

# **Conducting Suicide Assessments Interview Techniques**

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**Horizon Health Teleconference  
May 2013**



# Agenda

1. Objectives of a purposeful Suicide Risk Assessment
2. Challenges and common missteps when interviewing patients about suicidal ideations
3. Validity Techniques when inquiring about sensitive subjects
4. CASE Approach
5. Assessing Hopelessness, Lethality, and Protective Factors
6. Special Considerations for interviewing the “chronically suicidal” patient

# Principal References and Recommended Suicide Assessment Resources

- APA Practice Guideline for Suicidal Behavior  
[www.psych.org/practice/clinical-practice-guidelines](http://www.psych.org/practice/clinical-practice-guidelines)
- David Knesper, MD – University of Michigan Depression Center (video)  
[www.depressioncenter.org/suicide\\_assessment](http://www.depressioncenter.org/suicide_assessment)
- The Practical Art of Suicide Assessment, Shawn Christopher Shea, 2003, Wiley
- Harvard Medical School Guide to Suicide Assessment & Intervention, Douglas Jacobs, 1999, Josey-Bass



# Objectives of SRA

- Categorize the individual patient according to *relative* risk
  - Identify predisposing risk factors
  - Identify immediate risk factors
  - Identify Proximal Risk factors
  - Identify Protective Factors and
- Intervene to minimize suicide by reducing severity of *modifiable* risk factors and fortify protective factors
- Provide a clinical encounter where the patient feels safe in disclosing actual suicidal ideation

# The Challenge of Assessing Suicidality

- Suicide is impossible to statistically predict
- Many factors converge to lead to a completed suicide
- Most completed suicides are not spur-of-the-moment impulsive acts (possible exceptions: Cluster B Personality and organic toxicity)
- People who complete suicide often spend a great deal of time thinking and planning the specifics of the suicide.
- People who have made a commitment to suicide will not volunteer this fact unless skillfully asked
- 75% of patients deny or minimize suicide risk immediately prior to suicide

# Interviewing Techniques

## Assessing Suicidal Risk

The Validity of Answers we get depends on how we ask questions.

### General Questions

- Descriptive
- Experiential
- Non-committal

Generally asked at the beginning of an interview

Example (Chief Complaint):

*“Tell me about what happened that brought you here today?”*

### Specific Questions

- Detailed
- Exact
- Committing

Generally asked later in an interview

Example:

*“How many pills did you plan to take?”*



# Potential Missteps In Interviewing

## Being too specific too soon

*“Are you suicidal?”*

- The patient may not identify their experience as being “suicidal”
- They are hopeless and in pain and just want the pain to stop.
- “Suicidal” may carry stigma in mind of patient (crazy, mentally ill, etc.)
- Patient may think you and others would view them as being weak, with no resilience
- Patient fears you may over-react

# Potential Missteps In Interviewing

## Being too general in questioning throughout the interview

*“How are you feeling?”*

- Likely to be met with a rote, socially acceptable reply: *“fine.”*
- Commits patient to “being well” and patient loses face if they have to amend their answer later in the interview.



# Potential Missteps In Interviewing

## Using Evasive Questions or Psychiatric Jargon

*“Are you having thoughts of hurting yourself or others?”*

*“Do you feel you are a danger to yourself or others?”*

- **Affront to self-esteem:**
  - Patient considers self a decent person who does not wish to “hurt” others, and does not want to be considered dangerous or a menace to society
- **Implies a Taboo:**
  - They know, at a certain level that we are referring to suicide, but because we side-stepping a direct question, we give subtle message that the subject is shameful or taboo.
- **Impersonal:**
  - It distances the questioner from a sincere inquiry; we are trying to check-off a box on a form and move on, rather than listen to what the patient is actually experiencing

# Potential Missteps In Interviewing

## Asking the Negative

*“You’re not having any thoughts of suicide, are you?”*

Implies you do not want to hear an affirmative answer

# When In the Interview Should You Probe for Suicide?

- Presenting Problem (Chief Complaint)
- Precipitating Crisis/Triggering Event
  - *Reinforce the patient's decision to seek help*
- Immediate and Chronic Stressors
- Past Psychiatric History
- Risk Factors (Suicide, Violence, Impulsivity)
- Deterioration from baseline of functioning
- Strengths and Social Supports
- Recommendations for treatment



# Validity Techniques in Interviewing

(From: *The Practical Art of Suicide Assessment*, Sean Christopher Shea, MD)

*To establish presence or absence of suicidal ideations*

1. Normalization
2. Gentle Assumption
3. Symptom Amplification
4. Shame Attenuation

*After confirming positive suicidal ideations*

5. Behavioral Incident
6. Denial of the Specific

# Validity Techniques in Interviewing

## Normalization

(Sean Christopher Shea, MD)

Overcoming a client's anxiety or hesitancy by letting them know that others have experienced the same thoughts, feelings, or behaviors.

