Part Two: Further Discussion about Developing More Comprehensive Guidelines for Lethality Assessment--Revised, November 2011

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This article has been published as an American Association of Suicidology Crisis Center Best Practice. It is an expansion of an article originally published within the AAS Organization Accreditation Standards Manual as a complement to the lethality assessment standard (which itself addresses essential risk factors and other key elements of practice). [The original 2011 article was updated with more inclusive pronouns, but no other changes, in April 2021.]

This discussion will explore some of the principles which may be involved in a center's decision to take institutional responsibility for developing more comprehensive guidelines for lethality assessment--as a supplement to the specific steps outlined in the standard.[1] For instance, many individuals feel a strong desire to kill themselves on a regular basis over an extended period of time. Assessing lethality in a traditional, step-wise, manner can lead to prolonged power struggles with some of these individuals--for instance with those who have experienced a previous involuntary hospitalization as traumatic and non-therapeutic. (They may have actually experienced more desire to kill themselves upon release, as well as less willingness to speak truthfully about suicide again.) These suffering individuals may cry out to crisis workers for help--expressing recurring pain, hopelessness and desire to die--while also knowing what they must avoid saying to prevent another involuntary hospitalization.

Such statements may evoke a crisis worker's genuine concern or fear without providing clear indication of whether or not there is immediate suicide danger. The harder the crisis worker pushes for more information, the harder the distressed individual may push back. Such struggles can become increasingly unproductive in terms of providing any credible data regarding current level of risk.

Any persisting effort by the crisis worker, instead, to build a mutually credible safety plan--and thus lower ambiguous danger to a less concerning level--may also be frustrated. For instance, the vicious cycle of persistent suicide danger often involves the suffering individual's ongoing difficulty finding effective ways to manage overwhelming, intense emotion. The possibility of killing him, her, or theirself may become the only means this person can envision for escaping frequently unbearable emotional pain--which threatens to eclipse him, her, or them. Any suggestion of creating a plan which would take away this hope for relief may be seen as unacceptable, unless the individual can first find other real hope for living and coping more effectively.

Some individuals will, thus, continue to suggest an unclear level of suicide intention without either providing clear evidence of immediate danger or moving toward reduction of risk through creation of a credible safety plan. In these cases, unremitting and unproductive efforts by a crisis worker to ask lethality assessment questions or build a safety plan may also be ill-advised, therapeutically, in terms of exacerbating interpersonal friction, helplessness and hopelessness. The crisis worker may unintentionally join the distressed individual in re-enacting difficult--and frequently traumatic--interpersonal relationships. The distressed individual, who then also experiences repeated conflict with crisis workers, misses an opportunity--which could be offered persistently by the workers--for a healing emotional experience, for the cultivation of a more protective therapeutic relationship and for support of any steps taken toward recovery--and without benefit gained from pressing the unproductive lethality assessment process.

With some individuals, then, given evidence of such a non-productive and even harmful dynamic, centers may choose to take responsibility for a clinical decision to forgo some aspects of traditional lethality assessment in favor of other means. Especially with some individuals who

are persistently or recurrently suicidal, the presence or absence of face-value statements of intent will often not differentiate between higher and lower immediate lethality in any event. It may be necessary to assess lethality in terms of a mindful evaluation of ambiguous and conflicting evidence.

Lethality assessment would never be abandoned with such individuals. Yet, it may be clinically advisable, for instance, to watch for changes in presentation as a potentially more valid means of observing for crisis points and possible escalations in lethality. That is, an individual may begin talking about a gun who has been talking for over a year about taking pills. Another, who has been talking about a spouse's threats to leave, suddenly tells us, with a different desperation, that the spouse is now gone.

Resistance to the use of a literal checklist method of lethality assessment is by no means always present with or limited to individuals who experience persistent or recurrent thoughts of suicide. Clinical experience suggests it is possible to take an overly routine or detached approach to assessing lethality with anyone who is experiencing intense emotions. There are times when the AAS directives to be empathic, respectful and to build genuine rapport as quickly as possible can be in direct opposition to the directive to assess lethality thoroughly—even in the presence of expressed suicidal intent.

