Integrating Strengths-Based and Traditional (Medical Model) Approaches to Suicide Assessment

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Free Resources: https://johnsommersflanagan.com

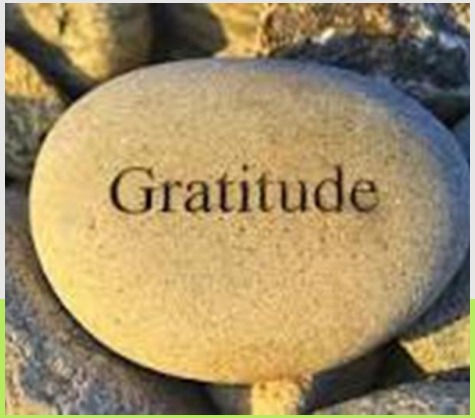
Intro and Gratitude



- Welcome and thanks to VCA
- 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/
- **And YOU**







Preparation and Plan

- 30+ years ago – 2021 Networker article: https://www.psychotherapynetworker.org/article/myth-infallibility
- Please practice **proactive coping**
- The plan: SB principles, then assessment with pausing for discussion





REAL Learner Objectives

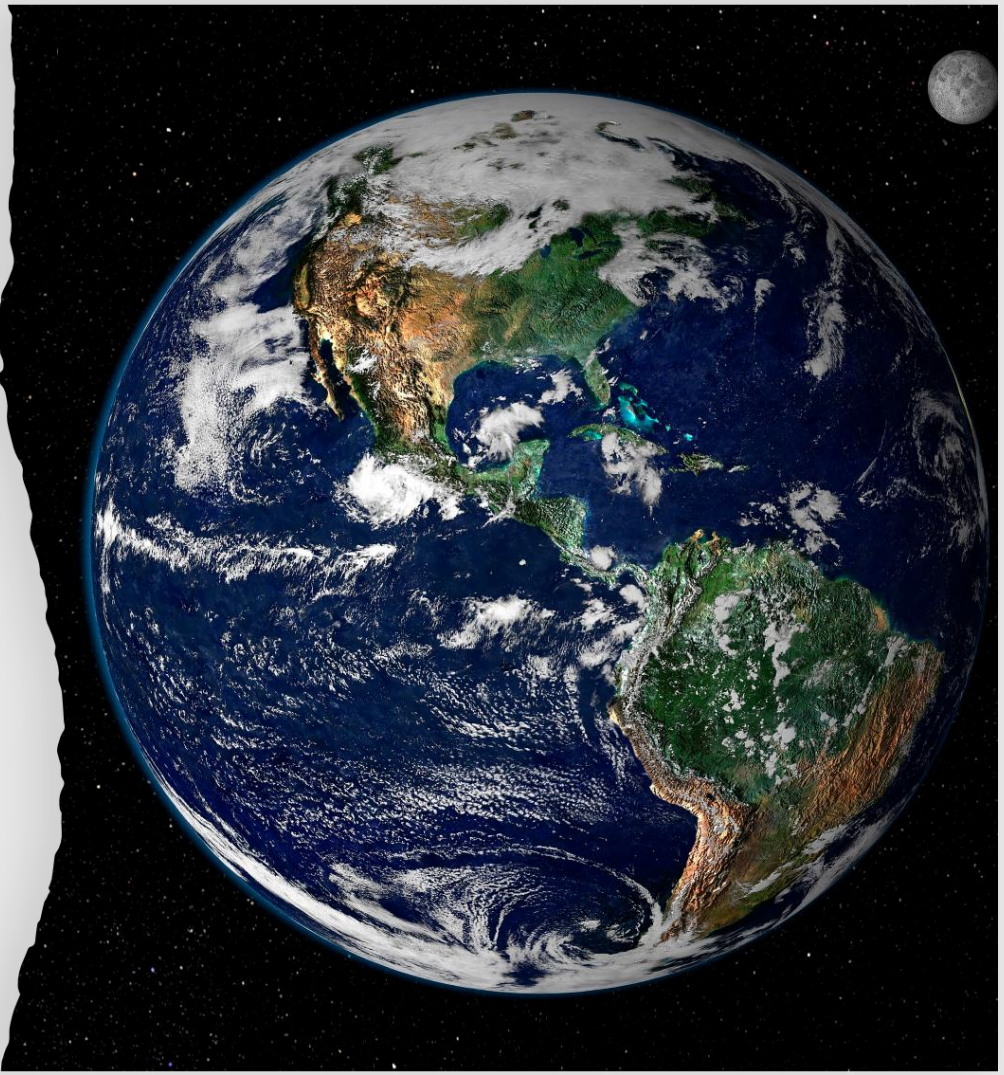


- You come with **YOUR** knowledge, experience, and expectations – You come with **YOUR WHY** and **PURPOSE**
- I offer **ideas** and exchange **experiences**
- You take **what fits for you** and apply it to your life and work
- **Caveats**: These are ideas. Nothing always works.