### Underlying Principles:

- Clients are more apt to give valid details if they think their experience is "normal."

### Examples:

- *"Sometimes, when people are concerned about their weight, they do things to make sure they can't gain weight, like vomit after meals. Have you ever tried that?"*
- *"Many of my clients tell me that, at times, the pain of their depression can be so great that they have thoughts of wanting to kill themselves. Have you ever had any thoughts like that?"*

### Caveat:

This can elicit false positives from patients who are malingers, or who want to appear sicker than they truly are.

# Validity Techniques in Interviewing

## Gentle Assumption

(Sean Christopher Shea, MD)

Leading questions in which the questioner anticipates an affirmative response.

### **Underlying Principles:**

- Clients are more likely to acknowledge hard-to-discuss topics, if the interviewer seems to be soliciting a positive response.
- They are made to feel less deviant.

### **Examples:**

- *“What other ways of taking your life have you considered?”*
- *“How often have your past attempts to kill yourself come after you have had a few drinks?”*

### **Caveat:**

Gentle assumptions can lead to “false positives” in gullible clients:

- Do not use gentle assumption with clients who are trying to please you.
- Do not use gentle assumption with young children (especially when questioning about sexual abuse).



# Validity Techniques in Interviewing

## Symptom Amplification

A method to overcome a client's minimalization, or attempts to downplay the frequency or severity of a problem by over-stating the anticipated range of answers.

### **Underlying Principles:**

- Giving a client a hypothetical range of answers with exaggerated "high" ranges can make their true answer seem "normal" or less-deviant.
- This is a useful method in eliciting symptom frequency and severity from anti-social personality disorders or substance abusers.

### ***Examples:***

- *"On the days when your thoughts of suicide are most intense, how much of your time do you spend thinking about killing yourself, 50%, 80%, 90%?"*
- *"How much liquor can you hold in a single night; a pint, a fifth?"*

# Validity Techniques in Interviewing

## Symptom Amplification

### ***Examples (continued):***

- *“How many times have you struck your children in the last month; twenty times, thirty times?”*
- *“How many times have you exposed yourself to others, even if you weren’t caught; forty times?”*

### **Caveat:**

- Do not place upper limit at a ridiculously high number for the particular client.

# Validity Techniques in Interviewing

## Shame Attenuation

Phrasing a question in such a way that giving an affirmative answer is not experienced by the client as self-incriminating.

### Underlying Principles:

- Disarm a patient's reluctance to admit to shame-inducing topics, by
  - a) Giving unconditional positive regard and
  - b) Showing sincerity and wanting to understand the framework in which the patient experienced the event.
- Useful when questioning behaviors which could be construed as self-incriminating.
  - Heavy drinking
  - Illicit drug use
  - Violence
  - Criminal activity
  - Self harm
  - Suicidality
- Used as a bridge from data gathered in history to solicit the rationale for why a person might think or do something, they might otherwise not.



# Validity Techniques in Interviewing

## Shame Attenuation

### **Examples:**

- *“Getting arrested in front of your parents must have been very distressing. Sometimes when people go through embarrassing situations in front of others they can have drastic thoughts, such as thoughts of suicide. Have you experienced any thoughts like that?”*
- *“You said earlier that you were caught completely by surprise when your girlfriend walked out on you. For many people, that could result in impulses to seek revenge, even if just momentary. Were you experiencing any such thoughts or impulses when the police picked you up outside her new apartment?”*

### **Caveat:**

Shame attenuation should not be construed as an endorsement of dangerous or illegal behavior, but as a sincere attempt to understand the person’s rationale in context

# Validity Techniques in Interviewing Behavioral Incident

Ask for specific examples of behaviors, rather than conclusions or opinions.

## **Underlying Principles:**

- Distortions are more likely when a client is asked for conclusions or opinions, rather than a description of events.
- Follow-up with “what happened next?”

