Instructor’s Manual

for

SUICIDE AND SELF-HARM: HELPING PEOPLE AT RISK

with Linda Gask, MD

by

Randall C. Wyatt, PhD,
&
Linda Gask, MD

psychotherapy.net
Table of Contents

Tips for Making the Best Use of the DVD 4
Some Factors Affecting Suicide Risk and Prevention 6
The Four-Stage Model of Suicide Prevention 8
  Assessment 8
  Crisis Management 18
  Problem Solving 22
  Crisis Prevention 25
Reaction Paper for Classes and Training 28
Related Websites, Videos, and Further Readings 29
Discussion Questions 31
Complete Transcript 32
  Assessment 33
  Crisis Management 47
  Problem Solving 59
  Crisis Prevention 64
Video Credits 69
Earn Continuing Education Credits for Watching Videos 71
About the Contributors 72
More Psychotherapy.net Videos 73
Tips for Making the Best Use of the DVD

1. USE THE TRANSCRIPTS
Make notes in the video Transcript for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during the video and post-viewing.

2. REVIEW THE GUIDELINES
Provide viewers with copies of The Four-Stage Model of Suicide Prevention outlined in this manual. Reviewing the written material will help them integrate key points before they attempt to apply the model in role-play scenarios.

3. LET IT FLOW
Allow the scenarios to play out some so viewers can appreciate the work over time instead of stopping the video too often. It is best to watch the video in its entirety since issues untouched in earlier parts often play out later. Encourage viewers to voice their opinions; no therapy is perfect! What do viewers think works and does not work in the sessions? We learn as much from our mistakes as our successes and it is crucial for students and therapists to develop the ability to effectively critique this work as well as their own.

4. SUGGEST READINGS TO ENRICH VIDEO MATERIAL
Assign readings from Suggestions for Further Readings and Websites prior to viewing. You can also time the video to coincide with other course or training materials on related topics.

5. CONDUCT ROLE-PLAYS
Stop the video after each of the four sections—Assessment, Crisis Management, Problem Solving and Crisis Prevention—to conduct role-plays, giving viewers the opportunity to internalize new material. Organize participants into pairs to role-play a scenario of helping a person at risk of suicide or self-harm. Participants should take turns playing the roles of counselor and patient so that everyone
can practice these essential skills. The “patient” may resemble one of the people in the video, a current or previous real-life patient, or a fictional person in crisis. Using The Four-Stage Model of Suicide Prevention as a guide, encourage counselors to try different ways of assessing and managing the patient’s risk. Emphasize the importance of being direct, asking specific questions, and using the general interviewing skills at every stage of the process.

After the role-plays, have the pairs come together to discuss the exercise. First ask the patients to share their experiences, then have the therapists talk about what the sessions were like for them. What did participants find challenging about this way of working? Finally, open up a general discussion on what participants learned about helping people at risk of suicide and self-harm.

6. ASSIGN A REACTION PAPER
See suggestions in Reaction Paper section.

7. FACILITATE DISCUSSION
Pause the video at different points to elicit viewers’ observations and reactions to the concepts presented. After viewers have watched the video and practiced these approaches themselves, the Discussion Questions provide ideas about key issues that can stimulate rich discussions and learning.
Some Factors Affecting Suicide Risk and Prevention

The information in this section and the following one have been adapted from the original Teaching Package Linda Gask, MD designed to augment the learning value of this video.

**RISK**

- At least half of all suicides are associated with drug or alcohol abuse, with particularly increased risk among the young and the old.
- Unemployment has a complicated relationship to suicide; suicide is more common in those under threat of layoff or who have recently lost their job than among those with an expectation of continued employment.
- Suicide is 40-60 times more frequent in people who are recently discharged from a hospital with a psychiatric disorder, compared to the general population. 70% of people who commit suicide have been diagnosed with depression. Other psychiatric disorders associated with suicide include schizophrenia, bipolar disorder and personality disorders.
- Suicide is more common in those who are socially isolated or have no particular aims or responsibilities in life.
- Suicide risk is greater in those who have recently separated from a partner (marital or other close relationship), have lost contact with their family or have recently been bereaved.
- Suicide is more common in people with catastrophic or stigmatized illnesses such as AIDS.
- In general, women who are pregnant or have young children are less likely to commit suicide. However, women who have delivered a baby in the last six months are at increased risk of depression and may develop suicidal ideation.
PREVENTION

• Only a small proportion of people who commit suicide do so without any prior warning.

