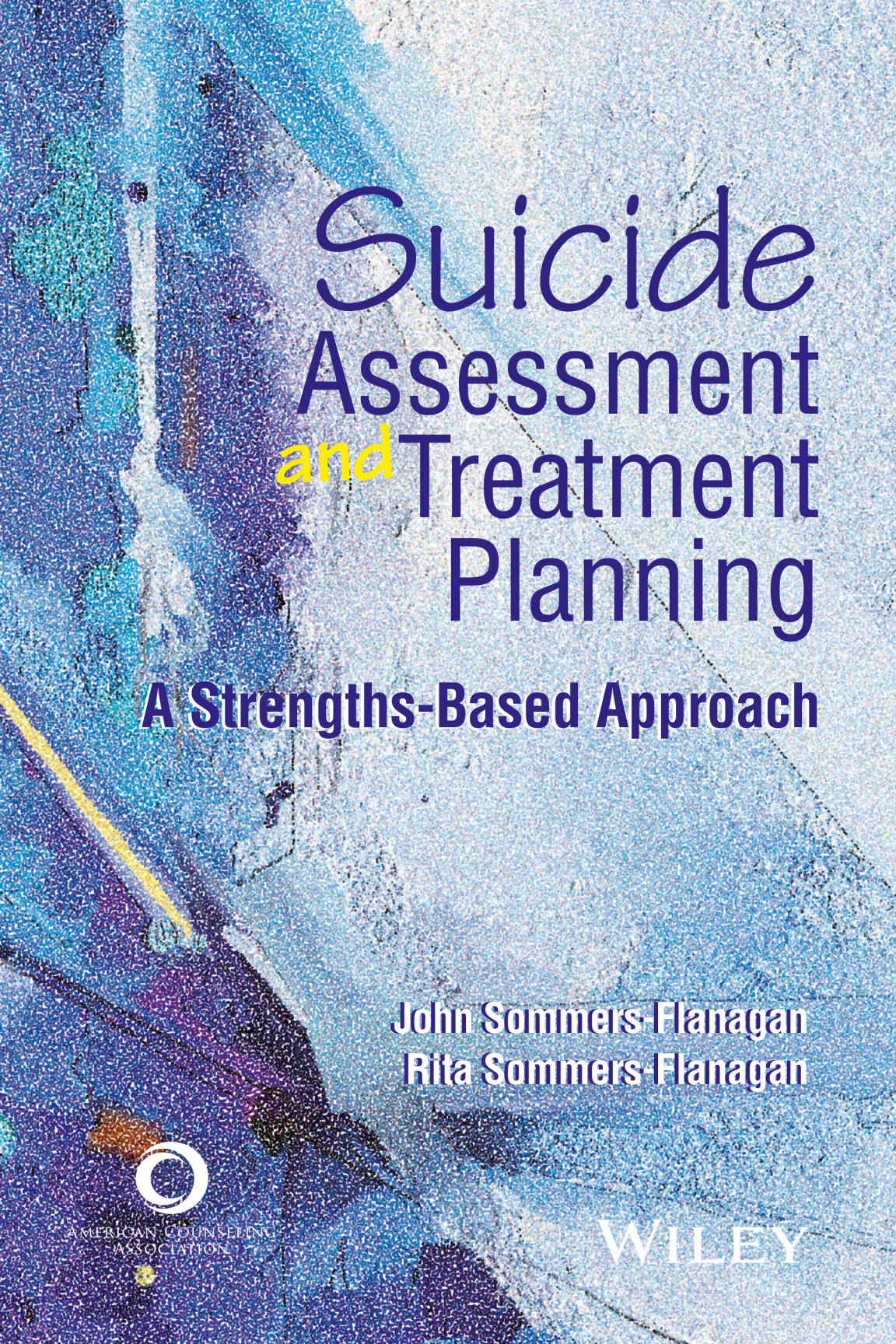
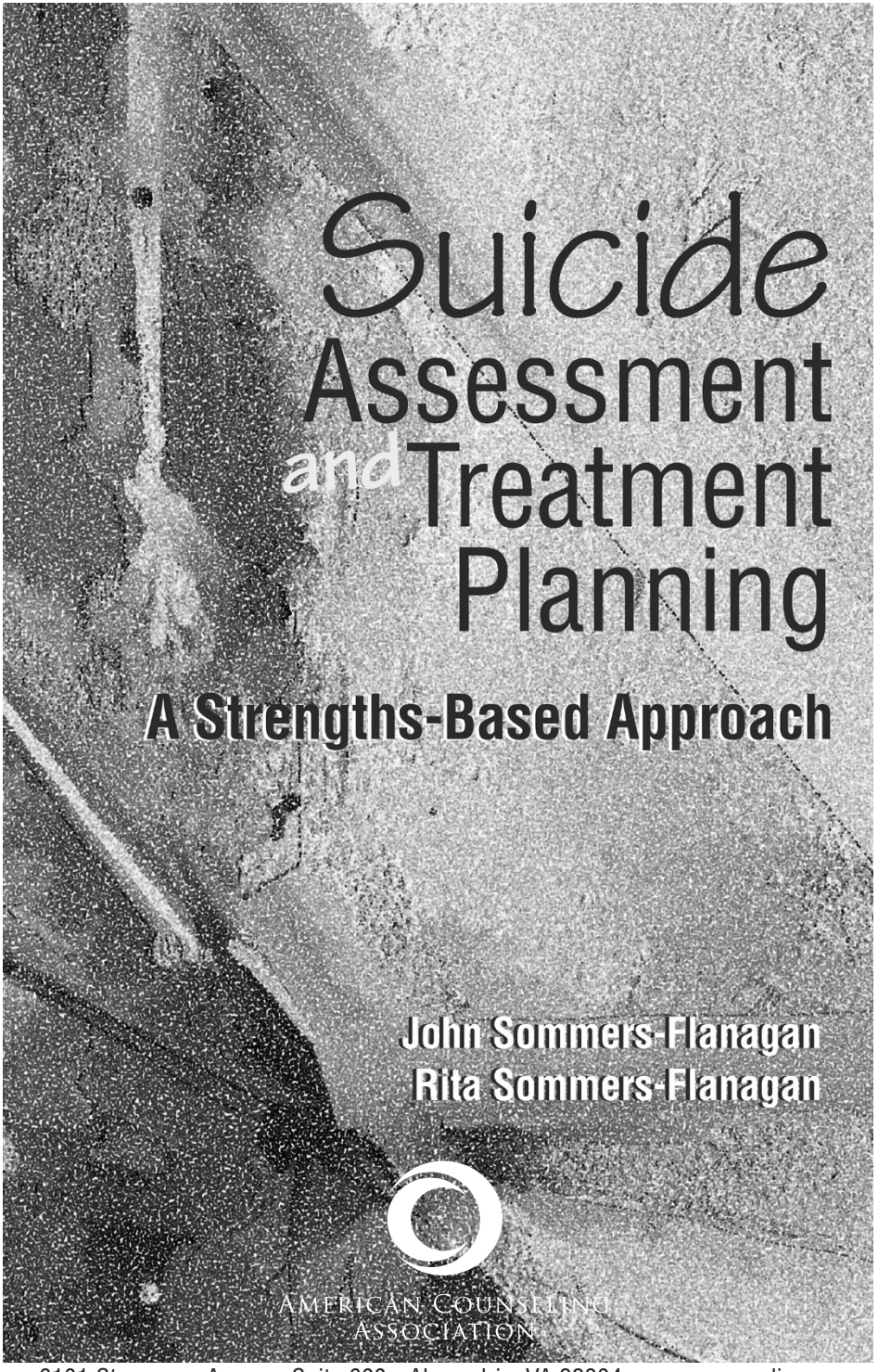