Resistance may be passive, as clients acquiesce to answering our lethality assessment questions--all the while telling us with their tone, we are dragging them through a process they perceive as completely unhelpful or even victimizing. Without direct words they may let us know, repeatedly, we are choosing to forgo any opportunity to build an ongoing relationship with them. The longer we are directed by logic and protocol alone, the more we may risk losing the heart-to-heart connection which both clinical experience and research suggests is a critical

preventive factor. Again, even in the face of evidence which suggests varying degree of suicide intention, it may be necessary to make clinical decisions about balancing the building of rapport with conducting a more and more in-depth lethality assessment.

Often, pausing a lethality assessment and returning to a primary focus on reflective listening will allow a crisis worker to move past such an impasse. With an individual considering suicide, listening deeply will often lead, anyway, to an unfolding of that person's own understanding of why he, she, or they may have to die. When the individual feels heard and understood, in general, the worker may sometimes also be able to return to assessing lethality more thoroughly--completing any remaining appropriate steps from the standard--before deciding with the person what needs to happen next.

Otherwise, crisis workers plow through tangible statements of escalating resistance or rush forward, ignoring observable evidence of mounting detachment and distrust, at some risk. We know from experience that suicidal callers can hang up suddenly, with caller ID blocked and no identifying information given. Clearly distressed callers and face-to-face clients can clam up, never communicating the real extent of whatever suicide danger they are facing--never allowing the crisis worker any opportunity to respond accordingly. They may never seek contact with the crisis agency again if they did not experience that enough energy was devoted to understanding their pain and their needs—that their direction was followed adequately.

Seasoned crisis centers gain institutional and individual clinical experience, working with clients' emotional states and behaviors. These may be less visible to empirical research, which cannot measure emotion directly. Nor do common research practices often support the patience and inclination necessary to sit with painful, frightening emotions--hour after hour, avoiding

interpretation, reflecting them back, one at a time, until distressed individuals acknowledge we understand.

In regards to suicide, we learn from experience that intention may be complex and difficult to differentiate. We remember distressed individuals who did not move gracefully and definitely with us through the logical steps of a lethality assessment. When enough rapport is built, human beings present evidence of ambivalence, of competing desires, of shifting states of mind. (These varying states of mind might not even be taken into account if a suicide prevention agency's response to danger were based only upon a checklist which directs crisis workers to find a single, accurate answer to every assessment question.)

The presentation of one caller would not validate the statement, "I intend to kill myself tomorrow"—but at the same time would not entirely rule out any passing movements toward intention. Another caller will tell us, genuinely, he is feeling much better and no longer thinking of killing himself after a recent suicide attempt. He may then express real surprise when heartfelt discussion of his life evokes an intense suicide desire he is still not prepared to weather safely. The expression of yet another caller will suggest a hidden intention we suspect but simply cannot flesh out, despite all our best efforts.

There will be times when a crisis worker can help a distressed individual de-escalate initially presented lethality to an adequate--if not always optimal or desired--level, by means of the most basic, essential lethality assessment questions. Other clients will continue to suggest an unclear level of suicide intention without either providing clear evidence of immediate danger or moving toward reduction of risk and creation of a credible safety plan. In either case, we may reach a point where clinical experience and the observed details of an individual call suggest we

have built as good a relationship with an individual caller as we are going to build, created as good a safety plan as we will be able to in this call.

Through initial efforts to do so, we may observe evidence that any additional questions are perceived by the distressed individual as interrogation or evidence of non-genuineness and emotional detachment. From these initial efforts, we may judge we are not gaining enough additional information to justify observable deterioration of a growing therapeutic relationship--which we judge as the best hope for planning or encouraging future contact. Through the development of an ongoing relationship, we may also judge we have reasonable hope to build an increasingly more substantial safety arrangement--and possibly, a more thorough assessment--as we work to support the individual to move through emotional distress and to cope with external difficulties.

