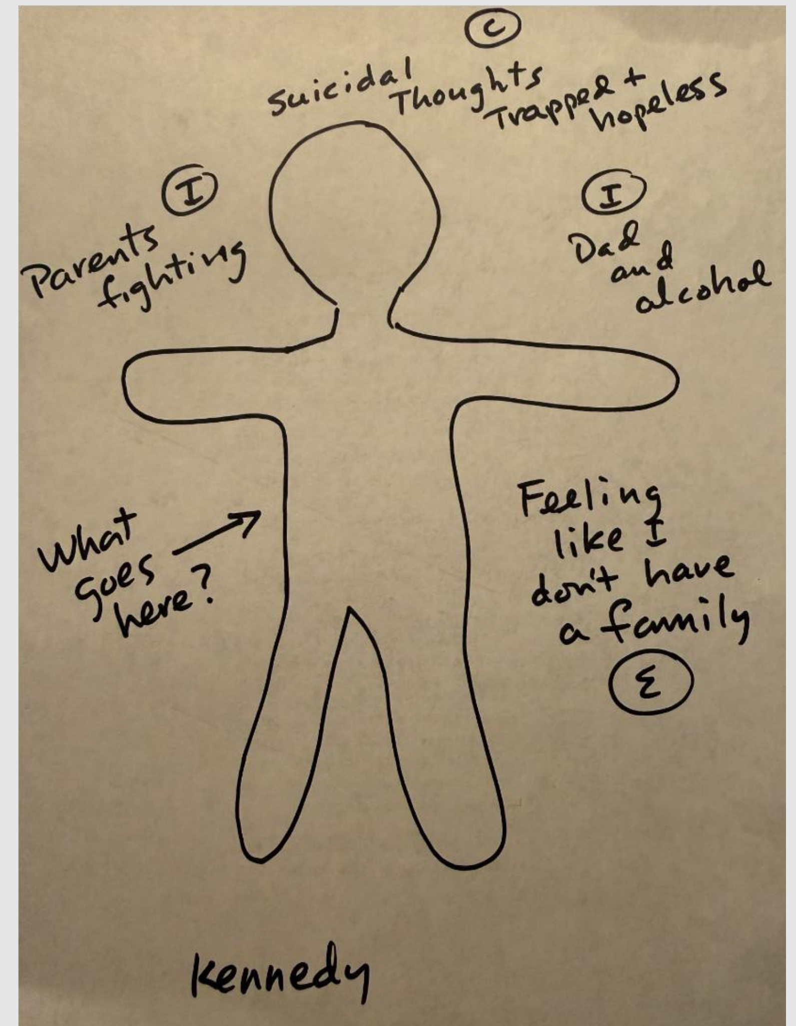
Watch for:

- Opening statements and focus
- Collaboration?
- First mention of suicide
- The “gun” mention
- Individualized distress and risk
- What makes Kennedy suicidal?

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 emotional regulation tools

- DBT (Linehan): Mindfulness+
- Distress tolerance: Just breathe + Cold water splash
- Wise mind

Clients will have idiosyncratic regulation methods. . .
[Use: Yes. . . And]

2. **Cognitive Dimension [9:55]**

Main Treatment Planning Targets

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

Cognitive Dimension

Erikson’s Stages: Developmental Vulnerabilities and Focus

Adolescence – **identity** vs role confusion: Jaylen (15, he/him; identifies as Black and straight) didn’t make the cut for basketball after four years of club ball. “If I can’t play basketball and earn a scholarship, I can forget about college.

Young Adult - **intimacy** vs. isolation: Rene’ (25, she/they; identifies as Indigenous, Blackfeet, two-spirit) moved for job and then laid off due to company downsizing. “I have no friends, no job, no prospects; and now I’m stuck here. No one can help me.”

Alternatives to Suicide

- Shneidman Story – An intervention for mental constriction [don’t get distracted by the shiny thing]

- 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].

- Activity: What’s Good About YOU? **What’s bad**??

3. Interpersonal [Social] [10:10]

Main Treatment Planning Targets

1. **Unwanted Social Disconnection*** [aka thwarted belongingness; Joiner; for Kennedy?]