• Research suggests that many people who go on to commit suicide have been in contact with a medical doctor, a mental health professional, a hospital emergency room or some kind of community social support organization shortly before the act.

• According to research, at least 50% of suicide victims over the age of 35 consulted a healthcare professional in the month before their death. 1/3 of these people gave a clear indication of suicide intent during that interview and 1/3 would reveal suicidal intent under direct questioning from a sympathetic interviewer.

• Young men are less likely to contact their doctor, but when they do so, they show up for appointments with increasing frequency.

• Many health workers come into contact with potentially suicidal people including: doctors, nurses, emergency room staff, prison staff, mental health workers, social services workers, probation officers, and certain voluntary workers, especially those dealing with drug and alcohol misuse, crime and mental health.

• Reasons for not seeking help include: reluctance to trouble others, practical difficulties in making contact and concerns about confidentiality.
The Four-Stage Model of Suicide Prevention

This section provides a detailed outline of the four-stage model demonstrated in the video. It will help viewers gain a deeper and more thorough understanding of the material presented in the video vignettes, so that they are better prepared to apply the model to role plays and, eventually, real life situations.

**ASSESSMENT**

General Interviewing Skills: These should be employed throughout the interview

**ESTABLISHING RAPPORT**

- Introduce yourself by name.
- Explain the purpose of the interview.
- Interview the patient in a quiet setting, if possible.
- Assure the patient of confidentiality.
- Ask permission to take notes.
- Maintain eye contact (beware of looking excessively at notes or computers).
- Keep the pace of the interview unhurried and non-challenging.

**QUESTIONING STYLE**

- Start off with open questions.
- Avoid ‘why’ questions at first, which require opinion rather than fact.
- Avoid questions that can simply be answered ‘yes’ or ‘no.’ These shut the patient down.
- Listen more than question or advise at the start of the interview—the patient should do most of the talking at first.
- Once the patient speaks about specific problems, ask direct questions to obtain needed information.
• Use closed questions, which are answered ‘yes’ or ‘no,’ only to clarify facts.

PICK UP VERBAL AND NON-VERBAL CUES
Pay attention to key words or phrases that refer to emotional topics and social information (e.g. “I have been feeling very wound up lately”). Also look for non-verbal signs of possible emotional disorder, such as tearfulness, sighs, agitation, restlessness, pacing, lack of eye contact, and slouched posture.

DEMONSTRATE ACCEPTANCE OF THE PATIENT
Non-verbal communication encourages the patient to speak (e.g. nodding, saying “uh huh,” maintaining eye contact). Reflect or paraphrase what the patient says and empathize. This helps the patient speak about difficult issues (“I can see that things have been very difficult for you lately”).

CLARIFY AMBIGUITIES
Sometimes patients do not express themselves very clearly. Try to be precise about a patient’s subjective experience—e.g. “what exactly do you mean by ‘wound up’?”

SUMMARIZE
Go over what has been discussed and ask if it is correct—this enables the patient to correct any misconceptions or factual inconsistencies. This also shows the patient that you have listened and are taking the problems seriously—this in itself gives some hope to the patient that his/her situation can improve.

CLARIFY CURRENT PROBLEMS
Specify problems over the last few months and the last 24 hours. The assessor should check if there are any problems relating to the following that the patient has not spontaneously mentioned:
• Relationship with partner, other family members, friends
• Social isolation
• Bereavement
• Separation
• Employment
• Studies
• Finances
• Housing
• Legal, including current court/police proceedings
• Physical health
• Use of illicit drugs/alcohol
• Mental health

QUESTION SPECIFICALLY ABOUT SUICIDAL INTENT

You cannot assess suicide risk without specific questioning. Asking a person about suicidal thoughts will not plant an idea that was not there before. Most people who are contemplating suicide feel relieved to be able to talk about it. If you need to refer the patient to other professionals, it is helpful if you can give specific information—this may even speed up the process.