Obviously suicide prevention agencies want to understand any individual's suicide danger as fully as possible in order to respond to it appropriately. And if crisis workers can find ways to support a client's expression of emotion, all the while returning intermittently to the indicated steps of an appropriately thorough and productive evaluation, they should do so. (It can help workers to have a template for organizing their observations and impressions, such as Joiner, et al's model of suicide desire, intention, capability and buffers against suicide.[2])

This very practice of interweaving reflective listening and lethality assessment can often reduce lethality. Having another human being work to hear and understand why he, she, or they is considering or planning suicide--without judgment and without reflexively trying to make those thoughts and feelings stop--can have a real impact on an individual experiencing unbearable emotional pain. Turning over the stones of any remaining essential risk factors may reveal additional sources of danger lurking beneath them--which can also be explored through

reflective listening. In this way, distressed individuals may be supported to face overwhelming life circumstances and overwhelming emotion--often including terror evoked by their own real danger of suicide. As they experience and tolerate these dreaded states of mind in a new way, distressed individuals are often able to plan to survive them--or, in some cases, at least to postpone suicide for a time, making a plan to be safe while they try to get through them.

This interwoven evaluation and crisis intervention process naturally includes assessment of protective factors, as well as risk factors. Lethality assessment is not an objective measurement of the fixed quantity of suicide danger. It is a dynamic, interactive process. Assessment of protective factors includes exploring a distressed individual's internal and external resources. It includes exploring his, her, or their ability, with the crisis worker's support as rapport develops, to build a mutually credible safety plan--adequate to the given danger of suicide--through engaging new or existing resources. This may include engaging active support from significant others in an individual's life. It may include planning ongoing support from the suicide prevention agency.

We would not want to take any presentation of suicide danger lightly--and certainly not potentially imminent lethality. The human mind can be terribly deceptive. There is an uncanny tunnel vision which can set in, obscuring every other avenue for our escape from pain besides death.

At the same time, it may be difficult for anyone who has not experienced it personally, to understand how profoundly traumatizing and disempowering an involuntary hospitalization--and all that accompanies it--can actually be. A best practice of the lethality assessment process would always respect the civil rights and empowerment of clients to the fullest extent possible.[3] Given the potential for any involuntary action--and certainly involuntary hospitalization--to

traumatize or re-traumatize our fellow human beings and even increase suicide danger in the long run, these specific interventions would only be undertaken as a last resort in cases of genuinely imminent lethality, when all other possible avenues for reducing lethality and creating a mutually acceptable safety plan have been exhausted.

Underestimating the level of distrust--and in many cases, genuine terror--which the possibility of involuntary hospitalization can evoke for some individuals may also lead to an unnecessary escalation during the lethality assessment process. For example, an individual may have been hospitalized previously, after verbalizing a level of danger she will eventually report she has experienced nearly every day for over five years. She may have found the hospitalization traumatizing and anything but helpful. And she may have vowed to herself never to let that happen again.

Yet, in a new town, in the loneliness of her daily hopelessness and desperation, having a crisis worker listen genuinely--as one human being to another--she may open up again, unexpectedly. She may again express thoughts, feelings and a real consideration of suicide. She may suddenly say she is going to kill herself, today, soon, right after the conversation. She may do this without explaining, or even considering in the moment, that she has planned or at least hoped to carry out this suicide on an almost daily basis—without actually trying to kill herself again since her one attempt almost five years before. She may suddenly feel trapped and panicked, because she has now voiced the same words again--which two years before led to the police arriving at her door and all that followed. Her terror--and the perception of inescapable defeat rushing toward her, again--could lead to disengagement of clinical contact and to a genuine escalation of lethality, beyond her everyday level of risk.

In a face-to-face meeting, as this individual begins to rise and move for the door, it would be possible for a crisis worker to say something like, "If you leave now, I will have to consider calling law enforcement. And I REALLY don't want to do that." If the individual pauses, the worker might continue, "I truly do not want to threaten your control and your rights. But I also can't and won't sit back and do nothing if I believe you are going to go kill yourself. So can you please stay and talk with me about this, to see if we can find some way, together, for you to be safe?"

