

Conversations About Suicide: Strategies for Detecting and Assessing Suicide Risk

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When patients disclose suicidal thoughts, clinicians often feel their anxiety rise. The best remedies for clinician anxiety include an understanding of suicide dynamics and a thoughtful and empathic engagement with patients. Engagement with patients typically includes collaborative exploration of eight psychological, interpersonal, and situational dimensions related to suicidality. These dimensions are rooted in suicide theories and empirical research. In this article, specific strategies are described and illustrated, including strategies for initiating conversations about suicide, exploring different dimensions of suicide, and engaging patients in steps to increase their safety.

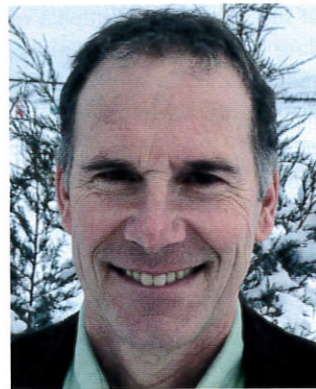
Your new patient, Susan, just arrived for her 2:00 p.m. intake session. When she called three days ago asking for an appointment, she sounded alert and upbeat. She said she wanted a psychologist to help her work on “life issues.” Finding an appointment time that fit both your schedules was a smooth and easy process. Susan’s voice was strong and her speech clear and coherent; after hanging up, you found yourself looking forward to meeting her.

But the person in the waiting room looks nothing like what you expected. Susan’s clothes are wrinkled, her eyes puffy, and her hair greasy and unkempt. After folding herself into your office chair, she says, “I hate my life. I feel beaten down. I’ve tried everything. I don’t know how much longer I can go on. Nobody understands.”

Settling into the Clinical Situation

Susan’s words hang in the air as your expectations for an engaging clinical interaction dissipate. Instead, you hear hopelessness, social disconnection, and a veiled reference to suicide. Naturally, in response to her statement that “Nobody understands,” you know your first task is two-pronged: to provide empathy, while gathering information. You say, “It’s very hard right now. You hate your life and don’t have much hope. I’d like to know more about your situation. What’s been going on that has you feeling this way?”

She begins speaking again. One part of you is listening empathically, while another part is wondering when and how to ask about suicide. You know that asking patients directly about suicide is de rigeur; it is usual and customary practice. Not asking about suicide would be unethical and reflect incompetence. You also



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know that asking about suicide ideation does not “put the idea in her head.” Despite knowing all these things, you find the whole idea of conducting a suicide assessment stressful and daunting. Your “easy” session is long gone.

Like everyone, psychologists are thinking beings. Given our professional training and interests, we might even “think” more than the average person. This is one reason why initiating a suicide assessment can be so challenging. Just as soon as we notice a patient is possibly suicidal, a cascade of thoughts are likely to follow. These might include:

- Do I really need to ask about suicide? Maybe I’m overreacting?
- Asking directly about suicide isn’t harmful, but this patient seems so vulnerable. Could she be an exception?

- She seems overly dramatic. If I mention suicide, things will just get more complicated.
- If I ask her about suicide, maybe she'll think I'm judging her as weak.
- Shit. I don't want to deal with another suicidal patient today.

Encountering suicidal patients is inherently stressful (Kleespies & Dettmer, 2000). Anxiety is a common clinician response; however, it is also natural for clinicians to respond to suicide crises with irritation, resistance, avoidance, and a range of other suboptimal reactions.

Guidelines and competencies in suicide assessment routinely include the sage advice for clinicians to become aware of and address their own attitudes toward suicide (Schmitz et al., 2012). This recommended competency, similar to the well-known guideline of always asking directly about suicide, is first-rate guidance and helps build a strong foundation for clinical work with potentially suicidal patients. If you ask patients directly about their suicidal thoughts and manage your own reactions to the suicide issue, you are off to an excellent start.

In this article, I focus on and discuss nuanced clinical skills and strategies for asking about, exploring, and managing patient suicide ideation and impulses. I assume you will do the important work of exploring your own cognitive and emotional reactions to suicidal patients. Knowing how to respond to patient suicidality and feeling competent as you work in this stressful practice domain are two of the best remedies for clinician anxiety. To help boost your suicide assessment skills and competencies, this article includes 1) contemporary information on suicide risk factors, 2) how to use suicide theory and research to deepen your understanding of patient suicidality, 3) strategies for initiating conversations about suicide and addressing core issues, and 4) strategies for exploring and managing suicide ideation and intent.

Risk and Protective Factors

Death by suicide is a complex, multidimensional, and low base-rate phenomenon. There have been many efforts to develop useful prediction models. Some of these models operate moderately well in controlled, retrospective research conditions, but no models have shown predictive utility in clinical practice (Bolton, Spivak, & Sareen, 2012; Lester, McSwain, & Gunn, 2011). When asked why some individuals die by suicide and others do not, experienced suicidologists usually respond with "I don't know" (Litman, 1995, p. 135).

Risk Factors Are Poor Predictors

The presence of suicide ideation is not especially predictive of

suicide (Nock, Kessler, & Franklin, 2016; Tucker, Crowley, Davidson, & Gutierrez, 2015). Patients with chronic or intermittent suicide ideation often never make a suicide attempt or die by suicide. For many reasons, leading researchers now emphasize that categorizing patient risk as high, medium, or low is unhelpful and sometimes contraindicated (Konrad & Jobes, 2011; Large & Ryan, 2014).

One practical reason why risk factors are unhelpful is because a single risk factor can increase risk in some patients, while decreasing risk in others. For example, for some patients, self-mutilation (or cutting) serves as an emotional regulating behavior. These patients use cutting as a coping strategy and eliminating cutting as a behavioral option can increase suicidality. In contrast, for other patients, progressive cutting can increase desensitization to suicide and consequently increase suicide risk (Zahl & Hawton, 2004).

