FEATURES

Can Suicide Protocols Empower Clients? From Assessment to Assistance

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The COVID-19 pandemic has skyrocketed the demand for mental health services in many locations, city and rural areas alike (Richtel, 2022). Experiences such as loss of loved ones, disappearance of jobs, derailing of social activities, isolation, depression, alienation, etc., have contributed to an increase in people thinking of the unthinkable: ending their lives. Mental health professionals have been faced with a surge in demands for services by people struggling with despair, depression, overwhelm, and grief, which require more than ever before, the use of suicide assessment protocols. In this context, it becomes crucial to examine how these are performed, and their effects. Are these protocols conducted in the best possible way to ensure the wellbeing of clients?

Considerations of suicide have existed since far back in mankind's evolution and have been handled differently historically. In many medieval European countries, it was a religious issue that leaders portrayed as a sin, while in the 19th and 20th century, it became considered a crime handled by the justice system. In modern times, it is considered a sign of mental illness and handled by health professionals. With the medicalization of suicidal intervention came a protocol developed to assess the severity of ideations along with the necessity of documenting certain information. While the original intent is to protect clients from desperate acts, it has in some settings also evolved as a method to protect therapists from liability, requiring documentation of answers to a list of questions. Examining all categories of suicide assessment required by our Code of Ethics (AAMFT, 2015) can look the same on paper, regardless of *how* it is performed. Too often, clients' experience of the process (*how* it is done) leads to further alienation, feeling different, disconnected, further convinced of being "weird," and unfit to live. This unfortunate effect also arises because clients often consider the act of suicide as a solution while professionals view it as a problem (Szasz, 1999). Ideally, the process of assessing for suicidal intent should *not* inadvertently contribute to further articulating plans, or increase clients' sense of being disconnected from people and incompetent.

The question becomes: Are there ways to respect the requirements of our profession, and, simultaneously, empower clients to move away from suicidal ideations? The answer is: Absolutely.

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Take for example, Laura, a college student who has been struggling on and off with issues of depression, and the impulse to swallow the entire contents of bottles of Advil, especially after drinking at parties. She is scared of herself, as ultimately, she wants to live and wishes to realize her dream of working as a veterinarian. She has already been hospitalized twice, and has periods of feeling stable and others of feeling the depression swell in her mind. She has been through the standard suicide assessment protocol many times: *Do you have thoughts of hurting yourself?* "Yes." *Do you have a plan?* "Yes, I think swallowing pills would be a nice way to end the pain". *Do you have access to pills?* "My friends always have a bottle of Advil somewhere; it's easy to find." This line of questioning raises the stakes for therapists and clients, and exposes the high risk level of the situation, leaving Laura feeling scared of herself and out of control.

However, an alternative is possible. This is the process which was actually followed with Laura: *How often does the depression make you think of hurting yourself?* "Um…at least 30 times per day." *What is the depression getting you to think about more specifically?* "To find someone's pills and swallow them." *How long has the depression been doing that?* "It's been doing that every winter between January and April, on most days for the last four years." *Let's add this up to get an idea of what you've been dealing with. This means four months for four years, multiplied by about 30 times per day, which amounts to 14,400 times. How many times has the depression actually gotten you to swallow some pills?* "None!" *Does that mean that the part of you that is determined to live has a 100% success rate at controlling the depression and controlled it about 14,400 times?!* (Laura smiles: "I never thought about it this way!") *What is it like to notice this; what does it mean about your abilities to manage the depression?*

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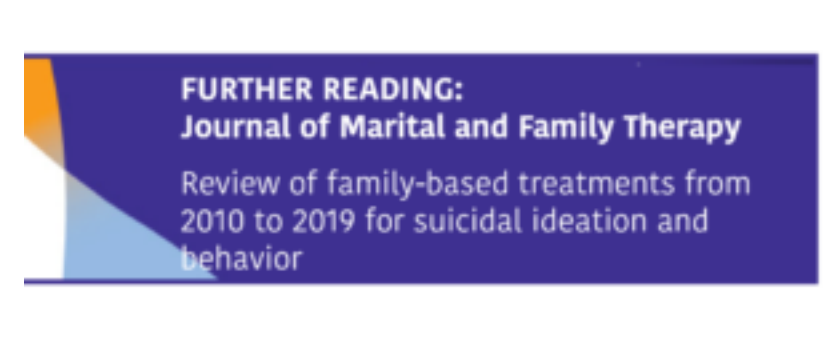
This process is shifting the primary focus from *assessment* to *assisting* the client in feeling capable, while still collecting important information. The therapeutic conversation becomes about acknowledging the complex and contradictory nature of experience (Beaudoin, 2010). A person can be dreadfully depressed at home alone and enthusiastically outgoing in other settings. A child can be incapacitated by shyness at school, and a popular player on the soccer team. Human beings are significantly influenced by their environment, and develop many ways of being. One can be depressed like their father, confident like their mother, calm like an uncle, compassionate like a grandmother, and perseverant like a sister. All of these ways of being and their respective streams of thoughts co-exist in this same person and are available at any moment in time. Western psychology influenced by individualistic notions can sometimes simplify and reduce a person to a single description (e.g., a "suicidal client"), when people tend to be much more than that (Gergen, 2011). A person may experience a stream of suicidal thoughts, which co-exists with yearning to live, a love for someone, or a dream to change the world. Why would this not be equally important, if not more, to assess? And can those streams of thoughts be bolstered to then reduce the dominance of the suicidal ideations? Clients struggling with thoughts of self-harm can redefine themselves, not as people wanting to end their lives, but rather as people in pain who are disconnected from, or under-connected with, their sense of agency, what they value in life, their passions, dreams, sense of worthiness, and relationships. Such an understanding allows mental health providers to modify their focus from solely assessing risk, to one where they empower clients to regain dignity and allegiance to their purpose in life.