Suicide
Assessment
and Treatment
Planning
A Strengths-Based Approach
John Sommers-Flanagan
Rita Sommers-Flanagan
AMERICAN COUNSELING ASSOCIATION
WILEY



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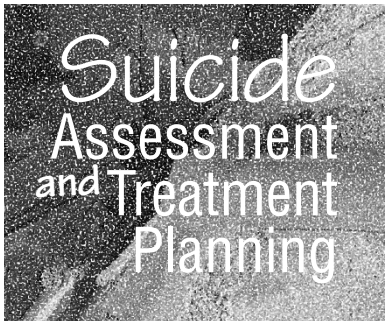

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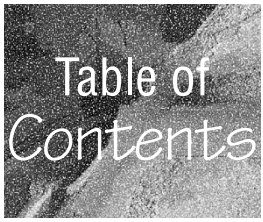
Dedication

We dedicate this book to all the school, mental health, health care professionals, and students who are so busy saving lives that they will probably skip this dedication. We see you, and we honor you and your work.



Writing a book about suicide may not have been our best idea ever. Rita made the point more than once that reading and writing about suicide at the depth necessary to write a helpful book can affect one's mood in a downward direction. She was right, of course. Her rightness inspired us to pay attention to the other side of the coin, so we decided to integrate positive psychology and the happiness literature into this book. As is often the case when grappling with matters of humanity, focusing on suicide led us to a deeper understanding of suicide's complementary dialectic—a meaningful and fully lived life—and that has been a very good thing.

Before diving into these pages, please consider the following.

Do the Self-Care Thing

In the first chapter, we strongly emphasize how important it is to practice self-care when working with clients who are suicidal. Immersing ourselves in the suicide literature required a balancing focus on positive psychology and wellness. While you are reading this book and exploring suicide, you cannot help but be impacted emotionally, and we cannot overstate the importance of you taking care of yourself throughout this process and into the future. You are the instrument through which you provide care for others, and so we highly encourage you to repeatedly do the self-care thing.

What Is a Strengths-Based Approach?

Many people have asked, "What on earth do you mean by a strengths-based approach to suicide assessment and treatment

planning?" In response, we usually meander in and out of various bullet points, relational dynamics, and assessment procedures and try to emphasize that the approach is more than just strengths based—it is also wellness oriented and holistic. By "strengths based," we mean that we recognize and nurture the existing and potential strengths of our clients. By "wellness oriented," we mean that we believe in incorporating wellness activities into counseling and life. By "holistic," we mean that we focus on emotional, cognitive, interpersonal, physical, cultural-spiritual, behavioral, and contextual dimensions of living.