Patients with chronic or intermittent suicide ideation often never make a suicide attempt or die by suicide.

Other patient variables can also alternate as risk or protective factors; this is even true with risk factors (e.g., previous suicide attempts) that are traditionally considered "good predictors of suicide." In one case, I was an attending psychologist at a vocational-residential training center. A young man was admitted who had an obvious bullet scar on his forehead from a previous suicide attempt. His admission triggered high anxiety among the training center staff; however, when I directly asked about his previous suicide attempt and current risk, he responded with reflective wisdom, saying something like:

"I learned so much from that. I was being bullied and harassed. After I shot myself, I was in the hospital bed. Suddenly, I realized who really cares about me. No way would I do that again. I can handle things now that I couldn't handle before."

Although this young man's statement is no guarantee of his safety, his previous attempt appeared to be serving as a protective factor, rather than a risk factor.

Traditional suicide risk factors, protective factors, and warning signs may be useful as a means for understanding unique patient and contextual factors, but collaboration with patients is necessary (Fowler, 2012). Without taking time to understand how individual patients think about suicide, it is difficult to know whether

the presence or absence of specific factors are operating to increase or decrease suicide risk. Asking directly about suicide ideation is essential, but it is equally essential to explore patient experiences and symptoms and to ask direct questions like, “What makes you feel more suicidal and less suicidal?” On the other hand, asking direct questions about suicide can elicit defensiveness or resistance; this is why competent suicide assessment and intervention is impossible without first establishing empathic and collaborative relationships with patients (Ganzini et al., 2013).

When combined with high psychological distress and impaired problem-solving, agitation or arousal seems to push patients toward acting on suicide as a solution to their distress.

Not Targeting Suicide Ideation as a Treatment Goal

Through her work with patients diagnosed with borderline personality disorder, Linehan (1993) concluded that clinicians should not include patient suicide ideation as a primary target for treatment. Not only is suicide ideation a poor suicide predictor, as Linehan articulated, with some patients (especially the chronically suicidal), efforts to eliminate suicide ideation can backfire and increase patient suicidality (Linehan, Comtois, & Ward-Ciesielski, 2012). In the case of Susan, she may want to hold on to suicide as a last-ditch potential solution to her psychological pain, even while building hope for other, more positive future scenarios.

Eight Pre-Suicide Dimensions: Theoretical and Research-Based Support

Moving away from an effort to predict suicide and toward a greater theoretical and empirical understanding of suicide is helpful. Several theoretical perspectives have practical implications for clinicians (Sommers-Flanagan & Shaw, 2017). These theories include 1) Shneidman’s (1985) mentalistic theory, 2) Joiner’s (2005) interpersonal theory of suicide, and 3) Klonsky and May’s (2014) ideation-to-action framework. Shneidman’s and Joiner’s work have guided research for decades. Along with the ideation-to-action framework, these theoretical perspectives have broad empirical support; together, they capture eight important psychological, interpersonal, and situational dimensions that often precede completed suicides. In this article, I refer to the eight theory/research-based factors as dimensions. In many ways, they operate as super-ordinate factors that stimulate or

compel individuals toward suicidal behaviors. As you will see, specific suicide risk factors (e.g., previous attempt, insomnia, command hallucinations, family history of suicide, physical illness, childhood trauma) typically load onto one or more of these super-ordinate suicide dimensions. Although the dimensions described here are general, the ways in which they manifest in individual patients are idiosyncratic.

Unbearable Psychological/Emotional Distress (Shneidman’s Psychache)

Shneidman (1985) originally identified “psychache” as the central psychological force leading to suicide. He defined psychache as negative emotions and psychological pain, referring to it as “the dark heart of suicide; no psychache, no suicide” (p. 200). In more modern patient-oriented language, psychache is aptly described as unbearable emotional distress. Unbearable distress can involve many factors, or center around one main trauma, loss, or other psychologically activating experiences; it may be accompanied by distinct cognitive, emotional, or physical symptoms. In the opening case, Susan’s unbearable distress is expressed through the words, “I don’t know how much longer I can go on.”

Problem-Solving Impairment (Shneidman’s Mental Constriction)

Depression or low mood is commonly associated with problem-solving impairments. Originally, Shneidman called these impairments mental constriction, and defined them as “a pathological narrowing of the mind’s focus which takes the form of seeing only two choices: either something painfully unsatisfactory or cessation” (1984, pp. 320–321). Researchers have reported support for Shneidman’s original ideas about mental constriction (Ghahramanlou-Holloway et al., 2012; Lau, Haigh, Christensen, Segal, & Taube-Schiff, 2012). Comments like Susan’s, “I’ve tried everything,” are not unusual among patients who are suicidal. Her statement represents a problem-solving impairment, partly because, although she feels like she has tried everything, more likely, there are additional treatment options available to her.

Agitation or Arousal (Shneidman’s Perturbation)

Agitation or arousal is consistently associated with death by suicide (Ribeiro, Silva, & Joiner, 2014). Shneidman (1985) originally used the term perturbation to refer to internal agitation that moves patients toward suicidal acts. When combined with high psychological distress and impaired problem-solving, agitation or arousal seems to push patients toward acting on suicide as a solution to their distress. Trauma, insomnia, drug use (including starting on a trial of serotonin-reuptake inhibitors), and many other factors can elevate agitation (Healy, 2009). If Susan experiences significant agitation, she may not be able to resist her

internal impulses to end her life.

Thwarted Belongingness and Perceived Burdensomeness

Joiner (2005) developed an interpersonal theory of suicide. Part of his theory includes thwarted belongingness and perceived burdensomeness as contextual interpersonal factors linked to suicide. Thwarted belongingness involves unmet wishes for social connection. Perceived burdensomeness occurs when patients see themselves as flawed in ways that make them a burden to others. Suicidal thoughts and impulses are likely to increase when patients are in situations that trigger thoughts of social disconnection (e.g., relationship rejections) or beliefs about being a burden (e.g., physical illness). Understanding Susan's perception of her relationships is an important part of her assessment and treatment. Her statement that "nobody understands" implies a feeling of social-emotional disconnection.