## **Examples:**

- “Did you put the razor to your wrist?”
- “Exactly how many pills did you take?”
- “What happened next?”
- “In the past two weeks, have you had any thoughts of wanting to kill yourself, even if just for a fleeting moment?”

# Validity Techniques in Interviewing Behavioral Incident

## Examples (continued):

- “Did you take the gun in your hand?”
- “Did you hold it to your head?”
- “What happened next?”

## Caveat:

- Time-consuming in an interview.
- Probe *after* suicidal ideations have been verified.
- Reserve for sensitive issues where validity is crucial:
  - Suicidal potential
  - Domestic violence
  - Sexual abuse
  - Lethality



# Validity Techniques in Interviewing

## Denial of the Specific

Asking a client whether he has experienced anything from a list of potential or probable symptoms.

### **Underlying Principles:**

- It is more difficult to deny a specific rather than a generic question.
- This is a good method to solicit lethality of past and present suicidal ideations.

### **Examples:**

- “Have you ever tried cocaine?”
- “Have you ever smoked crack?”
- “Have you ever used Crystal Meth?”
- “Have you ever dropped acid?”

# Validity Techniques in Interviewing

## Denial of the Specific

### **Examples (continued):**

- *“Have you thought of shooting yourself?”*
- *“Have you thought of jumping off a bridge or other high place?”*
- *“Have you thought of hanging yourself?”*
- *“Have you thought of overdosing?”*
- *“Have you thought of carbon monoxide poisoning?”*

### **Caveat:**

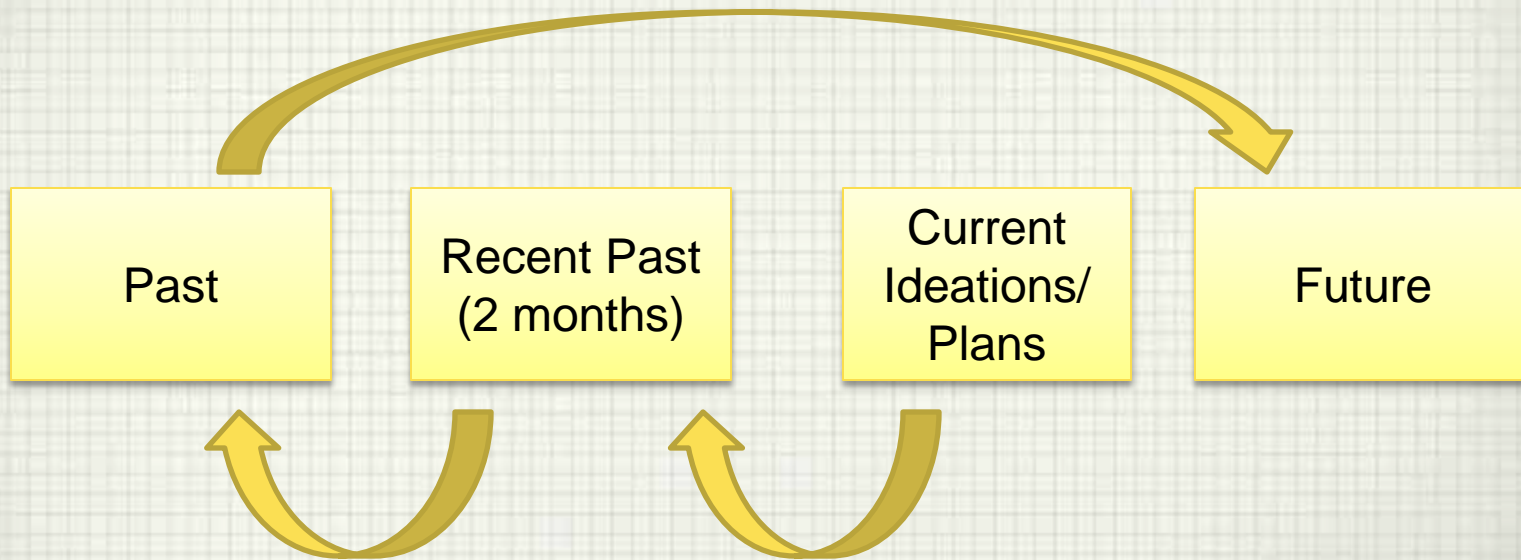
- Do not ask as a cluster. Wait for a denial or confirmation of each question before proceeding.