You will find the following strengths-based, wellness-oriented, and holistic principles woven into every chapter of this book:

1. Historically, suicidal ideation has been socially constructed as sinful, illegal, or a terribly frightening and bad illness. In contrast, we believe that suicidal ideation is a normal variation on human experience that typically stems from difficult environmental circumstances and excruciating emotional pain. Rather than fear client disclosures of suicidality, we welcome these disclosures because they offer an opportunity to connect deeply with distressed clients and provide therapeutic support.
2. Although we believe that risk factors, warning signs, protective factors, and suicide assessment instruments are important, we value relationship connections with clients over predictive formulae and technical procedures.
3. We believe that trust, empathy, collaboration, and rapport will improve the reliability, validity, and utility of data gathered during assessments. Consequently, we embrace the principles of therapeutic assessment.
4. We believe that counseling practitioners need to ask directly about and explore suicidal ideation using a normalizing frame or other sophisticated and empathic interviewing strategies.
5. We believe that traditional approaches to suicide assessment and treatment are excessively oriented toward psychopathology. To compensate for this pathology orientation, we explicitly value and ask about clients' positive experiences, personal strengths, and coping strategies.
6. We believe that the narrow pursuit of psychopathology causes clinicians to neglect a more complete assessment and case formulation of the whole person. To compensate, we use a holistic, seven-dimension model to create a broader understanding of what is hurting and what is helping in each individual client's life.

7. We value the positive emphasis of safety planning and coping skills development over the negative components of no-suicide contracts and efforts to eliminate suicidal thoughts.

The Book's Organizing Themes

This book includes 10 chapters organized to build on one another in ways that are consistent with our understanding of the research literature in suicide theory, research, and practice. We begin our discussion of the seven dimensions with the emotional dimension, because, as Edwin Shneidman (1993) wrote, psychological or emotional distress is the primary driving force at the heart of suicide. In our model, all risk factors and life dimensions contribute in some way or another to deep and excruciating emotional distress, and deep and excruciating emotional distress pushes people toward suicide.

Language Use

This book is written for counseling professionals and other professionals who work directly or indirectly with people who are suicidal. As a consequence, although we usually refer to *counselors* and *counseling*, we also use the words *clinician* or *practitioner* to recognize members of other disciplines who provide counseling or mental health services. When referring to the people who receive counseling or treatment, we usually use the word *client*, but we also use *student* or *patient* as a method of incorporating school counselors and health professionals who work in medical settings.

In all cases, we strive to use person-first language. Instead of reading the phrase *suicidal clients*, you will read the slightly more cumbersome *clients who are suicidal*. Using person-first language is essential to separating the problem from the person and is consistent with the constructionist or social constructionist theory that undergirds the strengths-based approach.

We avoid using language and phrases that have a history of offending people. For example, unless quoting others, we do not use the phrase *commit suicide*. We try to use positive language to refer to people who are suicidal. We occasionally use the language of mental disorders, but because we do not want to tightly construct suicide or mental disorders as internalized pathological states, more often we avoid negative labeling. These ways in which we are using language are foundational to our strengths-based approach.

Information in this book is broadly research based. When discussing evidentiary support, we use the following terminology:

Empirically supported is used when there is substantial and specific research support; *evidence based* is used when there is general research support, but that support may not be especially robust or specific. We avoid using *best practice* because this phrase implies direct comparisons and rank orderings of all potential practices (which have not been done) and is often used to communicate normative practice standards rather than procedures with underlying empirical support.

Incorporating Positive Psychology

Positive psychology is broadly defined as the scientific study of well-being and human experiences that contribute to a well-lived life. To balance our focus on suicide and to practice a strengths-based orientation in this book, in each chapter we include a pullout box on how to use a specific positive psychology intervention to elevate mood. We call these sidebars *Wellness Practices*. Each one is founded on research or common sense and can be applied to you—as a practitioner—or used therapeutically with your students, clients, or patients. We encourage you to try these wellness practices with a hopeful spirit of experimentation.

Case Material

Case material in this book is used to illustrate the many ways in which suicidality manifests and the many ways in which providers can work with clients and students. All cases are anonymous; they are often composites of multiple cases. Age, sex, gender, and other identifying factors were sometimes changed. Several cases are adapted from video simulations (for a three-part, 7.5 hour video training, see: https://www.psychotherapy.net/video/suicidal-clients-series.

John Sommers-Flanagan, PhD, is a professor of counseling at the University of Montana. He is the author or coauthor of more than 100 professional publications, including the books *Tough Kids, Cool Counseling* (2007, American Counseling Association), *Clinical Interviewing* (6th ed., 2017, Wiley), and *Counseling and Psychotherapy Theories in Context and Practice* (3rd ed., 2018, Wiley). When not immersed in writing, speaking, teaching, and researching, John keeps busy watering the zucchini, picking beans, and starring in videos along with his grandchildren. He also excels at making pancakes, waffles, and quiche. He was drawn to writing this book because of his earnest belief that effective suicide assessment and intervention simply must become more positive, skilled, and compassionate. You can find what he is up to on his blog, https://johnsommersflanagan.com/.

Rita Sommers-Flanagan, PhD, is an author, counselor, passive solar advocate, and professor emerita of counseling at the University of Montana, with many published books and articles. She enjoys collecting rocks and driftwood, jogging, blogging, and contemplating the meaning of life. Her experiences with and views about suicide have been shaped and changed by clients, colleagues, students, and friends who have had to cope with the phenomenon of suicide clinically and/or personally. She looks forward to writing further in this area, including addressing end-of-life policies and practices as they intersect with the materials in this book. In the meantime, you can follow her on her

blogs: https://drbossypants.wordpress.com/author/ritasf13/ and https://godcomesby.com/.