Hopelessness

Hopelessness is a broad cognitive variable related to problem-solving impairment and linked to elevated suicide risk (Hagan, Podlogar, Chu, & Joiner, 2015; Strosahl, Chiles, & Linehan, 1992). Hopelessness is the belief that whatever distressing life conditions might be present will never improve. In many cases, patients hold a hopeless view—even when a rational justification for hope exists. If patients can retain hope and view their disturbing symptoms or situations as transient, suicidal thoughts and impulses may emerge, but hope for a better future can protect patients from self-destructive actions. In contrast, when hope for improvement is absent, suicide potential is magnified (Joiner, 2005; Klonsky & May, 2015). Patients with depressive symptoms may make unequivocal statements representing hopelessness (e.g., "Nothing helps and nothing will ever help"). Although she does not use the word hopelessness to describe herself, Susan's initial comments do not include hopeful beliefs about her future.

Suicide Desensitization

Joiner (2005) and Klonsky and May (2015) have described how fear of death or aversion to physical pain is a natural suicide deterrent present in most individuals; however, at least two situations or patterns can desensitize patients to suicide and reduce natural suicide deterrence. First, some patients may be predisposed to high pain tolerance. This predisposition is likely biogenetic (Klonsky & May, 2015). Second, patients may acquire, through desensitization, a numbness that reduces natural fears of pain and suicide. Chronic pain, self-mutilation, and other experiences can be desensitizing.

Suicide Plan or Intent

In and of itself, suicide ideation is a poor predictor of suicide;

nevertheless, ideation is an important marker to explore with patients, and exploring ideation can lead to asking directly about whether patients have a suicide plan.

Suicide plans may or may not be associated with suicide intent. Some patients will keep a potential suicide plan on reserve, just in case their psychological pain grows unbearable. These patients do not intend to die by suicide, but they want the option and sometimes have thought through the method(s) they might employ.

The standard approach to evaluating patients' suicide plans is to follow the acronym, S-L-A-P (specificity, lethality, availability, and proximity of social support). Planning and intentionality often, but not always, load together as an antecedent to suicidal acts. Suicide plans are also sometimes related to previous suicide attempts. Strategies for collaborative exploration of suicide plans and suicide attempts are covered in the next section.

Lethal Means

Access to a lethal means is a situational dimension that substantially contributes to suicide risk. Firearms are far and away the most lethal suicide method. Specifically, Swanson, Bonnie, and Appelbaum (2015) reported that firearms result in an 84% case fatality rate. Although firearms can quickly become a politicized issue in the U.S., researchers have repeatedly found that access to firearms greatly magnifies suicide risk (Anestis & Houtsma, 2017).

The preceding pre-suicide dimensions, although important to suicide management, are not empirically validated estimators of suicide risk. In theory, the more suicide dimensions present, the more likely that death by suicide will occur; however, in practice, individual patients have idiosyncratic responses to internal and external stressors. For one patient, a single dimension (e.g., unbearable distress) may trigger a suicide attempt; for another, all eight may be present, but the patient continues to choose living over dying. In addition, cultural factors may cause some individuals to respond to unbearable distress (Shneidman's "dark heart of suicide") with increased determination to survive. For example, although further research is needed, cultural identity factors and their relationship to resilience may explain why Black or African American females consistently have extremely low suicide rates. Overall, the eight suicide dimensions are unique patient and contextual variables; they should be collaboratively assessed during an initial clinical interview (Sommers-Flanagan & Shaw, 2017).

Entry Points: Initiating Conversations about Suicide

There are many different strategies for initiating suicide-related conversations with patients. Some psychologists directly ask all patients about suicidality, simply as a part of a routine intake interview protocol. Others wait and inquire about suicide in

the context of relevant clinical variables (e.g., “You mentioned you’re feeling depressed. Sometimes people who are depressed also think about suicide. Has that been the case for you?”). Regardless of your particular approach, whenever possible, clinicians are advised to show empathy and build rapport prior to asking about suicide.

Showing Empathy, Building Rapport, and Staying Balanced

Working with suicidal patients may involve unique empathic responses. For example, patients with depressive symptoms may have long response latencies and may focus exclusively on negative emotions. Showing patience while waiting for patients to respond is part of the empathic rapport-building process. You might say, “Take your time” or “I can see you’re thinking about how you want to answer my question” or “Right now everything is feeling sluggish.”

It is also important to use emotional and behavioral reflections in ways that leave open the possibility of positive change.

Speech content for suicidal patients can be or can become singularly and profoundly negative. This profound negativity can naturally affect you, causing you to react in ways that are positive and encouraging, but not empathic. Examples include:

- This too shall pass.
- Suicide is a permanent solution to a temporary problem.
- Let’s focus on what’s been going well in your life.

The problem with these responses is that if they are used to counter patient negativity, patients may conclude that you “don’t get them,” and then will cling even more strongly to their negative perceptions, while feeling greater isolation. Consequently, instead of shifting to positive content, you should use empathic reflections, at least briefly, to clearly connect with your patients’ unbearable distress and depressive symptoms (“I hear you saying that, right now, you feel completely miserable and hopeless”).

Using a “completely miserable and hopeless” reflection can be useful in two ways. First, it demonstrates your willingness to be with your patient right in the midst of despair. Second, as motivational interviewing practitioners have discussed, your “completely miserable and hopeless reflection” might function as an amplified reflection (Miller & Rollnick, 2013). If so, your

patient might respond with positive change talk (e.g., “I’m not completely miserable and hopeless”).