- Default = **relationship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

Why a Strengths-Based Mentality?

- 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?)**
- Traditional assessment is TOO FOCUSED on **drilling down into what's wrong**





Why SB? – 2

- We know that **asking** about suicide doesn't plant the idea
- We know **asking directly is essential**
- But we also know that about 15-20% of people **feel emotionally worse** after a traditional suicide assessment
- We know **growing strengths** works better than trying to stop negative thoughts and behaviors
- SBSA **integrates** sensitivity to client or student emotional responses into assessment

The Scenario

You're with a client or student. You need to broach suicide.

Notice your reactions:

Tommie, 18 y/o Yup'ik tribe



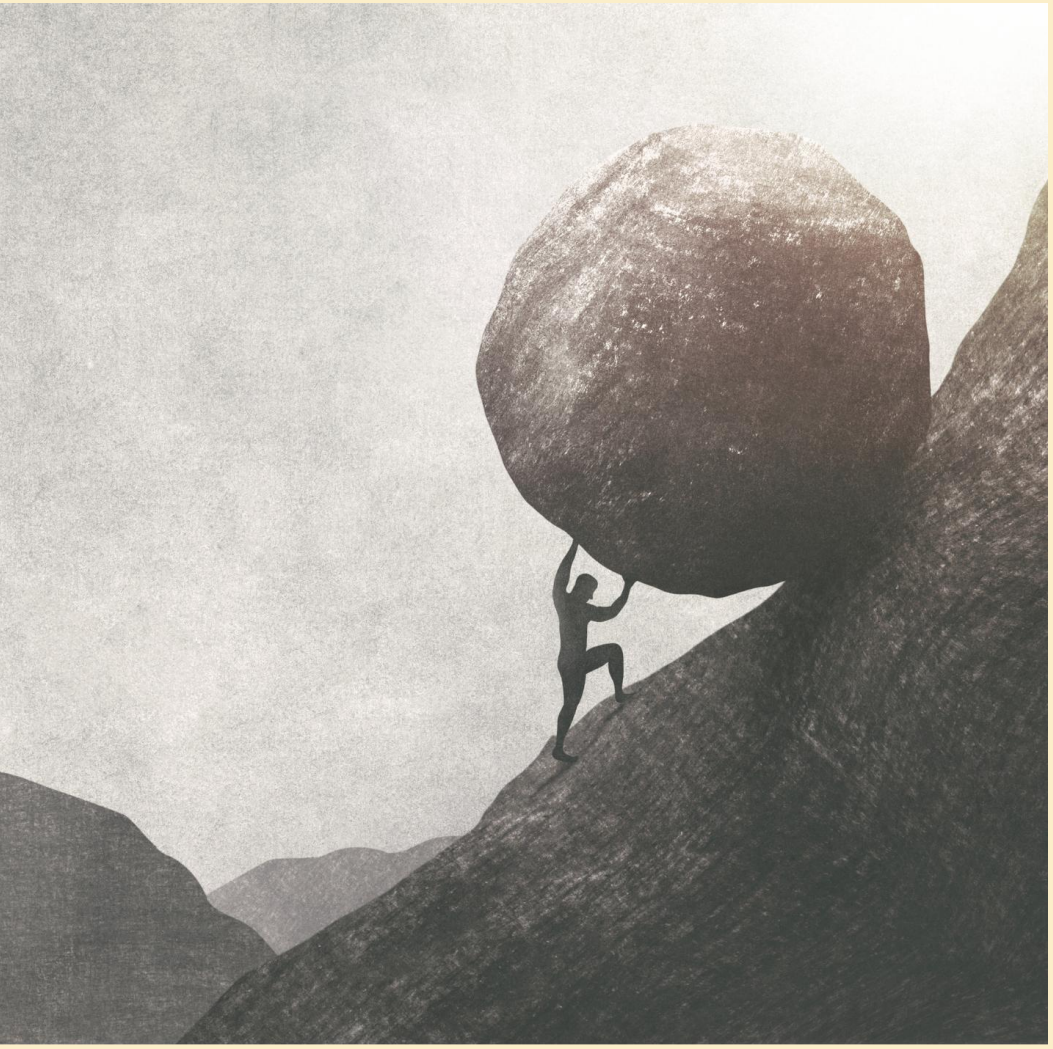
Part 1: Outside the Box Strengths-Based Principles and Suicide