As coauthors, the Sommers-Flanagans have stylistic differences that are distinct but usually complementary. John dives way too far down various rabbit holes, skims and reads too many journal articles and book chapters, jots notes on several hundred different small pieces of paper, and then begins a word processing version of loose associations about arcane facts. (Did you know that suicide rates among males older than 85 in the United States are 13.17 times higher than suicide rates among females older than 85 in the United States? Should we include results from that one cool study showing that trait impulsiveness is not associated with increased suicide attempts but that negative state-triggered impulsiveness is linked to suicide attempts?) At some point, Rita nudges John out of his loose associations and research reveries, takes her commonsense garden clippers to John's meandering prose, pulls a few of his worst puns, and voilà! After mostly agreeing with each other's brilliance, they send the resulting draft out to a plethora of volunteer readers, collect feedback, marvel at the diversity in perspective, integrate the input, get organizing and copyediting assistance through the publisher, and end up with pretty much what you are about to read.

Acknowledgments

This book was made possible by the amazing work of many researchers, practitioners, suicide survivors, students, clients, and suicidologists who came before us and illuminated the way. We are indebted to all of them. We are also grateful to the American Counseling Association's editorial team—Carolyn Baker, Nancy Driver, Bonny Gaston, and others—who have helped make our words clearer and our points sharper. A big thanks to Pete MacFadyen, Katie DiBerardinis, and Robin Hill of the Big Sky Youth Empowerment Program for their support of our work and their commitment to suicide prevention in Montana. Thanks also to Victor Yalom of Psychotherapy.net and Kelley Donisthorpe of the University of Montana.

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Emotional Preparation

All by itself, the word *suicide* activates anxiety for most mental health professionals. Imagine the following scenario:

> Your new Monday morning client shows up early for her 9 a.m. appointment. Her name is Alina. She is a 29-year-old lesbian woman. She lives alone, is unemployed, and complains that "life is impossible" without a partner. Alina is primarily of Croatian descent. Her family of origin lives about 500 miles away; Alina says she is glad to have distance from her family because "they're all about judging me."
>
> Alina talks about her chronic struggle with anxiety and depression and says, "I'm not sure anything can help me feel better." She discloses that she wishes she could "go to sleep and not wake up." You ask directly, "Have you had thoughts about suicide?" Alina admits to intermittent suicidality but denies an active plan. She says that even though she wants to stay alive, "thinking about suicide gives me a mental escape in case life gets worse." Alina made a suicide attempt about 6 months ago using a combination of pills and alcohol. She ended up in the emergency department of her local hospital. She was glad to survive her attempt, which gives you hope about her motivation to live. After her suicide attempt, Alina was on antidepressant medications and had three counseling sessions, but she did not find either treatment helpful. She tells you she has heard you are a good counselor but that she would rather not take any medications.
>
> Although you are worried about Alina's suicidality, you also feel positive about her openness and motivation to work in counseling.

> Before the session ends, you and Alina develop a safety plan, you get a signed release of information form so you can communicate with her physician, and you make a request for her previous treatment records. As she leaves, you feel confident about her short-term safety and her commitment to treatment, but she is a client you will be sure to think about during the week.

As Alina's counselor, you might feel uncomfortable because she has described several significant suicide risk factors. She has current suicidal ideation and a recent previous attempt. She feels socially isolated. Her family has not supported her sexual identity. She has symptoms of depression combined with high personal distress. All of these factors—and more—contribute to your concerns.

Cases like Alina's naturally ignite self-doubt and anxiety in clinicians. But cases like Alina's also hold great potential. If you connect with Alina, the two of you develop a therapeutic relationship, and she responds well to your work together, you might experience immense gratification. As a mental health professional, what could feel better than helping a distressed and struggling person through an extremely difficult time? For many of us, the chance to help people like Alina is exactly why we chose this challenging professional path.

Our goals for this book are to increase your self-awareness, knowledge, and skills for working effectively with clients who are suicidal. Whether you are working with a 16-year-old version of Alina in a school setting or a grieving 70-year-old who is considering whether life is worth living, we want to help you feel more prepared, comfortable, and competent to work with people who are suicidal.

In the 21st century, counseling professionals are more likely than ever to work with youth and adults who are suicidal (Binkley & Leibert, 2015; Lund et al., 2017). This is partly because the latest data available indicate that suicide rates in the United States have increased by 42% (from 10.0 deaths per 100,000 individuals in 1999 to 14.2 deaths per 100,000 individuals in 2018; American Foundation for Suicide Prevention, 2020). Although the relative per capita increase in suicide of 42% is troubling, the raw numbers are even worse. In 1999, an estimated 29,180 Americans died by suicide. In comparison, in 2018 (the latest year for which data are available), there were 48,344 deaths by suicide. This represents a 65.7% increase in the raw number of deaths by suicide over 19 years. Suicide is the 10th leading cause of death in the United States and the second leading cause of death among youth and young adults ages 10 to 34 years (Hedegaard et al., 2020).

Although we do not currently know how recent events like the coronavirus (COVID-19) pandemic or ongoing world events like climate change will affect suicide rates, most health professionals, suicidologists, and sociologists predict that social distancing, unemployment, and economic hardships will adversely affect mental health and contribute to further increases in suicidality, suicide attempts, and death by suicide (Bryan et al., 2020). The need for providers who can conduct suicide assessments and interventions will likely only increase in the coming years (Copelan, 2020).