Along with expressing empathy directly in ways that connect with patients in their despair, it is also important to use emotional and behavioral reflections in ways that leave open the possibility of positive change. This could involve saying “Right now you’re feeling . . .” instead of just saying “You’re feeling . . .”: The difference is that saying “Right now” leaves open the possibility that the sad and bad feelings may change in the next moment, next hour, or next day.

When possible, using the patient’s language is recommended. If, for example, a client says something like, “I feel like shit” or “I am completely stuck in this pit of despair,” you might want to use the words “shit” or “shitty” or “despair.” Additionally, offering an “invitation for collaboration” is important. This could involve statements such as, “I’d like to know more about what it’s like in your pit of despair” or “Do you mind telling me more about what’s feeling shitty right now?” Expressing your interest in working with and hearing from patients and intermittently asking permission to explore different problems or emotions can contribute significantly to collaborative psychologist-patient work.

Validation or reassurance also can facilitate rapport. Validation includes statements like, “Given the very difficult things going on in your life right now, it’s natural that you would feel down and depressed.” As long as your response is authentic, using immediacy or brief self-disclosure is another validation strategy that deepens the working alliance: “As you talk about the great sadness you have around the loss of your daughter, I find myself feeling sadness along with you” (Sommers-Flanagan & Sommers-Flanagan, 2017).

Suicidal patients are sometimes extremely irritable. In such cases, it may be difficult to develop rapport. Patient irritability also can provoke negative emotional reactions in you. Consequently, when patients express irritability, using a three-part response is recommended: 1) reflective listening, 2) gentle interpretation, and 3) a statement of commitment to keep working with and through the irritability.

- As you talk, I hear annoyance and irritability in your voice (reflective listening).
- When I hear that, to me it seems like it’s partly just an expression of how tired you are of feeling bad and sad. Irritability is really just a part of being very depressed (gentle interpretation).
- I want you to know that my plan is to keep on working with you and to try not to let any of the annoyance or irritability

you're feeling get in the way of our work together (statement of commitment).

Patients' expressions of irritability can also signal a psychologist-patient relationship rupture. You may have said something that your patient didn't like and, in response, your patient may show irritability and anger, or withdraw. If you think your patient's irritability is about a relational rupture (instead of irritability associated with depression), several options can be useful (Safran, Muran, & Eubanks-Carter, 2011; Sommers-Flanagan & Sommers-Flanagan, 2017).

- Acknowledge your empathic or interpretive "miss" or error: "I missed the importance you're feeling about your physical symptoms."
- Apologize directly to the patient: "I'm sorry for not getting how strongly you feel about your relationship break up."
- Concede to the patient's perspective: "I think I need to see this from your shoes."
- Change the task or goals: "What I'm sensing is that you'd rather not talk about your past. How about we shift to talking about right now or about the future?"

Before or after asking directly about suicide, you may find yourself using traditional diagnostic questions about depression and/or other suicide risk factors. In general, diagnostic and risk factor questions help deepen your understanding of the patient's unique psychological-emotional-behavioral state. Using a balance of positive and negative questioning is recommended. Specifically, if you ask about sadness, it is also important to ask about happiness (e.g., "What are the things in your life right now that lift your mood just a bit?"). Although it is possible that patients who are depressed and suicidal will answer all your questions (even the positive ones) in the negative (e.g., "Nothing lifts my mood, ever."), when that happens you gain valuable information about the depth of your patients' depression and whether they have a reactive mood. As needed, you can use Linehan's Reasons for Living Scale (Linehan, Goodstein, Nielsen, & Chiles, 1983) and solution-focused resources to identify questions with positive phrasing that balance traditional diagnostic assessment protocols (de Shazer, Dolan, Korman, McCollum, Trepper, & Berg, 2007).

Asking Directly About Suicide Ideation

The standard for all helping professionals is to ask patients directly about suicide ideation. Despite this universal guidance, asking directly can trigger clinician anxiety; it can also be difficult to find the right words to elicit an honest and open patient response. Many questionnaires and suicide prevention protocols encourage asking directly with a question like, "Have you been

having any thoughts about suicide?"

Using the "Have you been having . . ." question is a reasonable default, but it lacks clinical sophistication. Various writers in the suicide assessment and intervention area recommend using alternative wording and framing when asking patients directly about suicide (Jobes, 2016; Shea and Barney, 2015; Sommers-Flanagan & Shaw, 2017). Three distinct approaches are described here.

Using a balance of positive and negative questioning is recommended. . . . if you ask about sadness, it is also important to ask about happiness.

Using a Normative Frame

Wollersheim (1974) advocated for using a normalizing frame when interviewing suicidal patients:

Well, I asked this question since almost all people at one time or another during their lives have thought about suicide. There is nothing abnormal about the thought. In fact it is very normal when one feels so down in the dumps. The thought itself is not harmful. (Wollersheim, 1974, p. 223)

Although Wollersheim is offering reassurance to her client after asking about suicide, her recommendation captures the essence of using a normative frame. The question flows from the patient's descriptions of depressive symptoms or personal distress and then frames suicide ideation as normative, given the patient's distressing condition. Depending on the specific patient population and symptoms, normative framing could include:

- You're saying you've been very down and depressed. It's normal for people who are feeling depressed to sometimes think about suicide. Has that been the case for you? Have you had thoughts about dying or ending your life?
- It's not unusual for teenagers to sometimes have thoughts about suicide. I'm wondering if you've had thoughts about suicide.

Some clinicians resist using the normative frame. They complain that a normative frame increases their worry about putting the idea in the patient's mind. Although there is research indicating that most patients appreciate being asked directly about suicide, it can still be difficult to embrace the normative frame. If so, there are several alternatives, including the "I ask all my patients

about suicide” frame. Here’s an example:

I’m a psychologist and so part of my job is to ask all of my patients about suicide. And so I’m wondering, have you had any suicidal thoughts now, recently, or farther back in the past?