SB – 1 – Suicidal Ideation is not an Illness, Mental Disorder, Sin (or even a good predictor of suicide)

- Suicidal ideation is a **natural human response** to painful emotions and stressful circumstances, over which we feel little control. Think of being bullied, of historical trauma, of systemic oppression, sexual assault or abuse, unemployment, etc.
- SI means people are **living lives of despair and feeling hopeless.**
- The distress may not even be “IN” them. They might be in a traumatizing life situation.



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]

Strengths-Based Principles – 3

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

The student 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]

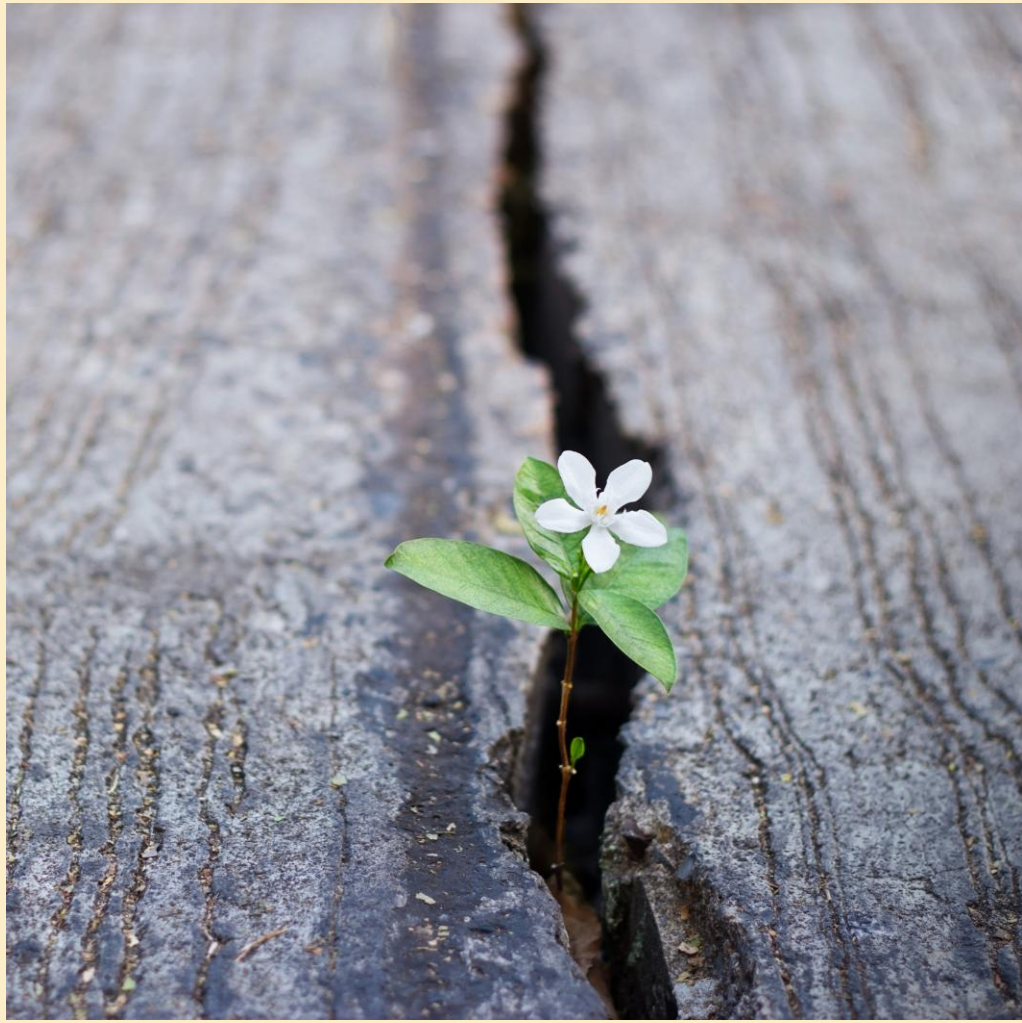


Strengths-Based Principles – 4

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

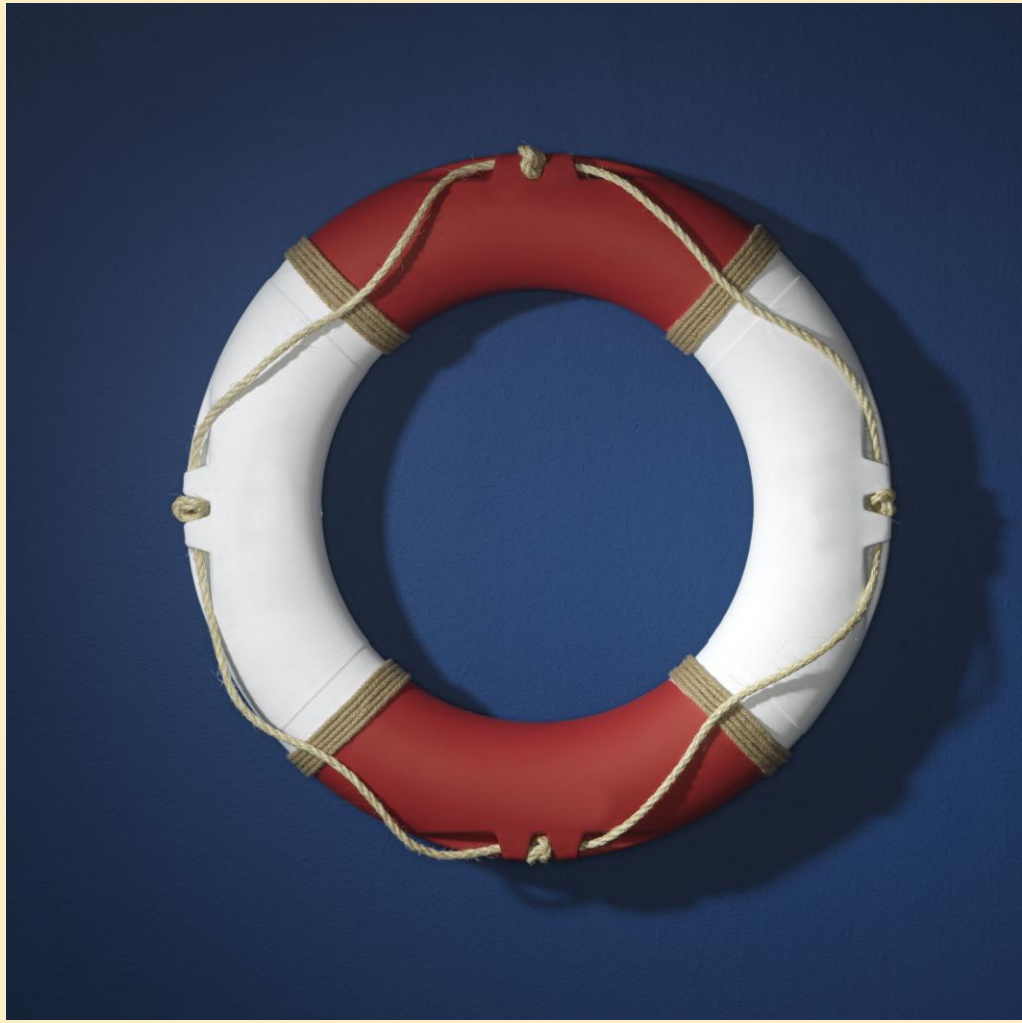
Treatment by diagnosis – not as effective

Remember – **Interventions can stimulate HOPE**



Strengths-Based Principles – 5

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





Strengths-Based Principles – 6

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 can **predict* and prevent** suicide
- We use **risk assessment** procedures and questionnaires
- We are **authority figures** who know more about patient health than they do
- The client is a **suicidal person**
- We treat **mental disorders**