Not only have suicide rates increased, but suicide attempts have also increased (to approximately 1.4 million in 2018; American Foundation for Suicide Prevention, 2020), and more clients and students than ever are talking about suicide. Many different cultural and sociological phenomena have combined to make it more likely that teenagers and young adults will use the word *suicidal* when describing their emotional pain or personal distress. Media productions like the feature film *Thirteen* (Levy-Hint et al., 2003), the Netflix television series *13 Reasons Why* (Season 1 released in 2017; Incaprera, 2017), and the proliferation of publications and internet websites oriented toward self-mutilation and suicidality contribute to increased thoughts about suicide (e.g., Asher, 2007; see also Ybarra, 2015). All of these factors speak to a need to redouble our efforts to gather knowledge and develop skills for working with people struggling with suicidal thoughts and impulses.

Throughout this book, we emphasize that suicidality does not represent a deviant or pathological state. During difficult times it is not uncommon for people to consider suicide an option (J. Sommers-Flanagan, 2018a). Counseling can help clients reduce or eliminate suicidal thoughts and urges. However, although we believe deeply in suicide prevention, we also respect human autonomy and individuals' right to die by suicide. Consequently, this book does not provide guidance for working with clients who have terminal illnesses and wish for compassionate assistance to end their lives. There may be some crossover, but along with Freedenthal (2018), we believe that those circumstances represent a distinctly different clinical domain.

Getting Ready

Despite rising rates, death by suicide is a rare event (about 14 to 15 deaths per 100,000 people in the United States in 2018; American Foundation for Suicide Prevention, 2020). However, early and

often throughout your career, you are likely to see many students and mental health clients who struggle with suicidality (Binkley & Leibert, 2015; Roush et al., 2018). Being ready to respond competently and calmly to suicidal thoughts and impulses is essential. As Joiner (2005) wrote, "Suicide is an urgent issue—it kills people—but urgency need not entail panic" (p. 17). Becoming and remaining competent is your best antidote to panic.

Practical Realities

Often, as in the case of Alina, concerns about suicide emerge partway into a session, even though suicidality was not the primary reason for the referral or meeting. Other times suicidality will be the immediate issue demanding your focus. In still other scenarios, your client will not mention distress or suicide until near the end of the session, leaving you with very little time to deal with a very big issue.

As you develop competence for handling suicide scenarios, at a minimum, you have your own attitudes and values to examine; assessment skills to learn, practice, and memorize; professional and ethical responsibilities to manage; intervention strategies to consider; and many other competencies to acquire and fine-tune. No wonder this is a stressful domain for most counselors. If thinking about these responsibilities causes you anxiety, you are not alone. Most health and mental health care professionals rate suicide assessment, management, and treatment planning as one of their greatest stressors (Binkley & Leibert, 2015; Maris, 2019). When clients talk about suicide, it is natural to begin worrying about a range of issues, including potential hospitalization and your responsibilities for keeping clients and students alive.

Increased suicide rates have translated into increased demand for competent professional assessment and treatment services. Unfortunately, suicide assessment and treatment competencies have not been systematically integrated into the training curricula of students in counseling, psychology, social work, nursing, and psychiatry (Cramer et al., 2013; Granello, 2010a; Morris & Minton, 2012). This lack of systematic training in suicide assessment and treatment has relevance for you and your practice. Along with most of the mental health and health care workforce, you may feel uncertain about suicide assessments, unclear about how to develop suicide-specific treatment plans, and uninformed about research-supported interventions for clients and students who are suicidal.

Before reading further, take a moment to check in with yourself. You know that this is a book about suicide assessment and treatment planning, but even that obvious fact deserves reflection. Although we are taking a positive, wellness-oriented approach, content in the following pages and chapters can and will be activating. You will find yourself reacting to the material.

In many places, we write about suicide directly, using actual and constructed suicide cases as well as composite and hypothetical suicide scenarios (note that identifying information is removed or modified to protect confidentiality). Our purpose is to prepare you to work in counseling situations in which suicidality is a concern. We write about suicide in provocative ways for several reasons:

1. You never know whether or when your next client or student will be suicidal. We believe that you can and should be prepared to address suicide and suicidality with competence and confidence.
2. Competence begins with understanding your own attitudes, beliefs, and values. Throughout this book, we will intermittently ask you to check in with yourself and to notice, accept, and manage your thoughts, emotions, and behavioral impulses.
3. Working with clients who are suicidal is emotionally activating. Becoming comfortable with suicide as an issue in counseling is a developmental process that takes time and practice. One way of looking at the content of this book is as an exposure experience that will improve your ability to self-regulate when facing crisis situations as a counseling professional.

If your goals are to become comfortable, confident, and competent when working with clients who are suicidal—and we hope these are your goals—your best route is to strengthen your professional suicide assessment and treatment competencies. Rigorous and direct exposure to suicide-related material in this book and others, along with workshop training and supervision, will get you on track toward professional competence in suicide assessment and treatment.

In the end, we want you to know—in your head and in your heart—that you have the knowledge and skills to provide effective suicide assessment and treatment. Having confidence in your knowledge and skills will be emotionally stabilizing; it will also help you develop a positive and optimistic attitude toward suicide

intervention and prevention that you can then pass on to your clients and students.

Emotional Responses to the Topic of Suicide

We began facilitating workshops, lectures, and trainings on suicide assessment and intervention in the 1990s. One presentation stands out. We asked about 80 school and mental health professionals, "How many of you have worked with clients or students who are suicidal?" Nearly everyone raised their hand. We followed up with, "How many of you have worked with a client who died by suicide?" About 15 hands went up. We asked how many had faced more than one client death by suicide; a few hands hesitantly went up. After thanking the group, we shared our own experiences and then transitioned to talking about coping strategies for professionals when clients complete suicide.