Although suicide ideation is not a good predictor of suicide attempts, it is obvious that patients do not make attempts or die by suicide without first having thoughts about suicide.

A normative frame lowers the bar and makes it easier for patients to admit to suicide ideation. Although suicide ideation is not a good predictor of suicide attempts, it is obvious that patients do not make attempts or die by suicide without first having thoughts about suicide. Additionally, it is important to note that whether you use a normative frame that focuses on reducing patients’ feelings of being deviant, or the frame where you emphasize that it is normal for you to ask all your patients about suicide, it is important that you practice, in advance and aloud, so that using normalizing statements becomes comfortable for you.

Mood Scaling with a Suicide Floor

My preferred suicide assessment procedure is to ask about suicide in the context of a mood assessment (as in a mental status examination). This procedure utilizes a scaling question to explore patient mood and possible suicide ideation (Sommers-Flanagan & Shaw, 2017). As you read through these steps, think about how you might apply this procedure with Susan, or with a recent or current patient of yours.

1. Is it okay if I ask some questions about your mood? (This is an invitation for collaboration; patients can say “no,” but rarely do.)
2. I’d like you to rate your mood right now, using a zero to 10 scale. Zero is the worst mood possible. Zero would mean you’re totally depressed and so you’re just going to kill yourself. At the top, 10 is your best possible mood (hold your hand up at a high level). A 10 would mean you’re as happy as you could possibly be. Maybe you would be dancing or singing or doing whatever you do when you’re extremely happy. Using that zero to 10 scale, what rating would you give your mood right now? (Each end of the scale must be

anchored for mutual understanding.)

3. What’s happening now that makes you give your mood that rating? (This is what psychoanalysts call binding affect; it links the internal mood to an external situation.)
4. What’s the worst or lowest mood rating you’ve ever had? (This question informs you about the patient’s lowest lows.)
5. What was happening back then to make you feel so down? (This question binds the sad affect to an external situation; it may lead to discussing previous attempts.)
6. For you, what would be a normal mood rating on a normal day? (You can insert this question at any point where it fits. Often, the best point is after the first mood rating because patients will immediately tell you whether they’re a little more up or a little more down than normal. The purpose is to get your patients to define their normal.)
7. Now tell me, what’s the best mood rating you think you’ve ever had? (The process ends with a positive mood rating.)
8. What was happening that helped you have such a high mood rating? (The positive rating is linked to an external situation.)

This procedure is a general map that can be used more or less creatively. No doubt, when you start the process with an individual patient, there will be opportunities to stray from the procedure. For example, when exploring the low end of her mood, Susan may begin sharing a traumatic experience. If so, you are at a key choice point. Should you continue with the next step in the procedure or focus in more detail about Susan’s trauma? Either option may be appropriate and will depend on one or more of the following factors:

- Based on your best judgment, does Susan want to talk about her trauma in more detail? If so, you should move in that direction and come back to the procedure later.
- Do you have time to immediately explore Susan’s trauma? If not, then you should say so and let her know that when you do have time, you will be interested in hearing details.
- Do you sense that your rapport is minimal and Susan is uncomfortable sharing details? If so, then the best option is to continue with the procedure, making a mental note to check back later when Susan is more comfortable.

Numbers can be useful in rating patient mood, but because every patient is unique, the meaning of specific numbers will be subjectively variable. I have interviewed teenagers and young adults who emphasize their distress by saying something like, “I’m a

negative three!” Despite the fact that having a negative three rating on the suicide scale indicates—in a quantitative sense—suicide certainty, these patients are typically making a point, and may or may not be an especially high suicide risk. In contrast, I have also worked with cases where adult patients burst into tears and admit to suicide ideation after giving themselves a current mood rating of 8 or 9. One patient who rated herself as “9” explained that she always thought of herself as being a 10. For her, anything outside of a perfect mood rating as terribly disturbing.

Several of my supervisees who work with teenagers have creatively transformed the scaling method to eliminate numbers. One supervisee engaged a patient in mood scaling using musical genres. After a collaborative conversation, they established that listening to opera 24/7 was equivalent to zero and imminent suicide, while listening to heavy metal was a solid 10. When working with a middle school boy, another former student used Yoga as zero and pizza as 10. The point of these examples is that practitioners can collaborate with patients to identify a method to discuss mood. Collaborative rating systems makes the method personally meaningful to the patient; it also involves interpersonal connection, implying that the assessment method has become simultaneously therapeutic.

The mood scaling procedure offers several advantages. First, it is a process that facilitates engagement, and engagement or interpersonal connection is central part of suicide interventions. Second, when patients bind their low and high moods to concrete external situations, you gain knowledge about the themes and triggers that lift and depress your patient’s mood. Third, as illustrated in the case where Susan begins talking about trauma, the mood scaling procedure can be abandoned (temporarily or permanently) in favor of more salient therapeutic opportunities. Fourth, mood scaling flows smoothly into safety planning or other suicide interventions (by opening a discussion):

“When you say that being a zero always involves you being alone, it tells me that one thing we should talk about now or later is how you can reach out to others, and we should talk about who you want to reach out to during those times when you’re feeling like a zero. It also tells me that we should talk some more about other methods you can use to move from a zero to a one.”

Gentle Assumption

Shea and Barney (2015) have described several “validity techniques” that psychotherapists can use to obtain valid information from reluctant patients. These techniques involve using special wording to make it easier for patients to be honest. One validity technique that can be especially useful during a suicide assessment is the gentle assumption.

Derived from substance abuse interviewing, the gentle assumption involves phrasing a question to presume the shameful thoughts or behaviors have already occurred. For example, instead of asking “Have you had thoughts about suicide?” you would ask, “When was the last time when you had thoughts about suicide?” Gentle assumption can make it easier for clients to disclose suicide ideation. After suicidal thoughts have been disclosed, you can move on to methods for exploring and managing suicide ideation and intent.