This shift in intervention is in line with the emergence of an extraordinary amount of research in neuro-affective sciences, which can have powerful effects in therapeutic conversations (Beaudoin & Duvall, 2017). We now have consistent data on how intense emotions can often over-ride the thinking process in the brain (Siegel, 2007). A client's anger, for example, affects the blood flow in the brain, reduces one's ability to connect, and impairs critical judgment. Despair can skew people's memories in ways to mainly recall moments of intense sadness, temporarily making happier memories less accessible. These fascinating findings make the practice of externalizing problems (White & Epston, 1990; White, 2007) completely supported by empirical work. For example, rather than saying, "You are discouraged, that's why you are thinking this way," a therapist can acknowledge that, "The discouragement is getting you to think X." By doing so, we are acknowledging linguistically that a person is more than this feeling or stream of thought. Several fMRI studies have shown that such labeling practices can have the physiological effects of dampening the activation of some key brain structures such as the amygdala, paving the way for enhanced regulation (Lieberman et al., 2007). Externalizing practices open the door to new conversational possibilities and greater therapeutic effectiveness with clients in the grip of powerful emotional states.

Here then, are some ways of modifying common questions:

Traditional questions intending to assess risk and lethality	Alternative questions intending to assist clients in regaining agency
• Do **you** have suicidal thoughts, or are you thinking of killing yourself? • Do **you** have a plan to do it? • What weapons or means to hurt self/other do you have? • Have **you** ever harmed yourself or another? • **I** don't want **you** to hurt yourself; can you agree that you will call me, someone, or the hotline before doing so? • We'll have to let Z know about this	• Does the **sadness** get you to think of hurting yourself? • When does the **sadness** do that to you? Can you give me an example of the **sadness** trying to convince you to hurt yourself but you contained it? What did it want you to do exactly? How did you fight back? Does the **sadness** still want you to hurt yourself now? Does the **sadness** get you to plan it? How…?

These questions allow mental health professionals to cover the same categories required by the laws and ethics governing our profession while also having a therapeutic effect and actually helping people seeking our assistance.

To efficiently succeed in this process, the suicidal assessment steps in the protocol then become modified as follow:

Traditional Suicide Assessment Protocol	Empowering Suicide Intervention Protocol
1. Ask about " thoughts of hurting" self 2. Inquire about previous attempts and frequency of ideation 3. Assess for a current and specific plan to hurt oneself 4. Assess availability of lethal means and location 5. Recruit the client in signing a no-harm contract 6. Consider a 51/50 if risk is high 7. Contact loved ones to share the risk and recruit them into keeping an eye on the safety of the client or removing lethal means; give crisis line number, and medical referral for medication evaluation if relevant 8. Consult a colleague and document 9. Write out a plan of action (next meeting, frequency, etc.) 10. Follow-up	1. Externalize the problem experience 2. Ask about moments of resistance to impulses, frequency, length 3. Inquire about strategies used to neutralize the suicidal plan 4. Ask how the client has controlled access to lethal means so far and if it can be reduced further 5. Wonder if it would be helpful to write some of these successful strategies down and what has kept the client going so far. Co-sign a document demonstrating a renewed determination to live, to ignore the impulses, or reach out if needed 6. Discuss if temporary hospital stay might be helpful 7. Contact loved ones to share the stories of success at overcoming ongoing suicidal thoughts, how they might have unknowingly contributed to these successful efforts, the type of support the client has appreciated, and secure their renewed involvement. Ask loved ones to enrich the document and maybe add symbolic items in a hope box, a letter, a photo, a symbolic object, etc. 8. Consult a colleague and document 9. Write out a plan of action 10. Follow-up

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In sum, transforming the suicide assessment protocol into an empowering process recognizes the complexity and multifaceted aspects of experience. No one tolerates suffering passively; people are wired to survive and minimize pain. Why would therapists ignore people's own internal "break mechanism" and self-regulation systems when it is possible to build on these? There are so many ways, supported by brain research, to bolster people's own self-regulation mechanisms, and this process can be applied to a variety of settings, whether we work with individuals, families, groups or even classrooms (Beaudoin, 2014). Many situations benefit from excavating clients' abilities to overcome hardship. Working collaboratively with people to bolster their own internal resources renders our work much more effective and sustainable. This is especially the case if we follow-up with conversations that systematically boost people's sense of preferred identities, connection to their values, and sense of being capable of contributing in meaningful ways to their communities.

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