EXPLORE HOPELESSNESS

Important! Hopelessness is the best predictor of suicide

Hopelessness is characterized by feelings that the current situation is not only intolerable right now, but will never improve in the future (“Do you think your life could ever get better?”). Hopelessness is often associated with helplessness—explore whether the patient believes anybody can help to improve the current situation. If a patient describes a degree of hopelessness or helplessness, or you have reason to believe a patient to be suicidal (i.e. a cut wrist), you should ask specifically about thoughts of suicide.

Does the patient have anything to look forward to? While the patients who are looking forward to a future event are less likely to commit suicide in the immediate future, be careful when patients plan to live until they have seen through a particular event, e.g. a birthday, before committing suicide.
Wishes to be dead

Active wishes to kill oneself are more serious than passive wishes to be dead (e.g. “I wish I could just go to sleep and not wake up”).

Specific plans for suicide

Has the patient had thoughts about harming or killing him/herself? Are these thoughts fleeting or persistent? Does the patient have any specific plans (e.g. how, where, when, etc.)?

Measures to prevent detection

Be aware of patients who have thought about measures to prevent detection, for example, planning to commit suicide when their partner is at work and the children are at school.

Avoid ambiguous questions

Some people are not directive enough in their questioning because they feel too embarrassed or awkward asking about suicide plans for fear of offending the patient. Patients may laugh at being asked about suicide, but it is rare they will be offended. Furthermore, patients who are feeling suicidal are more likely to feel comfortable talking about it if you are comfortable asking them. While some suicides are unpredictable, many people who go on to commit suicide have been in contact with social service agencies in the previous month. Most reveal suicide intent when questioned directly by a sympathetic interviewer, and only a minority of people deny suicidal intent when in fact they are planning suicide.

Ambiguous questioning may result in an inaccurate interpretation of the person’s response—e.g., “Have you thought about getting away from it all?” A ‘yes’ response may be interpreted as suicidal ideation, when in fact patients may simply feel they need a break away from the source of distress. So be clear and direct.

FACTORS WHICH MAKE SUICIDE MORE LIKELY

- Immediate intention to carry out suicide
- Specific plan of suicide
- Choice of violent method of suicide (e.g. hanging, shotgun)
SUICIDE AND SELF-HARM: HELPING PEOPLE AT RISK

- Access to means of suicide
- Plans for death (e.g. will changes, family farewells)
- Recent escalation of:
  - Suicidal behavior (e.g. self-harm)
  - Maladaptive behavior (e.g. drug/alcohol abuse)
  - Help-seeking behavior (e.g. visiting a doctor, emergency room, etc.)
  - Current symptoms of mental disorder (see below)
- Past high-risk suicide attempt
- Likelihood of further bad news—‘the last straw’
- A self-imposed deadline passes without the good news the person hoped for

FACTORS WHICH MAKE SUICIDE LESS LIKELY

- Looking forward to future events.
- A statement from patients ensuring they will not commit suicide if a particular event occurs. However, this lowers immediate risk only—beware if event is not under patient’s control (e.g. “I will not commit suicide if my wife comes back to me in time for our anniversary”).
- Fear of:
  - Death
  - Being left physically/mentally damaged
  - Attempt having no effect on family/friends
  - No one to look after children/significant others
  - No access to means of suicide

ASSESSMENT OF PSYCHIATRIC DISORDER

Depression
Depression is the most frequent mental disorder leading to suicide. You need to distinguish depression from sadness. Depression is more
persistent than sadness and is accompanied by other symptoms, such as: loss of interest or pleasure in anything, changes in sleep pattern or appetite, low energy, poor concentration, loss of self-confidence, hopelessness and/or suicidal thoughts. Depressed people can also have symptoms of anxiety, mania, delusions or hallucinations.

Schizophrenia
Schizophrenia is characterized by bizarre delusions, hallucinations, thought interference and personality change (apathy, loss of emotion). Suicide is particularly likely in schizophrenic patients experiencing social isolation or prominent symptoms of depression, particularly hopelessness, and among those who have recently been discharged from inpatient psychiatric care. Measures that will help include treatment of depression and the uncontrolled symptoms of schizophrenia, and measures to reduce social isolation, such as involvement in daytime activities.