Using Patient History Information, Including Previous Attempts

As a part of an intake process, you may have access to medical or psychological records, or you may uncover information pertaining to a previous suicide attempt. Both of these scenarios can lead you to inquire further about suicide.

If you have specific referral information about Susan’s suicidality or have reviewed her med-psych records, you should be open with Susan about the knowledge and information you have about her:

“I had a chance to review your records from when you were seeing Dr. Lopach. May I ask you a few questions about those records?”

If you have rapport and are transparent about what you know, how you know it, and the purpose of your inquiry, most patients will readily agree to answer questions about their med-psych records. You can also use information from their records to directly broach suicide.

“I saw in your records that you were hospitalized in 2015 for a suicide attempt. What was going on back then that led to the suicide attempt?”

.....

If you have rapport and are transparent about what you know, how you know it, and the purpose of your inquiry, most patients will readily agree to answer questions about their med-psych records.

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Previous suicide attempts can be difficult for some patients to talk about. Other patients will be eager to elaborate. When I was working with a population of late adolescents and early adults, the patients were often happy to talk about previous attempts.

One striking discovery: many of the patients had not made actual suicide attempts. They would describe situations where they seriously contemplated suicide, like, “getting out a gun” or “approaching the edge of a cliff” or contemplating whether to take a bottle of pills. These descriptions may have been over-dramatizations, or attention-seeking, or a simple misunderstanding of what counts as a suicide attempt. All the same, it was important to take the patients’ disclosures seriously, listen empathically, and consider how to therapeutically use the information.

If patients are reluctant to talk about a previous attempt, it may be helpful to use a positive frame to explain why asking about past attempts is useful.

“Some of the latest research on suicide suggests that if we can identify the specific stresses that made you suicidal before, it can help us work together to prevent those stresses from causing you distress in the future.”

Conversations about previous attempts can also focus on the positive (Sommers-Flanagan & Sommers-Flanagan, 2017).

“After a suicide attempt, some people say they discovered a new strength or perspective. How about for you? Did you have anything positive you learned after your suicide attempt?”

Practitioners who have a solution-focused orientation consistently focus and refocus patients on strengths and reasons for living; discussing negative past experiences is viewed as unhelpful.

Researchers, suicidologists, and psychologist practitioners hold at least three disparate views on asking about previous attempts. At one end of the spectrum are adherents to the medical model; these individuals encourage detailed questioning of every self-harm or suicide attempt (Zahl & Hawton, 2004). Conversely, practitioners who have a solution-focused orientation consistently focus and refocus patients on strengths and reasons for living; discussing negative past experiences is viewed as unhelpful (de Shazer et al., 2007). In the middle, a more moderate perspective is to ask directly, but to gather information only to the extent that you and the patient agree that it provides useful information. The moderate perspective emphasizes psychologist-patient collaboration; practitioners regularly check in with patients, respond empathically to patient distress, and shift the focus if talk-

ing about previous attempts is too disturbing or agitating.

Using Assessment Instruments

Some psychologists use assessment instruments to screen patients for suicidality. This can be helpful, partly because patients can be more comfortable disclosing past or present suicide ideation or attempts on a questionnaire. A paper and pencil or computer-based questionnaire that includes a suicide ideation item (e.g., the Beck Depression Inventory) is a reasonable screening process. If patients endorse suicide ideation on a questionnaire or intake form, follow-up questions are mandatory.

“I noticed that on the intake form, you said you’ve been having thoughts about suicide.”

Although assessment instruments are sometimes used for predictive purposes in research protocols, in clinical practice, their primary utility is as a tool for broaching suicide. One danger in using forms or questionnaires with suicide content is the possibility of routine administration without adequate follow-up. When suicide ideation is reported on a questionnaire, ethical psychologists can either initiate a therapeutic conversation or conduct a traditional suicide risk assessment interview. The suicide risk assessment interview includes, at minimum, development of rapport, asking directly about suicide thoughts, plans, self-control/agitation, suicide intent (including reasons for living), and development of a safety plan (Sommers-Flanagan & Sommers-Flanagan, 2017).

Exploring and Managing Suicide Ideation and Intent

If patients disclose suicide ideation, further assessment is needed. Traditionally, psychologists have been advised to ask questions focusing on the frequency, duration, and intensity of suicide ideation (Sommers-Flanagan & Sommers-Flanagan, 1995). Although exploring these areas is important, exploring suicide intent and what unique internal and external patient and situational factors increase and decrease suicide frequency, duration, and intensity is of greater importance.

Patients will often spontaneously begin talking about intent. For example, Susan says, “I don’t really want to die, but I can’t live like this anymore.” Later in her session, she adds, “The pressure is just killing me.” These statements speak to at least two dimensions or antecedents linked to death by suicide. Her first statement suggests that by separating Susan’s unbearable distress from the suicide act, you might be able to facilitate productive work on her unbearable distress. Her second statement captures how her suicidality is driven, in part from arousal or agitation; at least intermittently, she feels driven or pressured to act on her suicidal impulses.

Rosenberg (1999) wrote about a suicide intervention involving the separation of psychic pain from the self: “The therapist can help the client understand that what she or he really desires is to eradicate the feelings of intolerable pain rather than to eradicate the self” (p. 86). Rosenberg’s approach utilizes a narrative therapy approach involving externalization of the problem; it shifts the focus of the patient’s intent. Instead of intending to die, the psychologist can refocus Susan’s intention toward reducing her unbearable distress.

Susan: I don’t really want to die, but I can’t live like this anymore.

Psychologist: I hear two separate issues. There are the miserable feelings you’re feeling. You need them to get smaller or stop. But suicide is a separate issue. I hear you saying that if we can work successfully on you feeling less pain and misery, then your suicidal thoughts and feelings might go away too.

Susan: I think that’s true.

Psychologist: How about if we take all the misery you’re feeling and we put it right here (psychotherapist draws a circle on a piece of paper). You and I can work together to understand what this misery is about and then shrink it, one step at a time.