A Social Constructivist Philosophy

- Suicidal thoughts and behaviors are a **natural communication of pain** [de-pathologize]
- Suicide is mostly **unpredictable***
- We **individualize risk factors** and use **collaborative and therapeutic** assessment
- We **collaborate** to develop **individualized safety plans**
- The client is a **whole person**
- We treat client **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 – In informed consent and in first session
- Prep – **I will ask you personal questions**. For example, I'll ask about suicidal thoughts. Something you should know: Suicidal thoughts are common and not usually an indicator that people want to die. Thoughts about suicide are a sign of difficult life situations and painful emotions.

#1 **Assessment Skill/Tool: Normalizing**

Ask **directly AND normalize** the asking and normalize SI

- 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 may** think about suicide from time to time. Have you had thoughts about suicide?
- Normalize the asking: **"I ask everyone I see."**
- Acknowledge **"Thank you for sharing with me."**

#1 Practice: Use Normalizing Language

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.



Reflection: Think of a client or student, and, **for practice,** turn and share with a partner what you might 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; 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?
[What we explore, we grow]



Exploring Ideation **Therapeutically**

All assessment should be therapeutic

Tommie: Singing and poetry [self-expression]

Other examples:

- Sean – “Biking and playing basketball”
- Haley - "Snuggling with my dog"
- Chase – “Being with someone (or somewhere) that validates who I am”
- Cory – “Doing something meaningful with my niece or for my tribe”
- Your clients?

#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 😁

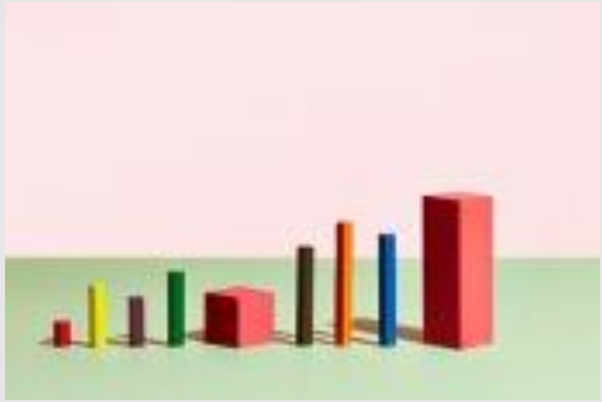
That One Thing (3/3)



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#4 Assessment Skill: **Mood Scaling with Suicide Floor**

- John's favorite **5-minute interview** strategy
- Demo?



- May I ask some questions about **your mood?**

#4 “Script” for **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.

And More Integration



Combine Two Approaches

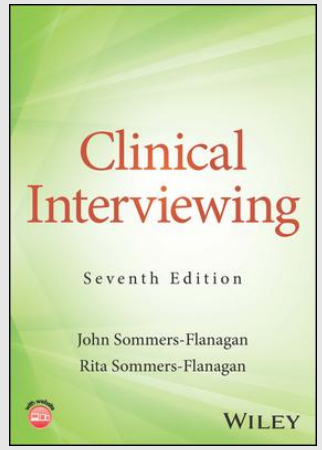
Example: Use a questionnaire and. . .



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

Balance Questions: If you ask about RFD, then ask about RFL

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

asQ
Ask Suicide-Screening Questions

Assessment Reflections: Notice. . .



1. Q and R on Assessment
2. What feels challenging?
3. Where do you need or want practice?
4. Prizes??



We’re in Bonus Time

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?

A 4-part question for someone who is experiencing depression?