2. Social Skill Deficits

3. Feeling Like a Social Burden [perceived burdensomeness]

Interpersonal [Social]

Erikson's Stages: Developmental Vulnerabilities and Focus

Young Adult- **intimacy** vs. isolation: Tony (27, they/them; identifies as Gay and White) having to live with parents during recovery from car crash. "They don't need their kid living in the basement. Even my friends aren't taking my calls anymore."

Older Adult- **integrity** vs. despair: William (88, he/him, identifies as straight and White) nursing home resident. "I need help to walk, and I hate to bother the workers, so I just stay in my room"

The Chase Video (7 min) – Watch for

Cognitive Interventions

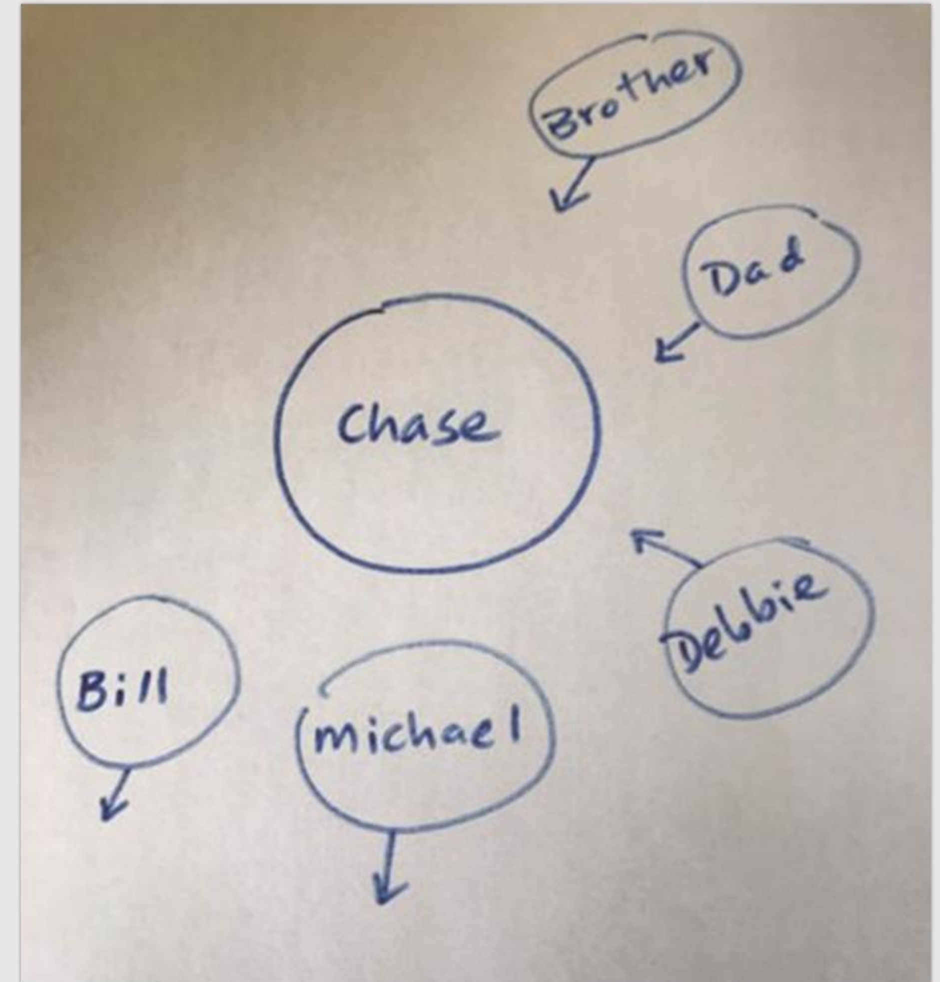
- Interpersonal interpretation of a longstanding pattern
- Building hope from the bottom up

Social Intervention

- Chase's social universe

Building Hope From the Bottom Up

- Who gives you validation?
- “No one gives me validation.”
- Who’s 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

Severe depression and suicidal thoughts can make you feel weak, helpless, and hopeless but you are stronger than your thoughts. You have the courage and strength it takes to choose life even when your mind tells you life is too painful, and death is the only option. #StopSuicide

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 [10:30]**

Main Treatment Planning Targets

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

Physical Dimension

Erikson's Stages: Developmental Vulnerabilities and Focus

Adolescence – **identity** vs role confusion: Marcus (15, he/him; identifies as straight and White) father died by suicide 7 years ago. Is jumpy in session and reports falling asleep after 2 am and waking up with his heart racing. "I'm too tired to make it to soccer practice so I quit."