Susan: I’m okay with that.

When patients can separate their pain from the self and then work actively and effectively on addressing and reducing the pain, suicidality should diminish. Another method for helping patients gain distance from their suicidal situation is to ask them to step outside themselves.

Psychologist: What if you had a good friend and your good friend was feeling just as you are now, what ideas or support might you offer your friend?

Susan: I would tell her that I love her and that I want her to stay alive and that suicide is a permanent solution to a temporary problem.

Psychologist: What if you were to say those things to yourself right now?

Susan: But I don’t deserve to have a friend like that.

As illustrated in this exchange, patients who are depressed and suicidal are inclined toward “spoiling” positive or hopeful thoughts. Although it can be discouraging for practitioners, when patients dispute or spoil hope, it opens up therapeutic opportunities. In particular, Susan’s therapist might shift toward cognitive, psychodynamic, emotion-focused, or mindfulness-based approaches to dispute or nonjudgmentally accept Susan’s spoiling cognitions.

In addition to being ready to therapeutically address your patient’s negativity, returning to the mood rating with a suicide floor can help you begin exploring factors that worsen or decrease suicide ideation. Even if you do not use a mood rating procedure, psychologists should directly ask and then explore the following three questions, usually in this order:

1. What makes you feel worse and more suicidal?
2. What helps you feel better and less suicidal?
3. What’s usually happening when the suicidal thoughts are gone?

When patients can separate their pain from the self and then work actively and effectively on addressing and reducing the pain, suicidality should diminish.

Many or most suicidal patients are probably experiencing depression and/or hopelessness. If this is the case, they will be predisposed to discussing what makes them more suicidal; it may be more difficult for them to identify factors linked to feeling less suicidal. States of depression and hopelessness drive patients toward negative rumination and act as fogging agents when it comes to exploring or considering positives.

Exploring and Addressing Hopelessness

Hopelessness is a common feature linked to clinical depression and suicidality. Although hopelessness can manifest in different ways, having a general strategy for assessing and working through hopelessness can be helpful. Specifically, Beck (Wenzel, Brown, & Beck, 2009) has emphasized that treatment of suicidal patients must address hopelessness. Here are two examples of how to explore and work with hopelessness.

Exploring intent, addressing hopelessness, and initiating problem-solving in the context of getting help. Once you have information about active suicide ideation or a previous attempt or attempts, you have a responsibility to acknowledge and explore suicidality. One common strength-based tool is a solution-focused question.

“You’ve tried suicide before, but you’re here with me now . . . what has helped?”

Unfortunately, if you're working with a patient who is severely depressed, it is not unusual for your solution-focused question to elicit a response like this:

"Nothing helped. Nothing ever helps."

In response, one error clinicians often make is to venture into a yes-no questioning process about what might help or what might have helped in the past; however, if you are working with a patient who is extremely depressed and experiencing mental constriction, your patient will discount every idea you come up with and insist that nothing ever has helped and that nothing ever will help. This process can increase hopelessness and consequently a different assessment approach is required. Even the most severely depressed patients can, when given the right frame, acknowledge that every attempt to address depression and suicidality isn't equally bad. Using a continuum where severely depressed and mentally constricted patients can rank interventions strategies (instead of a series of yes-no questions) is a better approach.

Psychologist: It sounds like you've tried many different things to help with your depressed feelings and suicidal thoughts. Let's look at all them. I'm guessing some of them are worse than others. For example, I know you've tried physical exercise, you've tried talking to your brother and sister and one friend, and you've tried different medications. Let's list these out and see which has been worse and which has been less bad.

Patient: The meds were the worst. They made me feel like I was already dead inside.

Psychologist: Okay. Let's put meds down as the worst option you've experienced so far. Which one was a little less worse than the meds?

Even the most severely depressed patients can, when given the right frame, acknowledge that every attempt to address depression and suicidality isn't equally bad.

You'll notice the psychologist emphasized that some efforts at dealing with depression/suicide were worse than others. Focusing on "worse" resonates with the patient's negative emotional state. It will be easier to begin with the most worthless strategy of all and build up to strategies that are "a little less bad." Building a unique continuum of helpfulness for your patient is the

goal. Then, you can add new ideas that you suggest or that the patient suggests and put them in their appropriate place on the continuum. If this approach works well, you will have collaboratively generated several ideas (some new and some old) that are worth experimenting with in the future.

Addressing hopelessness and initiating problem-solving in the context of social disconnection. As you explore Susan's social relationships, you ask, "Who is in your life that might provide you with support during this difficult time?" She answers, "I just don't get on with people. No one understands. There's no point talking to anyone." With this disclosure, Susan has revealed interpersonal disconnection, along with hopelessness about being socially disconnected forever. At this point, it's easy for clinicians to fall into an unproductive problem-solving pursuit in an effort to identify someone in Susan's environment who would show her kindness and compassion (e.g., "How about your mother?"); instead, because Susan is experiencing depressive symptoms, one way in which she might display problem-solving impairment is by denying that anyone in her world could be helpful. Consequently, the problem-solving process should begin with the psychologist resonating with Susan's hopelessness, and then move forward. Here's an illustration:

Psychologist: It feels like there's no one to turn to. Nobody really gets what you're going through.

Susan: That's the way it has always been.

Psychologist: This might sound weird, but I'm wondering who is the worst person for you to talk with? Who would really not get it and just make you feel worse?

Susan: That's easy. My dad doesn't get me. He would tell me I need a kick in the ass to get myself going.

Psychologist: And that would feel really not helpful. Not helpful at all.

Susan: That's never helpful to me.

Psychologist: How about someone who's not quite as bad as your dad? Who would be a little better than him, but still not especially good to talk with?