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

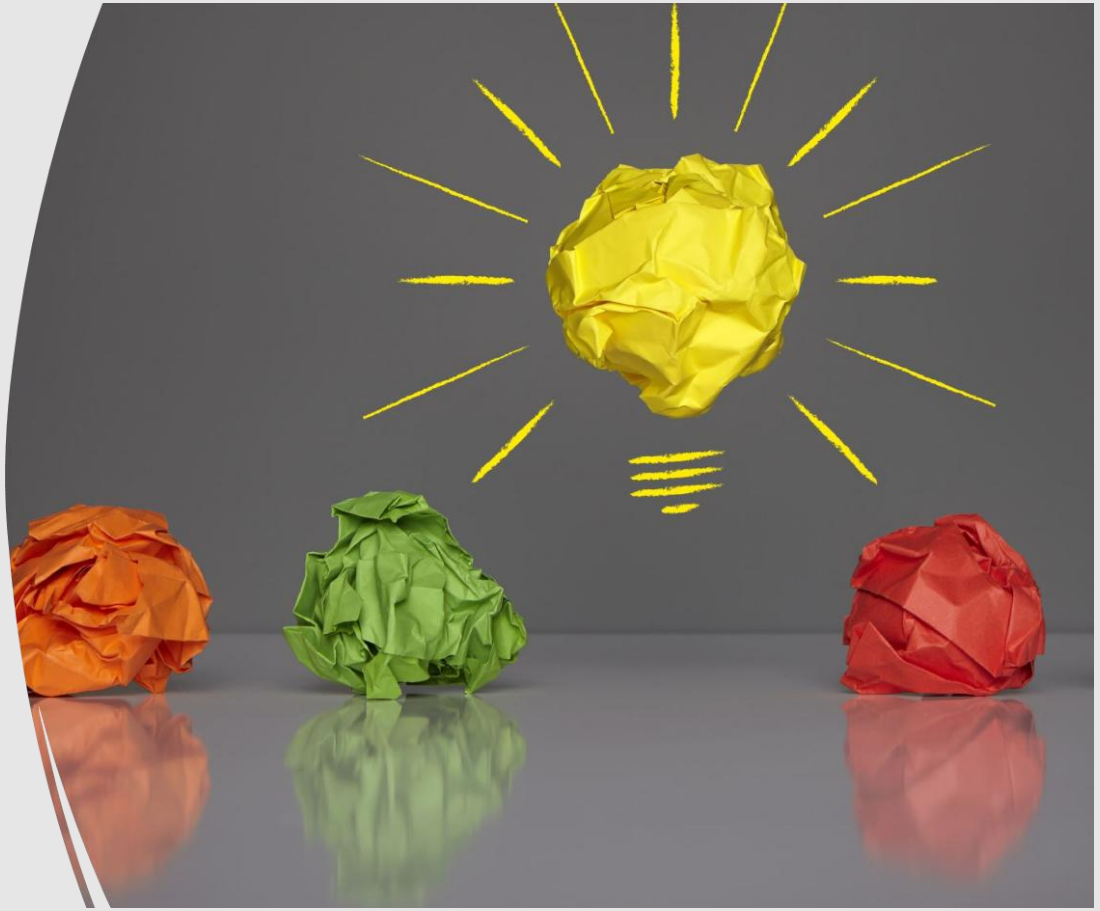
False positives – Passive SI, SI, intent, and suicide planning have low predictive value. Previous attempt* is likely better, but not good.

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

Part 3: Strengths-Based Suicide Interventions





A Treatment Planning Model

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 **(*something wrong* with the self)**