While talking, we noticed activity in the back of the room. Rose, a colleague we knew well, stood up and slipped out. Rose was a licensed mental health professional, an unflappable woman with a reputation for working with the toughest teens in town. We did not make much of her exit, but later Rose contacted us. "Sorry about leaving. You got to me. When you started talking about clients dying, I had to get out. I've had too many. Maybe I haven't dealt with some of my losses."

Regardless of your experience, suicide is a difficult topic, and emotional reactions run deep. Your own reactions may link to values, religious beliefs, losses, or future fears. Maybe you have had a friend, client, or family member die by suicide. In such situations, waves of painful emotions might come up whenever suicide is mentioned. Or you may struggle with suicidal thoughts yourself. No matter your background, conversations about suicide will activate or trigger your unique emotional response. Gaining experiences can reduce the intensity of your emotional responses to suicide scenarios, but there is also a chance it might magnify them. Either way, recognizing and having a plan for coping with your emotional responses will make you a more competent, ethical professional (Corey et al., 2018).

Professional Self-Care

Rose left the suicide workshop after recognizing that her emotional bucket was full. She stopped listening and removed herself from the room. She realized that she needed to take care of herself. We

recommend that as you read this book and work with people who are suicidal, you weave lifestyle strategies for managing the input of stressful information into your life.

Stop Reading

Be sure to follow Rose's example and stop reading if you need to. During suicide workshops and college classes, we tell people that to avoid being triggered, they can do what our teenage clients do: Just stop listening to us. Suicide information overload happens. One method for dealing with overload is to stop the input, step back, and take time to absorb and regroup.

If you are an avid reader, you can get swept into information about death and suicide and forget to take a break. Planning intermittent breaks from this book and other suicide-related material is wise. You can use the Pomodoro technique: Set a timer for 20 or 30 minutes, and then take a break. Consider inserting a fun, creative, social, or reflective activity into your break time.

You can use a variation on this "stop reading" approach during counseling sessions. For example, if you are feeling overwhelmed in a session, it is perfectly reasonable to take a break from information gathering and instead focus on coping in the moment. You might say something like "When we're talking about intense topics in counseling, we should also practice positive coping strategies at the same time. So let's pause, take some breaths, and then talk about how we can weave coping strategies like deep breathing and problem-solving into our session."

Taking breaks is one coping technique, but not the only one. We recommend having a variety of strategies for self-care. Based on numerous research studies, Norcross and Vandenbos (2018) identified effective strategies that professionals use to manage stress. What follows is our version of Norcross and Vandenbos's recommendations.

Recognize the Hazards

Facing and talking about death is an emotional undertaking. Do not expect to read this book without experiencing some distress. Humans are not built to continually focus on suicide and death. If you would rather avoid topics of suicide and death, join the club. You are not being weak. Recognizing and accepting that too much focus on suicide and human mortality can be hazardous to well-being is a healthy and reasonable start.

Once you have admitted that this is not easy, then you can take steps to address the dangers and make accommodations for yourself

as necessary. The sections below offer suggestions, but you know yourself and what you need, so you may want to make your own list.

Intentionally Focus on Positive and Rewarding Life Experiences

Professionals who cope effectively with powerful life stressors do not wait for positive experiences to come to them—they weave health-enhancing activities into their daily lives. As a counselor, you will hear harrowing client stories and be susceptible to vicarious traumatization (Foreman, 2018; Trippany et al., 2004). To care for yourself and to be a positive role model for clients, it is essential that you integrate healthy habits into your life. To inspire you to embrace positivity, at the end of every chapter in this book we feature one activity from the positive psychology literature that you can use yourself and/or offer your clients. We call these activities *Wellness Practices* (see Wellness Practice 1.1).

Beyond the Three Good Things activity in Wellness Practice 1.1, you can explore, through journaling, discussion, or counseling, what brings you joy, laughter, and gratification. When your busy life interferes with joyful or positive activities, you may need to post sticky notes or set your personal electronic device to remind yourself to focus on the joyful and positive. As professionals, we can get so caught up in helping others that sometimes we need explicit reminders to use positive interventions with ourselves.

Use a Variety of Self-Care Strategies

A single self-care strategy will not work as the best solution for everyone; we all have our own preferred coping techniques. The best way to cope with stress and stay healthy is to develop a smorgasbord of stress management and self-care strategies (J. R. Nelson et al., 2018). If you love exercise, that is great, but you cannot exercise incessantly. You need other activities in your stress management toolbox. Try meditation; support groups; recreational pursuits; your own personal counseling; gourmet food; excellent movies or concerts; spiritual, religious, or social justice groups; or whatever alternatives appeal to you. Your self-care mantra should be to use what works for you—and then keep expanding your repertoire.

What most people find especially health enhancing is to flex their personal choice-making muscles. The exact thing you do hardly matters. What matters is that you intentionally override natural tendencies toward lethargy, inactivity, or self-destructive choices. Free online apps that promote healthy behaviors include (a) 7 Minute Workout, (b) Happy Habits: Choose Happiness,

Wellness Practice 1.1
Three Good Things (or Three Blessings)

Positive psychology researchers have identified at least a dozen evidence-based activities that increase happiness and well-being. Martin Seligman (2002) developed one of the first and most well-known happiness activities; he called it Three Good Things. Three Good Things can work for you or for your clients.

The Three Good Things assignment is implemented each night, before going to bed, and goes like this: "Write down three good things that happened and why you think they happened" (Seligman et al., 2006, p. 776). (You can find a 1-minute video of Seligman describing the activity at https://www.youtube.com/watch?v=ZOGAp9dw8Ac.)

