0-10 SCALE OF PAIN SEVERITY

Severity		Description of Experience
10	Unable to Move	I am in bed and can't move due to my pain. I need someone to take me to the emergency room to get help for my pain.
9	Severe	My pain is all that I can think about. I can barely talk or move because of the pain.
8	Intense	My pain is so severe that it is hard to think of anything else. Talking and listening are difficult.
7	Unmanageable	I am in pain all the time. It keeps me from doing most activities.
6	Distressing	I think about my pain all of the time. I give up many activities because of my pain.
5	Distracting	I think about my pain most of the time. I cannot do some of the activities I need to do each day because of the pain.
4	Moderate	I am constantly aware of my pain but I can continue most activities.
3	Uncomfortable	My pain bothers me but I can ignore it most of the time.
2	Mild	I have a low level of pain. I am aware of my pain only when I pay attention to it.
1	Minimal	My pain is hardly noticeable.
0	No Pain	I have no pain.

Case Vignettes

Vignette #1.

Ms. P is a thirty seven year old woman self-referred for therapy. She denied suicidal ideation at any point in her life during the first session; however, she had some difficulty making eye contact and her voice became difficult to hear while at this point. She reported being in therapy "on and off" for years, without any sustained reduction in depressive or anxiety symptoms. Ms. P stated her reason for coming to therapy at this time is work-related stress. She stated that she has a boss who is "constantly on her" and also makes inappropriate sexual remarks when others are not around. When asked if these experiences remind her of anything in her past, she quickly changes the subject. Ms. P indicated that her friends often complain of her interrupting them or forgetting aspects of their conversation. She reported a consistent sense of dread about others deciding she is "too much" and decided they no longer want to be in relationship with her, which has been present "as long as she can remember." When asked about her childhood, she stated that she does not talk about it with anyone. She stated that she is an alcoholic and has been sober for 6 months. She reported she currently craves alcohol every day and had a recent rupture with her sponsor. The one detail she was willing to share is that her parents consistent told her that anyone who experienced mental health struggles was weak, and they were particularly vehement about people who died by suicide.

Vignette #2.

You have been working with Mr. S for three years. He is a transgender male, who was raised by parents who were addicted to methamphetamines and alcohol on local tribal land. He has visible scars on his forearms, although he has not reported new instances of non-suicidal self-directed violence in approximately six months. He recently found out that he was not accepted to college and his partner has struggled to maintain their sobriety. Mr. S has three suicide attempts in his past, with a combination of pills and hanging as the method. He has acknowledged having a consistent plan; however, has not been forthcoming about the specific details. When asked about whether he was getting closer to using his plan, he shrugged and said "not today." He experiences regular insults and derogatory comments when visiting his parents, which he does at least three days a week because of their persistent health problems. Although he is hesitant at times, he provides answers to specific questions in his usual level of detail.

Vignette #3.

Ms. T is a 46-year-old second generation Muslim woman who is currently in a protracted custody battle. She reported being ostracized from her community. Her parents both recently died and all remaining members live outside of the U.S. She described her father as domineering and she recalled being afraid of him consistently as a child. She does not have a history of substance abuse. She reported intense urges to "smash her face into a mirror," although she has not reported actually engaging in these behaviors. When asked directly about suicidal thoughts, she is quick to dismiss these conversations; however, she often says "I just want this all to be over." She expressed hopelessness regarding the court proceedings and uncertainty about how she is going to take care of herself and her three children. Her teenage son accompanied to session today and let you know she has not been eating or completing basic hygiene. He indicated that she has recently bought uncommon items, like acetaminophen and over the counter sleep medication, which has been confusing because she is not someone who uses the medications. When asked more about these decisions, she has difficulty engaging in further conversation.

Vignette #4.

Mr. Q is a 59 year old Caucasian male who presented to therapy with relationship difficulties and distressed mood. He had difficulty settling his body during the first two sessions, primarily sitting on the edge of the couch. He is a medical professional and reported concerns about what his colleagues might think if they knew he was in therapy. During the 5th session, he hands you a small note that states he is "extremely suicidal and barely hanging on." He has hinted at previous suicide attempts, but been hesitant to discuss further details. During the session, he reveals that he has had a consistent plan for more than 20 years, including the means to carry it out. While in session, he is engaged and you notice his body settles as you calmly and firmly evaluate his current risk. Mr. Q discusses plans for the future, his fear of being open about his struggles with any of his friends or colleagues, and the difficult relationship with is children. He later reports that he was fully prepared to walk out of the session and use his plan if he got the "same old crap" he had seen before.

Vignette #5.

Ms. O is a 33 year old African American woman who called to report she had ingested 25 sleeping pills. You have been working together for two years and she had consistently denied a history of suicidal ideation and self-directed violence in her life. You visit her briefly in the hospital and she is release to your care after a 72 hour hold. In the first session, she is quiet and hesitant. She stated that she experienced a sexual assault as a child that she has never really talked about, even with mental health professionals. She reported experiencing suicidal ideation periodically as a teenager, but the thoughts have been present "daily" since her partner left her suddenly approximately three years ago. Ms. O stated that she has been consistently told these thoughts only happen to "weak people" and she does everything she can to present as unaffected by life's experiences. Over the course of the next several months, she becomes more comfortable discussing her thoughts with you, including the experiences of having "cold" parents. She reported keeping a stash of pills "just in case" for the last 10 years. She has contemplated other methods occasionally, including jumping off a bridge. She has not engaged in preparation or rehearsal behaviors recently. She had a recent rupture with a close friend and her self-care has decreased. Ms. O denied a history of substance abuse issues.