Emotional: Dysregulation and Regulation

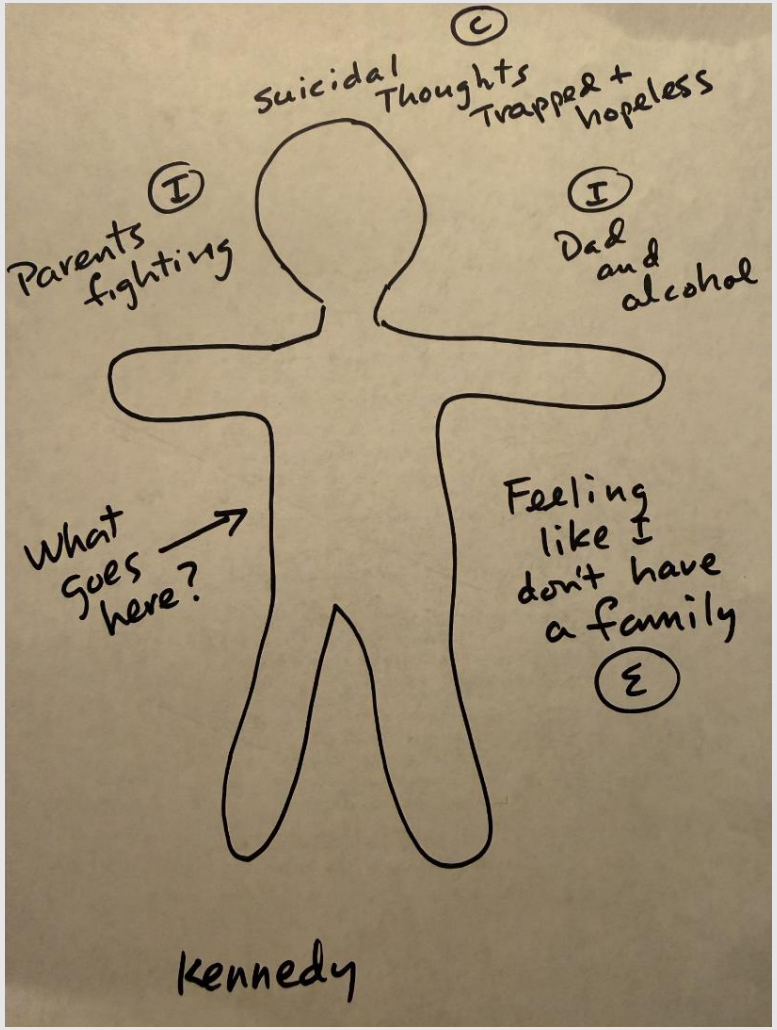
We want clients to learn emotional regulation and management tools

- DBT (Linehan): Mindfulness+, distress tolerance, breathing, cold water splash, wise mind
- Clients will have idiosyncratic regulation methods. . . [Use: Yes. . . And]
- Introduce positive emotions – Gratitude, savoring, 3 good things

Emotional: Separate Pain from Self

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

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



3. Interpersonal



Main Treatment Planning Targets

1. **Unwanted Social Disconnection***
   [thwarted belongingness; Joiner]

2. Social Skill Deficits

3. Feeling Like a Social Burden
   [perceived burdensomeness]



The Chase Video (7 min) – Watch for

Cognitive Interventions

- Interpersonal interpretation of a longstanding pattern
- Building hope from the bottom up
- Watch it here: https://johnsommersflanagan.com/2023/04/03/three-leftover-american-counseling-association-conference-videos/