## (**C**hronological **A**ssessment of **S**uicide **E**vents)

1. Present
2. Recent Past
3. Distant Past
4. Future

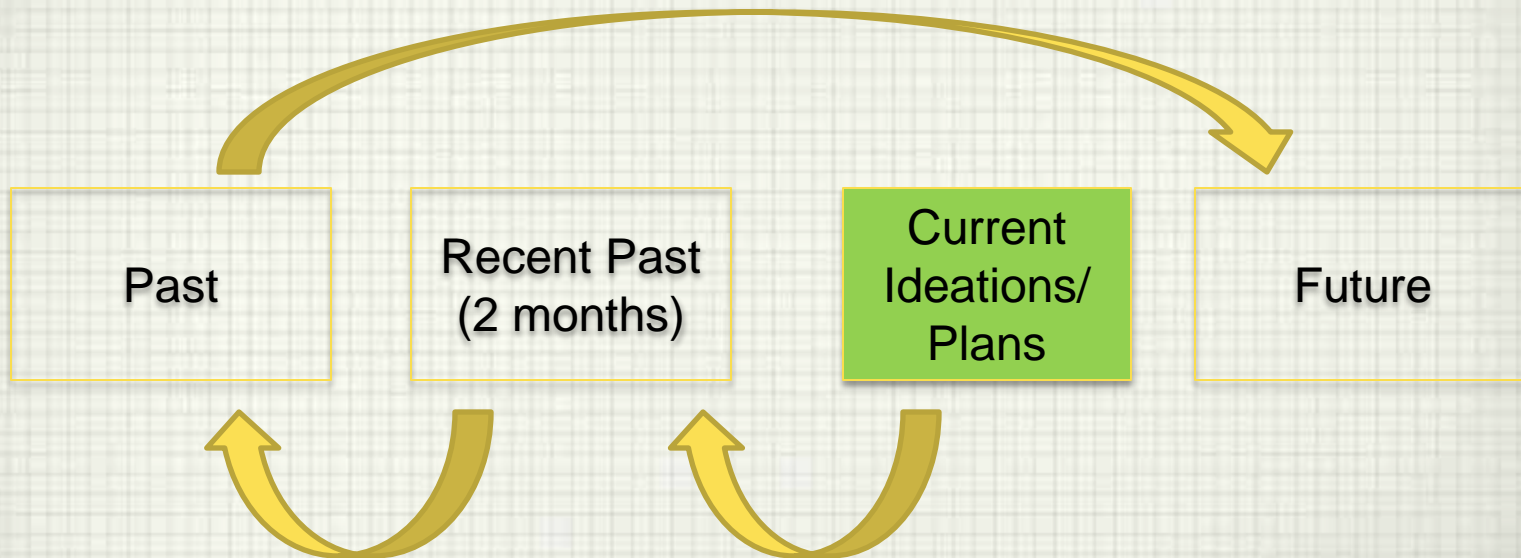


# Chronological Approach to Suicide Evaluation CASE



# Chronological Approach to Suicide Evaluation CASE

1



# CASE Approach

(Sean Christopher Shea, MD)

## 1. Exploring the Presenting Problem

Client is asked to describe the most recent suicide attempt from beginning to end.

*Determine:* The client's thought process at the time of the most recent attempt.

- How did the client try to kill himself?
- How serious was the action taken with this method?
- To what degree did the client intend to die?
- How does the client feel about the fact that the attempt was not successful?
- Was the attempt well-planned or an impulsive act?