In a phone call, this process can be far more challenging--when hang-ups often come with little or no warning (and the caller may not answer, if the worker is able to call back immediately). Yet a crisis worker can still be aware of a caller's potential to disengage and listen for indications that he, she, or they is becoming alarmed about the crisis worker's possible response to what he, she, or they has said. It may be essential that the crisis worker has already worked to demonstrate genuine respect for the caller and a genuine desire to understand the complete picture of what the caller is experiencing, including suicide danger. The crisis worker may then say words like, "I don't want you to die. Please don't hang up." Yet these words can have a very different power--depending on what efforts have been made to establish a heart-to-heart connection. A great deal can depend upon whether the caller perceives the crisis worker does genuinely desire to help reduce his, her, or their immediate danger of dying and to explore every possibility for creating a mutually acceptable safety plan for the near future without taking away his, her, or their self-determination.

We know the crisis worker cannot hope to control the caller's response, only his, her, or their own part of the process. In the example just given, however, one possible outcome might be less than an iron-clad safety contract and more of a shared understanding, by the end of the

call, that the caller is at least as safe as she has been—before the call—and as safe as they can arrange for her to be at this time. The caller and worker might agree that an interaction with the police and/or an involuntary hospitalization is not actually warranted and that, if anything, would appear likely to have increased her suicide risk. And with more genuine and thorough communication—and perhaps, optimally, with a pause for consultation with a supervisor or colleague--the potential escalation of lethality might actually be avoided.

Instead, the call might provide at least an initial opportunity for rebuilding trust. The caller might agree to more contact with the suicide prevention agency. And the agency may then eventually find a way to support her to talk (to someone) about the assault she survived over five years ago--which she is not ready to say anything more about today.

Of course, there are times when this kind of back-and-forth interpersonal process may not be possible--for example, when a caller has already taken an action which does require an urgent, life-saving medical response. (Even then, however, any possible efforts to engage a caller's active choice to live and be rescued may not only decrease the potential traumatic impact of the experience on the caller. They can also sometimes speed up the rescue process or even make it possible.)

These expressions of genuine human concern can often become a necessary part of the rapport-building process with individuals expressing potentially imminent lethality--whom a crisis worker hopes will stay engaged long enough to make a choice to live, or at least to create a safety plan for the immediate future. Again, a heartfelt statement like "I don't want you to die," spoken at the right moment, when enough genuine effort has been made to reach a client and begin to understand his, her, or their pain, can sometimes be powerful and effective. (Without that understanding and a real human connection, such a statement could be heard as contrived

and leave the caller feeling that the crisis worker does not understand his, her, or their suffering and so cannot possibly understand his, her, or their decision about whether to die or continue experiencing that pain.) Even with callers who are not communicating any immediate danger but whose safety in the future may be unclear, a crisis worker might say, with the same genuine feeling, “You're telling me you're safe, that you will call us before taking any steps toward ending your life. But I'm not sure what may happen, if you do lose your job and you start feeling like you did last year, when you took the overdose."

This practice is consistent with Joiner, et al's (2007) observations that (1) "interventions during the call" can impact the final level of suicide risk at the end of a call, (2) "an individual's self-assessment of suicide risk may outperform clinical judgments," (particular at the end of a call) and (3) the best practice of lethality assessment is, therefore, "a highly collaborative process" (p. 362). The ready availability for consultation--during calls--of a seasoned crisis worker, experienced with this entire lethality assessment process and philosophy, is also vital. This is especially important when a crisis worker has been unable to establish genuine rapport with a caller in crisis, who may not communicate his, her, or their thoughts about suicide clearly without that human connection. It is especially important whenever the worker has any concerns—including any gut level discomfort--about whether he, she, or they and the caller have done everything which might fittingly be done to assess and address the suicide danger which the caller is facing.

This understanding of the lethality assessment process is consistent with the understanding of crisis as a period of danger and opportunity. It is consistent with an understanding of crisis intervention as providing support to tilt the balance from danger to

opportunity whenever possible. This is not sentimental or wishful thinking. We would never want to forget the real danger of suicide, nor shy away from facing it directly.