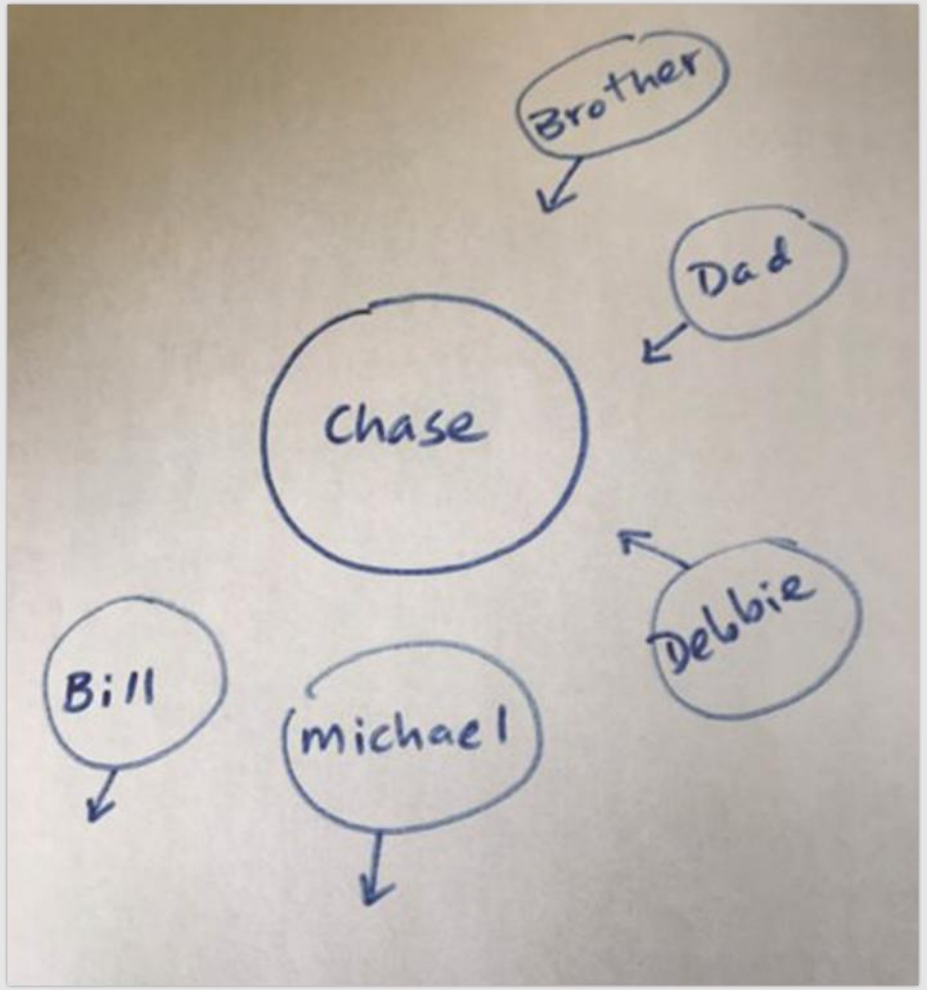
Social Intervention

- 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

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).

6. **Behavioral**

Main Treatment Planning Targets

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

COLLABORATIVE Safety Planning

- 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?

COLLABORATIVE Safety Planning II

- Follow the Stanley and Brown SPI protocol – or whatever your agency is using
- Be explicitly collaborative and compassionate
- To watch an 8-minute safety planning example of JSF with Kennedy: https://johnsommersflanagan.com/2021/03/30/how-to-do-suicide-safety-planning-a-case-example/



Closing Thoughts

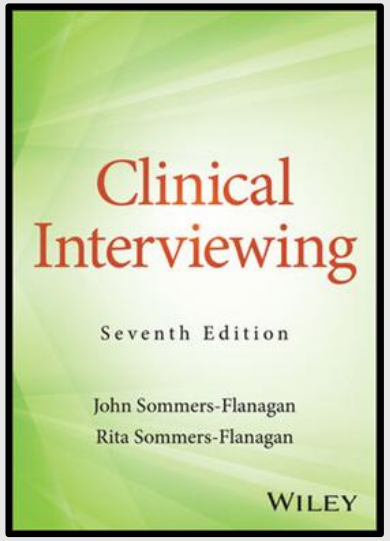
The Bridge

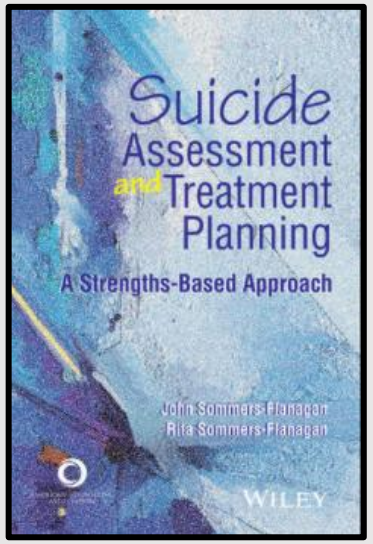
How About You?

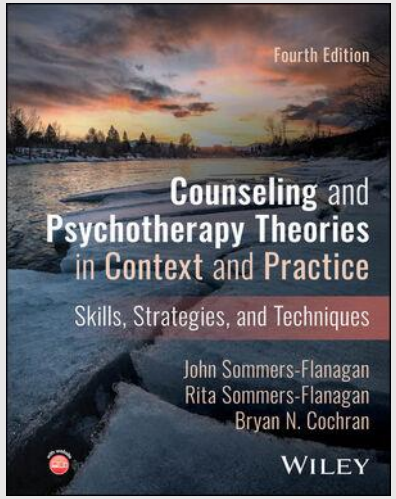


- What do you want to remember?
- What can you implement soon?
- **Thanks for being you . . .**
- Monitor and take care of yourself and your colleagues

Books by… JSF


Clinical
Interviewing
Seventh Edition
John Sommers-Flanagan
Rita Sommers-Flanagan
WILEY


Suicide
Assessment
and Treatment
Planning
A Strengths-Based Approach
John Sommers-Flanagan
Rita Sommers-Flanagan
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Fourth Edition
Counseling and
Psychotherapy Theories
in Context and Practice
Skills, Strategies, and Techniques
John Sommers-Flanagan
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