# CASE Approach

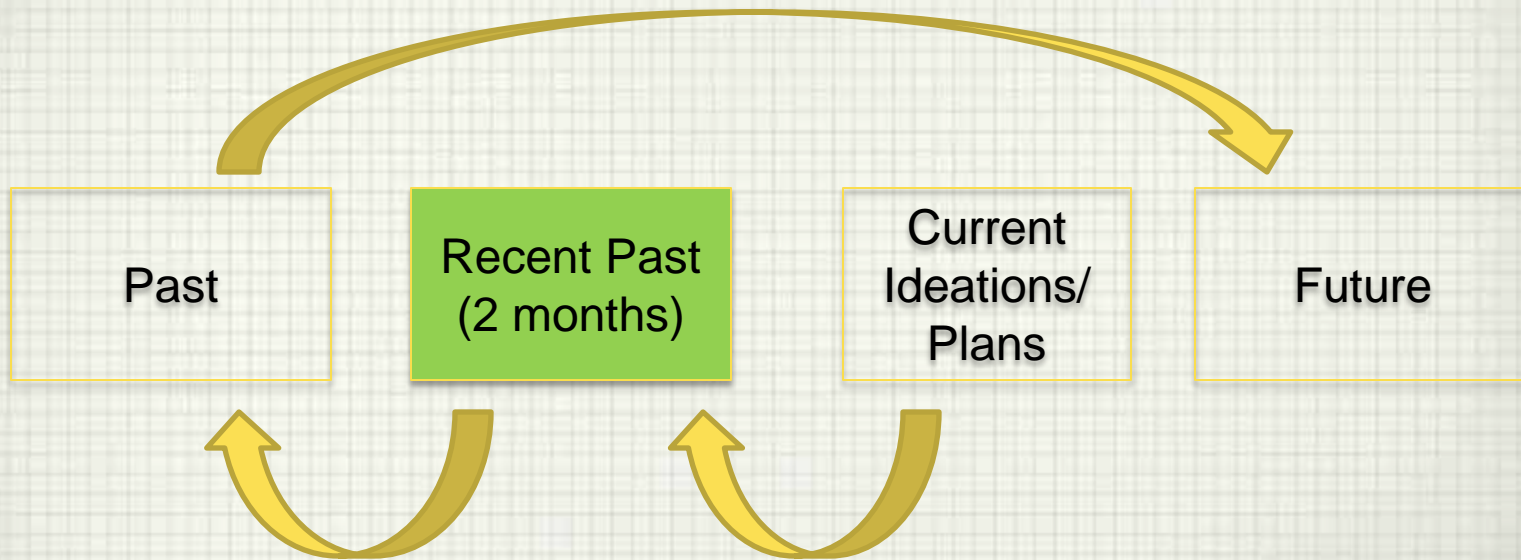
(Sean Christopher Shea, MD)

## ***Exploring the Presenting Problem (cont.)***

- Did alcohol or drugs play a role in the attempt?
- Did a specific stressor or set of stressors prompt the attempt?
- At the time of the attempt, how hopeless did the client feel?
- Why did the attempt fail?
- How was the client found, and how was help summoned?

# Chronological Approach to Suicide Evaluation CASE

2



# CASE Approach

(Sean Christopher Shea, MD)

## 2. Exploring Recent Suicidal Events

- The eight week period preceding the most recent attempt offers a window over the ***degree of planning*** and pervasiveness of suicidal ideation.
- This is the period of time when the truly suicidal person is weighing the pros and cons of taking his life.

*Determine* the extent and lethality of suicidal planning:

- The specific plans (or methods) that have been contemplated.
- How far the client took actions on these plans.
- How much of the client's time has been spent on these plans.



# CASE Approach

(Sean Christopher Shea, MD)

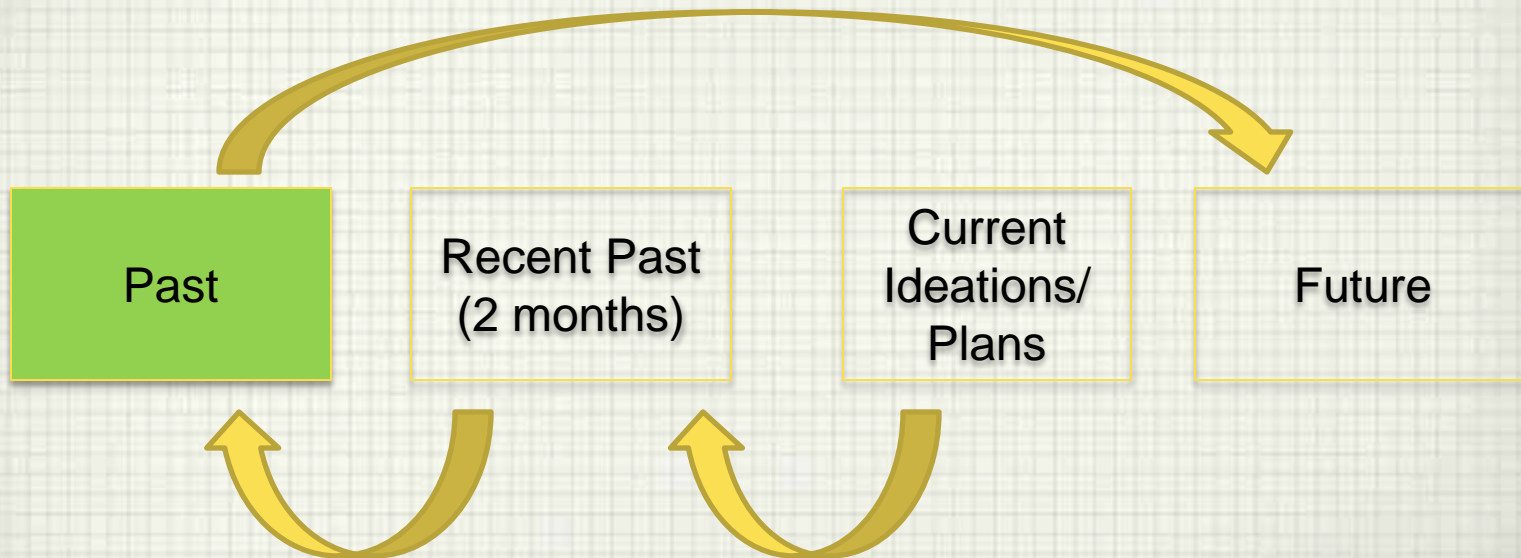
## 2. Exploring Recent Suicidal Events (cont.)