Sometimes a caller will just tell us enough to be very concerned. Sometimes a caller will not agree to call back. Sometimes we can only reach out, first with deep empathy for the caller's pain and then—after some time spent listening, if possible--with a genuine statement of concern and a heartfelt offer of support.

We would also never want to forget that a suicide crisis can actually present a distressed individual with the opportunity to move through experiences of loss and trauma, feelings of hopelessness and perceptions of inevitable defeat toward re-empowerment--by making a conscious, active choice to live (and thus both to escape life-threatening danger and to value him, her, or theirself in a different way). Knowing life will remain difficult and waves of overwhelming emotion will return-- he, she, or they can also plan to engage internal and external resources available to support this choice over time.

This is consistent with classic principals of crisis intervention and trauma recovery. From this point of view, the lethality assessment process is not only an essential tool of suicide prevention. It can also be a tool of recovery and healing.

Given all this, AAS would not support efforts to eliminate the specific general guidelines elaborated in the lethality assessment component. It would not support policies which forgo addressing suicide entirely with clients in crisis. It would not support policies forgoing thorough assessment--as indicated by a specific presentation of intention and lethality—unless those policies elaborate (because it may not always be possible to specify) with some sophistication when this should happen.

Optimally, we recommend documenting any decision to move from the general guideline. Any checklist item, provided to acknowledge such a decision, should provide some space to elaborate why this was done, from specifics of the call. A decision might also be made, generally, to assign a different action plan to a given client, for instance after a formal staffing or the decision of a clinical coordinator.

Principals of active intervention require efforts on the part of the phone worker to secure communications with callers demonstrating adequately significant suicide risk--even in otherwise anonymous systems. This effort would be all the more important in cases where a post-contact consultation or case management may suggest a follow up call to a client is needed, to clarify vital information that was not assessed, to work toward building a more elaborate safety plan, or simply to make another effort to build a stronger human connection.

Notes for “Further Discussion . . .Guidelines for Lethality Assessment"

[1] The process of lethality assessment described here is consistent with what I learned, practiced and then taught while a volunteer and staff member at the Alachua County Crisis Center in Gainesville, Florida.

[2] Joiner, T., Kalafat, J., Draper, J., Stokes, H. & Knudson, M, Berman, A., and McKeown, R. (June 2007). "Establishing Standards for the Assessment of Suicide Risk among Callers to the National Suicide Prevention Lifeline." Suicide and Life-Threatening Behavior, 37 (3) pp. 353–365.

[3] In a classic text of the early crisis intervention movement, Gerald Caplan (1964) argued for an empowering, non-medical approach to supporting people through crises, while avoiding the passive role into which people frequently fall when they enter medical treatment. Caplan argued that a "better result might be obtained if this ego-weakening could be avoided by defining

the role. . . in such a way that" the individual's "self-respect, mature status, and responsibility were not reduced" (p.102). [Caplan, G. (1964). Principals of Preventive Psychiatry. NY: Basic Books.]

Those of us who have recovered from extreme emotional distress--including many of us who have exited the mental healthcare system as consumers--would argue that such empowerment (or re-empowerment) remains no less essential after entry into that system. This issue is tremendously relevant to lethality assessment and suicide prevention. As one example only, the availability of peer-run respites in some communities offers individuals experiencing extreme emotional distress an alternative to hospitalization. These facilities are often experienced by the distressed individuals, themselves, as offering more genuine sanctuary and opportunity for healing—without the same risks of trauma and disempowerment. These peer-run respites may thus be considered as a genuine option for safety by many individuals in those communities--before they reach a point of complete hopelessness or otherwise risk losing self-determination as they are overrun by emotional distress.

An adequate discussion of these issues is far beyond the scope of this brief article. Although not officially sanctioned by AAS, the current author would direct anyone interested to the following websites, for an introduction to the mental health recovery movement: The National Empowerment Center: www.power2u.org . The National Coalition for Mental Health Recovery: http:/www.ncmhr.org .