Adult – **generativity** vs. stagnation: Ceasar (54, he/him; identifies as straight and Latino) uses opioids for chronic back pain after a work-related accident. "I have nightmares that I'm falling again, I can't sleep."

Trauma, Insomnia, Nightmares

- TF-CBT, EMDR, CPT . . .
- CBT-I
- Imagery Rehearsal Therapy (IRT)

Next Up: Cory video: Physical, 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 [Note: **This is an intense video describing Cory’s trauma**]

Cory Debrief – Chat Time

- What do we know about Cory in the emotional, cognitive, interpersonal, and other dimensions?
- What barriers are there to working with Cory on emotions? [Your clients?]
- What will goal-setting look like with Cory?
- What are your thoughts on his risk level?

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

6. **Behavioral**

Main Treatment Planning Targets

1. Suicide (Rehearsal) Desensitization
2. Lethal Means
3. **Suicide Intent and Planning***

Behavioral

Erikson's Stages: Developmental Vulnerabilities and Focus

Adolescence – **identity** vs role confusion: Jacob (14, he/they; identifies as non-binary and White) experiencing depression and anxiety tried to hang himself after briefly searching the internet for methods to die reports "I didn't really plan it out; I just did it."

Adult – **generativity** vs. stagnation: Steffon (65, he/him; identifies as straight and White) recently retired police officer "My grandfather killed himself, I figure that's how the men in 'our' family check out."

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
- 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/

Closing Story

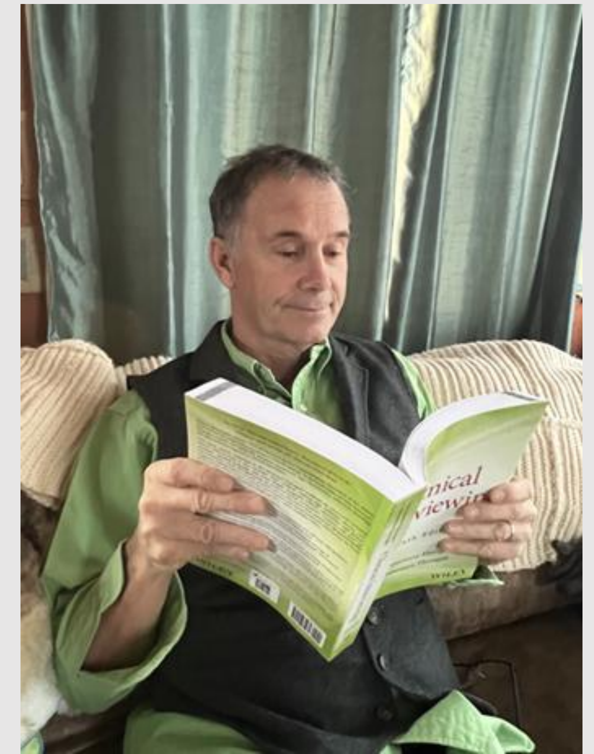
The Bridge

How About You?

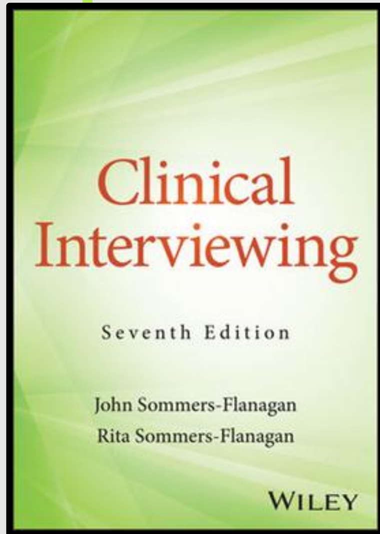
- What do you want to remember?
- What can you implement soon?
- **Thanks for being you . . .**
- Monitor and take care of yourself and your colleagues