After establishing the list of methods considered, evaluate the frequency, duration, and intensity of suicidal ideation.

- *“Do you have a gun in the house?”*
- *“Have you ever gotten the gun out with the intention of using it to kill yourself?”*
- *“Have you ever loaded the gun?”*
- *“Have you put the gun up to your body or head?”*
- *“How long did you hold the gun there?”*
- *“Did you take the safety off?”*
- *“What stopped you from pulling the trigger?”*

# Chronological Approach to Suicide Evaluation CASE

3



# CASE Approach

(Sean Christopher Shea, MD)

## 3. Past Suicidal Events

Gather only enough past history that could/would change your determination for need for hospitalization.

*Determine:*

- What was the most serious past suicide attempt?
- What is the approximate number of past gestures and attempts?
- Beyond the past two months, what was the most recent attempt, and how serious was it?

Caveat: This region can be a bottomless pit of time-consumption with clients who have severe Borderline Personality Disorders.



# CASE Approach

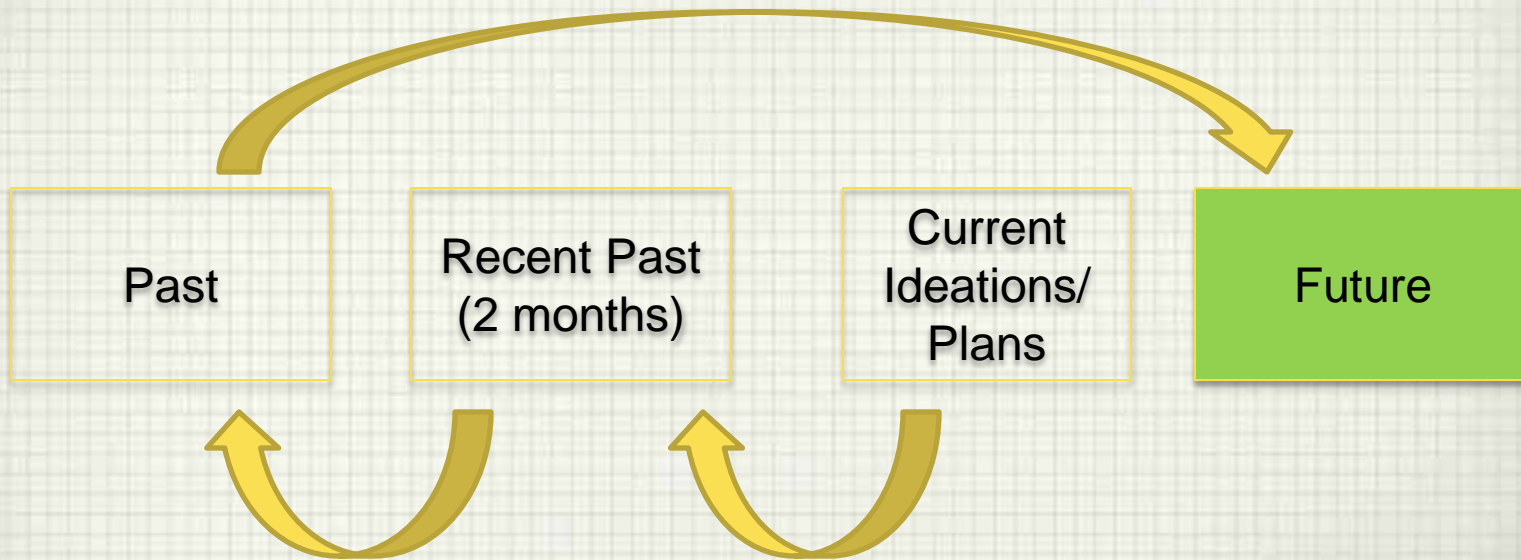
(Sean Christopher Shea, MD)