According to Seligman, after doing this for a week, most people continue doing the Three Good Things activity because it feels so good. Intentionally focusing on good things helps orient people toward the positive, but perhaps even more important, asking individuals to reflect on why the good things happen seems to remedy the human tendency to ruminate on daily mistakes. Contemplating why good things happen initiates a process of ruminating on the positive.

Clients who are deeply depressed may reject the idea that anything good could be happening. If so, we recommend you consider shifting the language to something your client views as more possible. For example, instead of monitoring for three good things, clients can be asked to monitor for three "not so bad" things. However you frame it, we recommend that you experiment with this positive psychology activity for yourself and for your clients.

(c) Sleep Better, (d) Headspace, (e) Calm, (f) Happy Now, (g) Pzizz, and (h) Inner Balance.

Manage Your Environment

Achieving complete control of your environment is impossible, but there is solid research on stimulus control as a tool for resisting temptation and triggering healthy behaviors (Quinn et al., 2010). Stimulus control means making sure your environment prompts positive behaviors; it might mean a pair of running shoes by the door, healthy snacks in your desk, or your best friend in your

Favorites or on your speed-dial. Because you know yourself best, strive to create an environment that not only is comfortable but also will prompt you to engage in healthy behaviors.

Accept Your Distress and Engage in Self-Soothing Behaviors

If you are feeling distressed, one healthy response is to find a safe time and place to accept and explore the emotion. First, notice the distress and accept it. There is no shame in being distressed. Then, when you are ready, ask yourself, "When I'm upset, what helps me calm down?" The answer might include going for a walk, breathing deeply, coloring, or holding hands with a friend or romantic partner. Several forms of counseling require that clients find their safe space before facing difficult or traumatic memories (Shapiro, 2001; J. Sommers-Flanagan & Sommers-Flanagan, 2018). As you read this material, consider what you can do to soothe and calm yourself when the content gets intense. One caveat here: We recommend that you remove the use of mind-altering substances for self-soothing from your list. Although using substances for recreational purposes is a reasonable personal choice, relying on substances for self-comfort is a bad idea in the long run.

Practice What You Preach

Many school and mental health professionals benefit from obtaining their own personal counseling or therapy. We recall listening with great interest to a famous behavior therapist speak of his preference for the emotional focus of gestalt therapy. He used behavioral approaches in his own clinical practice, but when he went for personal therapy, he chose experientially oriented counselors and psychotherapists who helped him explore deep emotions in the here and now. We hope that like this unusual behavior therapist who liked gestalt therapy, you will be open to pursuing whatever form of counseling you believe might be helpful to you and your situation.

Counselors and other helping professionals are consistently exposed to interpersonal and emotional stressors. In addition, perhaps more than ever, emotional stability is constantly affected by the global pandemic, social distancing, disrupted social networks (including networks of family and counseling peers), heightened awareness of racial and social injustice, sociopolitical upheaval, and other sources of uncertainty. To cope with common and uncommon stressors of professional counseling, you should consider whether you might benefit from engaging in personal counseling, creating

peer support groups, or obtaining supervision. If you are working regularly with clients who are suicidal, your need for counseling support is magnified.

Examining and Bracketing Attitudes and Beliefs

Ethical counselors cannot allow personal values and attitudes to interfere with the provision of professional services (American Counseling Association, 2014; Corey, 2020). For example, let us say you believe that death by suicide is a mortal sin. You may feel pressured to push clients to banish their sinful suicidal thoughts. Although in most cases, counselors are ethically mandated to help prevent suicide, suicide researchers emphasize that competent suicide assessment and interventions begin with the acceptance of suicidal impulses. If you advocate too hard and too soon against suicide, you may activate client resistance (Brehm & Brehm, 1981; J. Sommers-Flanagan & Shaw, 2017). Instead of saving lives, you may end up alienating clients, thus putting them at greater risk.

The opposite extreme can occur when professionals believe fervently in the right to die by suicide. This belief can be communicated in destructive ways. For example, if your client leaves the session thinking, "My counselor seems to be an advocate for suicide" or "I didn't get the sense that my counselor wants me to live," then you have done your client a disservice and probably engaged in malpractice.

If your personal, religious, or philosophical beliefs about suicide interfere with your ability to provide competent and nonjudgmental assessment services, develop a therapeutic relationship, establish a collaborative treatment plan, or provide ongoing management of suicidal behaviors and implement research-supported interventions, then you are engaging in unprofessional and unethical practice. Professionals must be cognizant of their sometimes less than helpful attitudes and beliefs about suicide. Awareness allows professionals to ethically bracket attitudes, beliefs, and biases that could potentially interfere with competent care.

What Is Ethical Bracketing?

Ethical bracketing is defined as "the intentional separating" or "setting aside" of personal values to "provide ethical . . . counseling to all clients" (Kocet & Herlihy, 2014, p. 182). Ethical bracketing requires that counseling practitioners honor their commitment to working in the best interests of their clients—even when doing so conflicts with their religious values or beliefs.

Staying Focused When Strong Emotions Rise Up

As a Catholic, Mateo had deep moral values and an especially strong belief that suicide was morally wrong. As a graduate student in counseling, Mateo was learning about the need to bracket his values and not impose them on his clients. In his second year of training, Mateo worked with two clients who talked a lot about suicide. Whenever the word *suicide* came up in counseling, Mateo felt himself flinch inside. He had an impulse to plead with these clients to focus on God's love as a solution to their suicidal crises. Mateo began questioning whether he could contain his moral judgments about suicide; he also began questioning whether he could continue in his training to become a professional counselor.