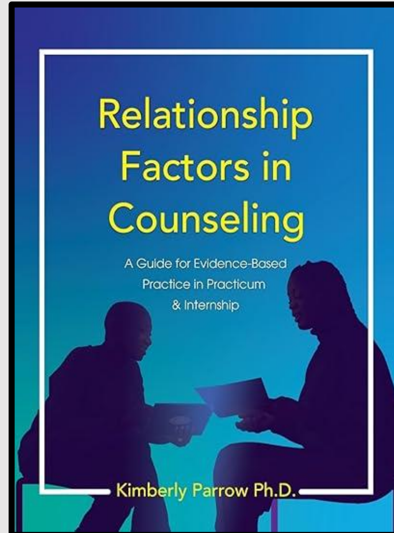
Resources

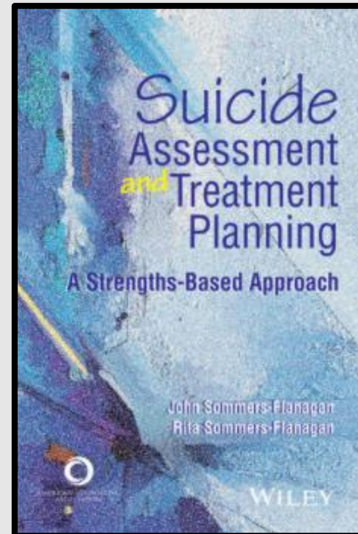
- https://montanahappinessproject.com/
- https://johnsommersflanagan.com/
- https://www.umt.edu/education/cape/
- Janssen et al., 2025: Cognitive Behavior Therapy With and Without Narrative Assessment and Suicide Attempts: A Systematic Review and Meta-Analysis https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2841680
- Rudd, M. D., & Kratholm, O. (2026). Brief Cognitive–Behavioral Therapy+ as a suicide-specific treatment add-on. *Practice Innovations.* Advance online publication. https://doi.org/10.1037/pri0000327

