*A FEW KEY IDEAS IN SOLUTION-FOCUSED SUICIDE PREVENTION*

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1. A critical take-away.

Ed Shneidman, “the father of American suicidology”, said that “there is a vast difference between ‘intolerable’ and ‘just barely tolerable after all’”. Viewing their problems and the associated pain as inescapable, interminable, and intolerable may push people toward suicide as a perceived solution. Empathic therapists are also vulnerable to feeling overwhelmed by the number and seriousness of the problems people face.

Shneidman’s maxim reminds us that even a small difference in even one problem area, as long as it is meaningful and noticeable to the client, may be enough to help them go on for one more hour, one more day, one more week…

Solution-Focused listening and solution-focused conversational tools help us to notice and focus on possible small changes that are meaningful enough to the client to create a “just-noticeable difference”. And any “jnd” is a challenge to that “inescapable, interminable, intolerable” mindset.

1. Maintaining connection.

One of the challenges of suicide intervention is that helpers are frequently trained, or even required, to conduct suicide risk assessments. Such assessments often interrupt a relationship-building conversation and replace it with a canned or scripted interview. Fifty years of outcome research tell us that in terms of what therapists do, relationship building is the most significant contributor to good client outcomes. So how can SFBT help us to maintain connection? Especially when our ability to remain mindful and fully present with clients may be disrupted by our natural concerns for their safety?

Some possibilities:

a) using solution-focused questions to help us tap into clients’ strengths and successes and to begin to see how clients are utilizing those resources even now;

b) relying on our previous solution-focused experience to remind us that there is always more to the story than the pain and trouble we see at first; and

c) practicing solution-focused habits of following and using clients’ language, hopes and goals rather than asserting our own ideas and agendas.

1. “A tiny molecule of hope”.

Paul Quinnett, a long-time leader in suicide intervention work, has said that the most important thing that can come from a conversation between a suicidal client and a helper is a tiny molecule of hope.

Examples of solution-focused conversational strategies that may contribute to that bit of hope include:

1. Inquiring about the client’s “best hopes”—a question that for people at risk for suicide may go right to the heart of things: do I have any hopes? And if so, what are they?—an attention-getting “tap on the shoulder” question for someone who has been entirely focused on what is wrong;
2. Relationship questions—if, for example, the client “doesn’t know” if they have any hopes, asking what their best friend would say about that often elicits a surprising wealth of possibilities;
3. Curiousity about the details of a future they would prefer, using strategies such as the “miracle question” and various “suppose” questions;
4. Scaling questions, e.g. “On a scale of one to ten, if one stands for ‘I think about suicide 24/7’ and ten stands for ‘I can think about a variety of things’, where are you now? –and where would you like to be?” Scaling by its very nature implies the possibility or even the expectation of change, and can be used to define and track even very small shifts; and
5. Being curious about exceptions to the problem, e.g. what clients are able to do in spite of being so depressed, or how they have survived hard times so far. Answers to such questions may offer important information about past, current, and potential reasons for living.
6. The possibility of a better future.

Brigitte LaVoie has said that “the address of hope is in the future”. Suicide researchers have demonstrated that people who see suicide as a solution experience a narrowing in their thinking which includes an inability to perceive a personal future. Its emphasis on the future, enacted in the use of conversational tools such as the miracle question, is perhaps the unique contribution of solution-focused brief therapy. The miracle question is a powerful “tap on the shoulder”, inviting clients trapped in all-negative perceptions to look beyond their problems and consider the details of a very different daily experience. Further, the miracle question is often a good fit with their views: “it would take a miracle, all right”. The opportunity to spend time thinking about a preferred future is at the very least a much-needed respite from a pain-filled present, and typically a source of motivation for change and ideas about possible pathways.

1. The hope of the helper.

What helps desperate people to survive terrible times? One factor that turns up in research is *believing that their helpers have hope for them.* Even when they are not able to feel hope for themselves, seeing that hope for them in someone else makes a difference: those clients have better outcomes. What follows from that is that I have a professional responsibility to keep my own hope alive. Self-care is a part of that, but more important is everyday professional practice that is “hope-friendly” (Yvonne Dolan). A Solution-focused orientation trains us to watch and listen for clients’ capacities, strengths, positive intentions, and histories of success. We can then use a variety of solution-focused conversational tools to amplify and reinforce those hope-full aspects. Such approaches allow us to notice from the very beginning what is hopeful about a particular client, even in the most difficult situations. Further, our expressed interest in the constructive elements in clients and their lives, and in the better futures they want for themselves, implicitly communicate our hope to them: *There is more to you than your problems.*