Mateo decided to discuss the feelings he was having with his supervisor. Mateo's supervisor listened and helped Mateo explore his feelings. Later they brainstormed and problem-solved different ways Mateo could become better at monitoring and bracketing his moral judgments. In the end, Mateo and his supervisor identified four self-statements Mateo could use to compartmentalize or bracket his moral reactions:

1. "I know the research and clinical guidelines say that I can more effectively prevent suicide if I accept my clients' suicidal ideation and remain nonjudgmental" (Jobes, 2016).
2. "I know that people who are feeling suicidal are already feeling shame; therefore, if I shame them in any way, I could increase their misery or sense of powerlessness."
3. "I want to prevent suicide for religious and professional reasons. My best chance at preventing suicide involves using evidence-based assessment and treatment strategies."
4. "When I feel triggered and judgmental, I will refocus my efforts on using nondirective paraphrases, reflections of feeling, open questions, and other motivational interviewing skills" (W. R. Miller & Rollnick, 2013).

Kocet and Herlihy (2014) offered a five-step counselor values-based conflict model to aid students and clinicians in ethical bracketing. Using Mateo's situation as an example, we walk you through the steps of the model.

1. *Determine the nature of values-based conflict.* Mateo's conflict was both personal and professional. Mateo believed that suicide was a sin, but he also knew that suicide competencies

required him to listen nonjudgmentally as his clients talked about suicide.

2. *Explore core issues and potential barriers to providing an appropriate standard of care.* When his clients talked about suicide, Mateo was emotionally activated and felt impulses to confront clients with statements like "God loves you" and "Suicide is immoral" and "If you kill yourself, you'll end up in hell." These moralizing thoughts interfered with Mateo's ability to have empathy for his clients.
3. *Seek assistance/remediation for providing an appropriate standard of care.* Mateo recognized his personal/professional conflict. He chose to meet with a supervisor he trusted to discuss the issues.
4. *Determine and evaluate possible courses of action.* Mateo and his supervisor agreed that Mateo could not avoid working with suicidality in counseling. They worked together to provide Mateo with a good rationale for using evidence-based (rather than religious-based) strategies for working with his clients. In addition, they identified internal cues that Mateo could use to alert himself to shift to using nondirective motivational interviewing skills.
5. *Ensure that proposed actions promote client welfare.* Mateo and his supervisor agreed to collaboratively and continuously monitor Mateo's values-based judgments and behaviors during counseling sessions.

As illustrated in Mateo's situation, personal values and attitudes have a complex and interactive relationship with self-care and ethical behaviors. Ethical bracketing is an important process for helping you juggle your values, attitudes, reactions, self-care, and ethical responsibilities. We return to ethical issues and counselor competence in Chapter 2 and beyond. For now, we turn to our strengths-based model for understanding and working with people who are suicidal.

Seven Dimensions of Being Human: Where Does It Hurt, and How Can I Help You?

We began this chapter by describing the case of Alina. Most likely, what you remember about Alina is that she is displaying several frightening suicide risk factors and has openly shared her suicidal thoughts. However, Alina is not just a person who is suicidal—she is a unique individual with a delightful array of idiosyncratic quirks, problems, and strengths who also happens to have suicidal thoughts.

When clients or students begin talking about suicide, it is easy to overly focus on suicidality. Suicidality is such a huge issue that it overshadows nearly everything else and consumes your attention. Nevertheless, all clients—suicidal or not—are richly complex and have a fascinating mix of strengths and weaknesses that deserve attention. To help keep focused on the whole person—and not just on weaknesses or pathology—we use a seven-dimension model for understanding people with suicidal thoughts and impulses.

Suicide Treatment Models

In the book *Brief Cognitive-Behavioral Therapy for Suicide Prevention*, Bryan and Rudd (2018) described and assessed three distinct suicide intervention models. The *risk factor model* emphasizes correlates and predictors of suicidal ideation and behavior. Practitioners who follow the risk factor model aim their treatments toward reducing known risk factors and increasing protective factors. Unfortunately, a dizzying array of risk factors exist; some are relatively unchangeable; and in a large, 50-year, meta-analytic study, researchers concluded that risk factors, protective factors, and warning signs are largely inaccurate and not useful (Franklin et al., 2017). Consequently, treatments based on the risk factor model are not in favor.

The *psychiatric model* focuses on treating psychiatric illnesses to reduce or prevent suicidality. The presumption is that clients experiencing suicidality should be treated for the symptoms linked to their diagnosis. Clients with depression should be treated for depression, clients diagnosed with posttraumatic stress disorder should be treated for trauma, and so on. Bryan and Rudd (2018) noted that "accumulating evidence has failed to support the effectiveness of this conceptual framework" (p. 4).

The final model is the *functional model*. Bryan and Rudd (2018) wrote, "According to this model, suicidal thoughts and behaviors are conceptualized as the outcome of underlying psychopathological processes that specifically precipitate and maintain suicidal thoughts and behaviors over time" (p. 4). The functional model targets suicidal thoughts and behaviors within the context of the individual's history and present circumstances. Bryan and Rudd emphasized that the superiority of the functional model is "well established" (pp. 5–6; they cited a meta-analysis showing that functional approaches are significantly superior to the psychiatric model for suicide risk reduction; Tarrier et al., 2008).