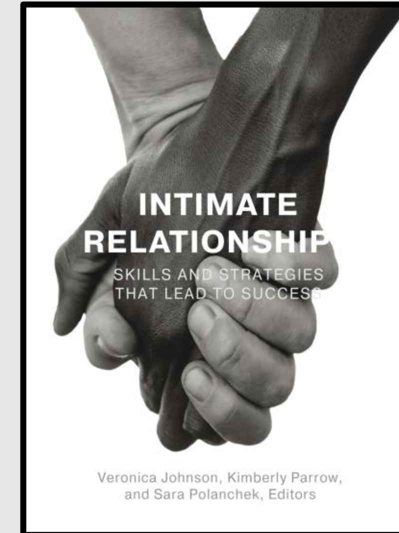


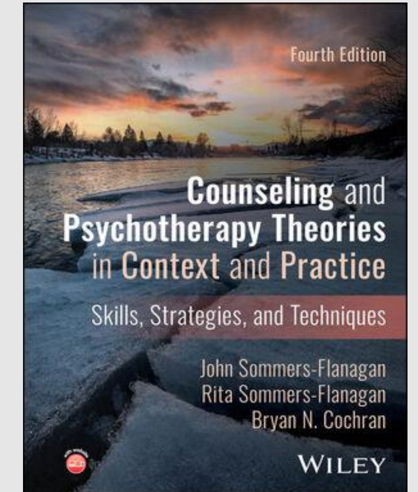
Books by… The Presenters











Flood the Zone

PJW_CAPE

Follow our Linkedin

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Happiness for Educators

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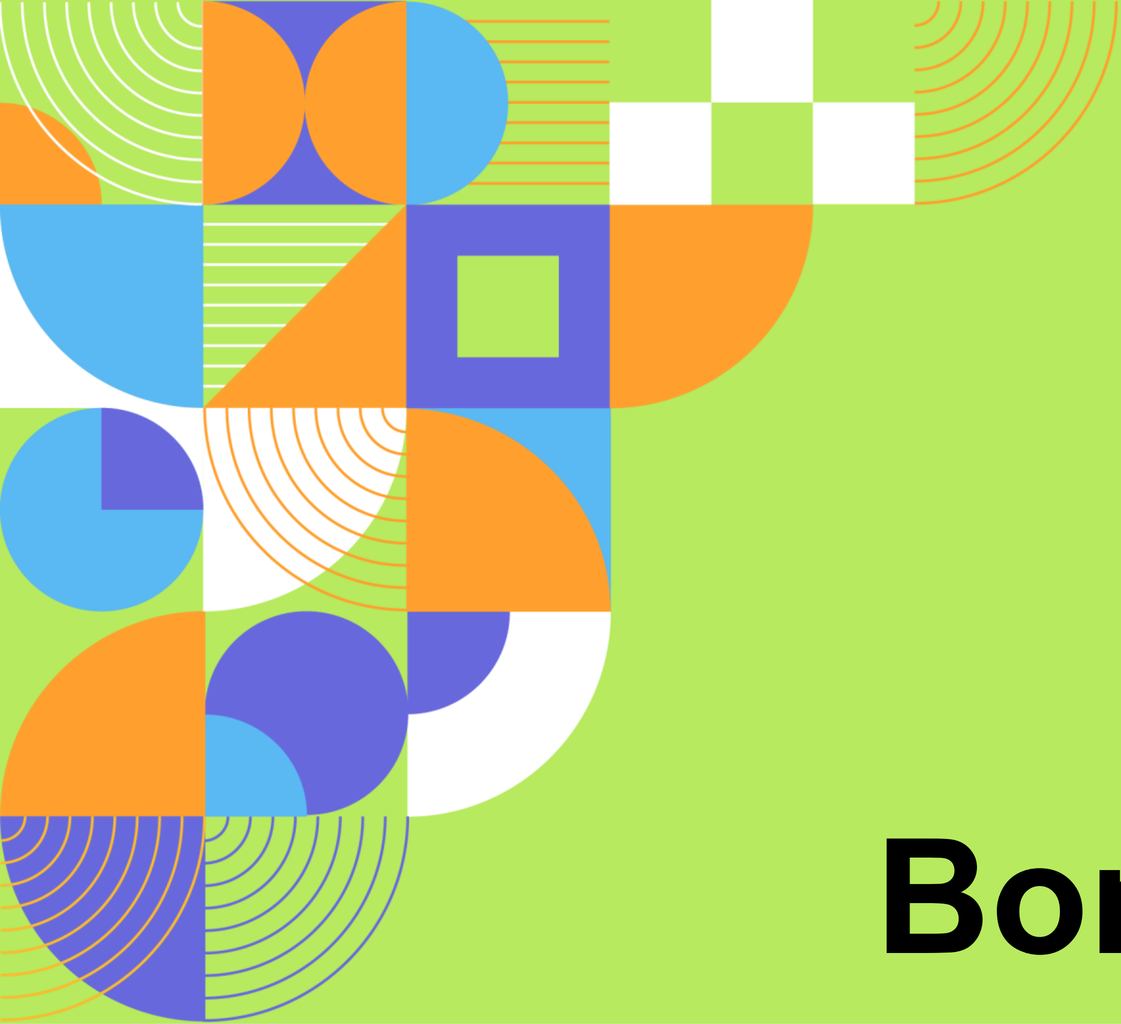

Bonus Slides!

Optional: Mood Scaling with Kennedy: https://www.youtube.com/watch?v=xMIIDvvD_xI

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.

Optional: Safety Planning with Kennedy: https://www.youtube.com/watch?v=jd7PM9HFDO4

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

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 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

5. Cultural and Spiritual

Main Treatment Planning Targets

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

Cultural and Spiritual

Erikson's Stages: Developmental Vulnerabilities and Focus

Young Adult- **intimacy** vs. isolation: Leila (25, she/her; identifies as straight and African) immigrated from Kenya 8 years ago. "I used to feel like I belonged and mattered, here I'm nothing, I don't fit in."

Adult – **generativity** vs. stagnation: Patrick (52, he/him; identifies as Gay and exploring Trans and White) attends same church from childhood, "I stopped believing a long time ago, I just go through the motions."

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

Contextual Dimension

Erikson’s Stages: Developmental Vulnerabilities and Focus

Adolescence – **identity** vs role confusion: Jae (17, they/them; identifies as biracial Black and White and as sexually fluid). Christian identifying. Parents kicked them out of home. Intense suicidal ideation and cutting. Couch surfing. “I don’t know who I am, but I know who I’m not.”

Adult – **generativity** vs. stagnation: Carla (59, she/her; identifies as straight and White) needing to get on Medicaid after her divorce and entering the workforce after 35 years. “I’m so embarrassed, I can’t even afford to get my mammogram this year.”

Context Examples

Rural

Isolation

Alcohol, Firearms, MH resources

Cultural values?

Urban

Density

Substances, neighborhoods, oppression

Cultural values?