You can also use a visual version of this approach. To do so, you draw a circle in the middle of the page and write your patient's name in the circle; then, you say you want to get a visual sense of who, in the patient's universe of social contacts, is most and least likely to be responsive and show support. In Susan's case, you would place her father as a very distant circle in orbit around Susan. As you generate additional names, you would follow Susan's guidance and place the circles closer or farther away from

the circle representing Susan. In the end, you will have a map of who—in Susan’s social universe—is closest (and furthest) and most (and least) supportive.

With patients who are depressed and experiencing problem-solving deficits, a good general strategy is to show empathy for the hopelessness and social disconnection, but then build a continuum from the bottom toward people who are “less bad” to talk with. This method 1) provides empathy, 2) addresses hopelessness, 3) addresses problem-solving deficits through the identification of alternative social support people, and 4) initiates problem-solving (by building a continuum that moves upward toward the best or “least bad” people for social connection).

Dealing with High-Risk Situations

Technically, as discussed previously, it is impossible for mental health practitioners to accurately estimate risk. When collaboratively exploring the eight dimensions of suicide, there will be times when you are convinced that your patient is in a high-risk situation. The high risk will include some or all of the eight suicide dimensions. In particular, it is likely that suicide intent and active planning will be present. Often, reasons for living will be absent or offset by unbearable distress, hopelessness, agitation, and the inability to realistically consider potential solutions to the suicidal crisis.

Hospitalization is the traditional next step when suicide risk is extremely high and the potential for death by suicide is imminent. The downside of hospitalization is that it usurps the patient’s sense of agency, can activate resistance, and possibly damage the therapeutic relationship (Jobes, 2016). One approach to hospitalization is to frame it as a temporary solution or respite from unbearable distress.

“Let’s do safety now. The research indicates that suicidal feelings come in waves. You’re in the middle of a big wave right now. What we need is a way to keep you safe now. Hospitals are good for that.”

In an unknown proportion of cases, outpatient management may be preferable to hospitalization—even when suicide risk is extremely high. The key to outpatient management is the development of an implicit or explicit agreement to safety planning (Stanley & Brown, 2012). If safety planning is nested in a situation where there is ample social support and removal of lethal means (e.g., firearms), it may support the patient’s current functioning and avoid the regressive responses sometimes associated with psychiatric hospitalization. Although space prohibits detailed discussion of safety planning, safety planning is a collaborative process, is different than a safety (or no harm) contract, and includes six components:

1. Discussing how patients can make their environment safe.
2. Listing the patient’s unique warning signs.
3. Listing and reviewing the patient’s internal coping strategies.
4. Identifying people and settings that provide support and distraction.
5. Identifying who the patient can ask for help.
6. Listing professionals or agencies who can be contacted for support.

(See Stanley & Brown, 2012, for more information on safety planning.)

Suicide Assessment: Summarizing a Clinical Process

When patients present with suicide ideation, you should treat the suicide ideation in a manner similar to all the other potential problems that patients bring to psychotherapy. Rather than viewing it as a sign of psychopathology that must be eliminated, it should be viewed as a communication of the patient’s distress. From that perspective, you can explore suicide ideation as a natural psychological phenomenon. Unless the patient has brought a weapon to the session, there is no need to treat suicide ideation as an immediate crisis. Approaching suicide ideation as just another problem that you have the skills to deal with effectively (while showing empathy) can help patients see you as competent and can increase their faith in you and in the psychotherapy process (Wollersheim, 1974); it can also help you become more comfortable working with suicidal patients.

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from unbearable distress.**

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When a Checklist is Not a Checklist

A checklist approach to suicide risk assessment is not recommended. At the same time, psychologists need structured guidance for how to assess and manage suicidal patients. To summarize the content of this article, a bulleted list is provided. My hope is that after reading this article, you will recognize that this checklist should not be used like a checklist (see Table 1).

Table 1: A General Guide to Therapeutic Conversations about Suicide

1. Use a matter-of-fact style when asking about and exploring suicide ideation.
2. Express empathy for the patient's distress.
3. Balance positive and negative questions, rather than just using questions that focus on depressive symptoms.
4. Use a normative frame, solution-focused scaling with a suicide floor, and gentle assumption when asking about suicide.
5. Identify the external and internal factors that depress and improve the patient's mood and contribute to or decrease suicidality.
6. To the extent that it is helpful, explore previous attempts.
7. As needed, collaboratively explore and assess the eight suicide dimensions:
 - a. Unbearable distress
 - b. Problem-solving impairment
 - c. Agitation/self-control
 - d. Interpersonal isolation or feeling like a burden to others
 - e. Hopelessness
 - f. Desensitization to physical pain or suicide
 - g. Suicide planning or intentionality
 - h. Firearms access
8. When patients express hopelessness, show empathy and then, beginning with the least helpful alternative, build a list of what might be helpful from the bottom up.
9. Use suicide interventions that address the patient's unique suicide drivers, such as separating the unbearable pain from the self.
10. Initiate safety planning, including a plan for safe storage of lethal means.

Ongoing anxiety about possible patient suicide is why developing and using your own best stress management skills is the second most important closing message for this article. Stress management training and practice for professionals is hard to overemphasize. Most psychologists consider working with suicidal patients as immensely stressful. As noted early in this article, enhancing your knowledge and skills for connecting and collaborating with suicidal patients can help you manage the anxiety and stress that can working with suicidal patients can trigger. Additionally, developing ongoing self-care strategies is essential. Self-care is an important personal and professional duty. Although many different approaches to self-care and stress management exist, maintaining social connection and support may be the most important.

As one of my former patients once said, "The mind is a terrible place to go . . . alone." I pass on his advice to you. When you work with suicidal patients, it can take you to dark places. Do not go there alone. Find a professional support group, a friend, or your own psychotherapist; take someone with you to those dark places. Maintaining your own mental health, optimism, and wellness will enable you to continue to meet the challenge of suicide assessment and management.

References available at NationalRegister.org