Vignette #6.

Mx. L is 44 years old, White, and non-binary. They have a long history of physical, sexual, and emotional abuse as a child. Although they have been in therapy throughout their life, they report therapists have emotionally "back up" or transferred care after hearing even a small piece of their trauma history. They struggle with chronic pain from work-related injury that limits their ability to work, which was one of the few ways they were able to experience a sense of competence. They have a history of tumultuous relationships, many of which involve similar abusive behavior that they experienced as a young child. Mx. L stated they have had two previous suicide attempts (cutting wrist and hanging), both of which were interrupted by roommates. Although they current report a high degree of hopelessness, they indicated talking to someone who can stay present with their trauma narrative is comforting. They recently bought a firearm for self-defense and leave it loaded in the bedside table. They smoke marijuana daily and have a history of methamphetamine and hallucinogen use. They have stated they are sticking solely with marijuana at this time and have cut the people who might supply other narcotics out of their life.

Vignette #7.

H is a 15-year-old Latino male with a long history of impulsive actions, including self and property-directed damage. He frequently has difficulty sitting still in your office and frequently storms out when you challenge him. He has acknowledged experiencing suicidal thoughts frequently over the past three years. During an angry exchange with his father, he grabbed a knife and threatened to cut his wrist; however, did not break the skin. When asked about his reasons to stay alive, he said "there are none, stop asking me such stupid questions." His parents are divorced, and he does not have contact with this father. He indicated that his father used to "smack him around for on reason." He estimates this happened 3-4 times a week, but "learned to take it." As rapport builds, he has begun to express more consistent suicidal ideation. He has been less willing to discuss the specifics of a plan, but has noted that he has a "few ideas that will work." His mother denied having firearms in the home. He stated his mother has a "whole bunch of pills" for various things, but has not brought you the specific names. H recently experienced the end of his first significant romantic relationship. He began to experience more consistent suicidal ideation after this and appeared to withdraw in therapy. When asked directly about urges to engage in self-directed violence, he stated "no, I'm fine, just leave me be!" He has been less willing that usual to engage in safety planning, stating "this is all bullshit."

Vignette #8.

Ms. R is a 46-year-old Caucasian female with a history of ritual abuse. She is highly dissociative and has experienced significant difficulties in therapy accepting the impact of her trauma. She has wanted to be dead "every day" for "as long as she can remember." Her first suicide attempt was an accident (too much medication) when she was 10 years old. She has made three additional attempts using medications. She recently had a suicide attempt, using a combination of rat poison and pills, which likely would have resulted in death if her daughter had not stopped by unexpectedly. While in the hospital, the attending psychiatrist told her "dissociation is not real" and "your therapist is clearly incompetent," which resulted in a significant increase in her distress. Although you called several times, hospital staff were not helpful in

facilitating the connection. Upon her release, you find out they did not let Ms. R know that you had called during her seven day stay. She is withdrawn and appears fearful during your first session. Ms. R reported that she is “uncertain what is real” after the hospital stay and is uncertain if she can trust you. Your usual validation does not appear to have the same impact, although she agrees to come to an additional session this week. During the second session, she brings her extra medication and the poison to session for you to dispose of it. She expresses significant hopelessness and an exacerbation in his distress and dissociative symptoms after the hospital. She expresses sadness and frustration the therapist “didn’t do anything” to get her out of the hospital sooner.

1. DISRUPTIONS & DEMANDS

	Client	Client's Significant Others
Risks	A) Loss/Failure of relationship B) Overwhelming expectations/obligations C) Loss of social position/financial status D) Legal/Disciplinary troubles E) Abuse/Bullying/Peril	a) Distressing expectations/demands of the client b) Abandoning the client c) Abuse/Bullying of the client
Resources	1) Effective problem solving 2) Positive personal/spiritual connections	i) Reasonable expectations/encouragement of the client ii) Helping the client meet obligations

2. SUFFERING

	Client	Client's Significant Others
Risks	F) Depressed/Manic mood G) Anxiety/Anger/Obsessive thinking H) Conflicted identity/Shame/Burdensomeness I) Hallucinations/Delusions J) Insomnia/Nightmares K) Pain/Illness/Injury	d) Viewing the client as flawed/a burden e) Limited awareness of/Unhelpful response to the client's suffering
Resources	3) Engagement in medical/mental health treatment 4) Variability in psychological/physical symptoms 5) Effective response to suffering	iii) Empathic response to the client's suffering iv) Supporting the client's medical/mental health treatment

3. TROUBLING BEHAVIORS

	Client	Client's Significant Others
Risks	L) Withdrawing from activities/relationships M) Substance abuse/Disordered eating N) Impulsive/Compulsive actions O) Harming self/others	f) Participating in the client's troubling behaviors g) Unhelpful attempts to regulate the client's troubling behaviors
Resources	6) Engaging in activities/relationships 7) Participating in therapy/rehab 8) Finding alternative behaviors	v) Reaching out to the client vi) Facilitating recovery/safety

4. DESPERATION

	Client	Client's Significant Others
Risks	P) Hopelessness Q) Intense desire for relief R) Intention/Plan to act on suicidal thoughts S) Communicating about suicidality T) Having/Gaining access to means U) Preparing for/Attempting suicide	h) Suicidality i) Ignorance/Denial of the client's suicidality j) Dismissive response to the client's suicidality
Resources	9) Hope/Reasons for living 10) Variability in suicidality 11) Willingness not to conceal suicidality 12) Active participation in developing and implementing a safety plan	vii) Compassionate response to the client's suicidality viii) Active participation in a safety plan