## 3. Past Suicidal Events (cont.)

- Age at first attempt
- Date of most recent attempt
- Approximate number of past attempts
- Methods and lethality of past attempts
- Did previous attempts result in treatment or increase in treatment?
- Circumstances that led up to previous suicidal ideation

# Chronological Approach to Suicide Evaluation CASE

4



# CASE Approach

(Sean Christopher Shea, MD)

## 4. Immediate and Future Suicidal Ideations and Plans

*(useful for pre-discharge assessment)*

*Determine:*

- Current level of hopelessness
- Does the client anticipate thoughts of suicide after she leaves the assessment?
- What would the patient do if suicidal thoughts were to recur later today or tomorrow?
- Is client open to help in dealing with current problems or stressors?



# Use of a Rating Scale in Interview

*Example:*

*Q: “On a scale of 1 to 10, what do you think the likelihood is of you acting on thoughts of suicide in the next two weeks?”*

*A: “I don’t know, maybe a 4.”*

*Follow-up:*

*“So what keeps you from being a 5 or 6?”*

*(protective factors)*

*“Why don’t you rate yourself a 2 or 3?”*

*(existing risk factors)*

# Assessing Hopelessness

## Hopelessness

- Rumination
- Things will never change
- No avenues of escape or vindication
- Tunnel vision
- Everything is hopeless
- Distorted cognitive schema

## Ask:

- *“It seems like you have been thinking about this quite a bit...”*
- *“Do you see any way that the pain will be lessened?”*
- *“What keeps you going day-to-day?”*
- For men: *“Things must be very tough for you”* versus “feelings”

# Assessing Lethality

- Means used in past attempts
- Means of suicide being considered
- Access to firearms
  - *“How easy would it be for you to obtain a gun?”*
- Severity of past attempts



# Assessing Protective Factors

**We are probing for whether the suicidal impulses are manageable.**

- Are resources in place?
- Would the person use those resources?

## ***Ask:***

- *“What would happen today or tomorrow if you began to have suicidal thoughts again?”*
- *“Have you used this resource in the past?”*
- *“Did it work out?”*
- *“The last time you contemplated suicide, what did you do?”*

# Involvement of Family/Significant Others

- Does the patient's family know about their suicidal thoughts?
  - If not, what is the patient's hesitation?
  - How do they think their family would react?
- Let the patient know why you think it is in their interest to enlist the family's aid
- Let consumer decide how much they are comfortable sharing
- “If we decide it is okay for your family to ask if you are feeling like things are getting bad, how should they go about it?”

# Special Considerations

## The “Chronically Suicidal” Patient

(Lambert, Psychiatric Serv. 53:92-94, 2002)

- Often Cluster B Personality Disorder
- Often brief situational/interpersonal crisis
- The dilemma of “compassion fatigue”
- Potential abuse/over-utilization of resources



# Special Considerations

## The “Chronically Suicidal” Patient

### Contingent Threats

- Leverage is applied
- Secondary gain
- Often presented in dramatic manner
- Risk contingent on meeting demands
- *“Unless you \_\_\_\_\_, I will \_\_\_\_\_”*

### Non-Contingent Threats

- Escape from severe emotional pain
- Passive, silent, hopeless, withdrawn
- Less demanding
- Requires knowing the patient’s history and baseline level of functioning

# Special Considerations

## The “Chronically Suicidal” Patient

- Severity and lethality are more important factors than frequency of ideations
- Avoid:
  - *“How bad is this situation compared to others?”*
- Instead:
  - *“How is this situation different from your most severe time?”*
- Set Limits & Offer Choices
- Go back to established crisis plan
- Ask about pets

***Questions?***