Personality disorder
A personality disorder is present when a person consistently behaves in a way that causes harm to him/herself or others, and this damaging behavior has been consistently present since the person’s late teens. A personality disorder does not explain antisocial or suicidal behavior in people who are depressed or have schizophrenia and do not exhibit these types of behavior when their mental illness subsides.

Common personality problems leading to suicidal behavior include:
• Impulsive rage
• Poor interpersonal skills
• Difficulty with peers
• Problems with the law
• Alcohol and drug problems
• Difficulty establishing any form of consistent identity or social role (e.g. no consistent job, sexual partner, peer group, sexual preference)
Alcohol and drug problems
Alcoholism and drug addictions are leading factors for attempted and eventual suicide, with at least half of all suicides being associated with drug or alcohol abuse. Males who abuse alcohol/drugs and have a history of self-harm are at particular risk. Drugs and alcohol have profound effects on mood and increase disinhibition, which may result in people acting on suicidal thoughts that they had previously resisted. Some people may self-harm or attempt suicide while intoxicated and later regret it when sober. However, for other patients, the act is fatal and regret too late. Be aware of patients who have taken an overdose of pills with alcohol—even if they are consequently regretful, the damage already done could be fatal.

Suicide tends to occur relatively late after the onset of an alcohol/drug related disorder. Suicide risk is particularly great when serious social consequences of drinking/drug abuse have just occurred (e.g. marriage break-up).

ASSESSMENT OF SUICIDE RISK AFTER SELF-HARM OR ATTEMPTED SUICIDE

Some people use self-harm as a coping strategy with no plans of suicide. Some people use self-harm as a way of communicating intense distress to others. You should be particularly wary of the high suicide risk in people who make a number of suicide attempts with increasing frequency and increasing seriousness. The risk of suicide following a suicide attempt is 100 times that of the general population.

Factors associated with suicide after self-harm:
- Male gender
- Social isolation (no friends or meaningful emotional support from family)
- No meaningful role in life (unemployment, retirement, no family role)
- Recent separation, divorce, bereavement
- Living alone
• Poor physical health (especially if not responding to treatment)
• History of violence to others
• History of violent self-harm (e.g. attempted hanging)
• Alcohol/drug misuse
• Current psychiatric disorder

To assess risk following self-harm or a suicide attempt, you should ask about:

**Antecedents**

• Duration and degree of planning of suicide attempt (greater risk of suicide if attempt was planned, especially if planning occurred over some time)
• Detailed account of events in preceding 48-hours
• Final act (suicide note, will, etc.)

**Attempt**

• Lethality (hanging, shooting, drowning, carbon monoxide poisoning are all very high risk)
• Expectation of outcome (the expectation of the person engaging in self-harm is more important than our own expectation—we may be aware that a handful of aspirin is unlikely to be fatal—the person taking them may not)
• Precautions against discovery

**Mental state**

• Mood (especially hopelessness/worthlessness)
• Suicidal thoughts
• Current attitude (regret or guilt concerning the recent suicide attempt is less likely to be associated with completed suicide)

The previous section will help you identify factors associated with suicide risk. Unfortunately, suicide is not always predictable and therefore cannot always be prevented. However, research suggests that increased awareness of risk factors and management strategies can
lead to a marked reduction in the number of suicides. The following three sections will help you to implement both short-term and long-term management strategies when dealing with suicidal clients.

**CATEGORIES OF RISK**
Use the following categories as guidelines to help determine level of risk and appropriate actions to take:

**Low risk**
- Fleeting thoughts of suicide which are soon dismissed
- No plan
- Mild mental illness—no or few symptoms of depression
- No alcohol/drug abuse
- Stable psychological situation

**Action for low risk**
- No follow-up required because of low suicide risk
- Diffuse emotional distress as far as possible
- Screen for evidence of mental disorder. If present, arrange for treatment.

**Medium risk**
- Fleeting thoughts of suicide
- No plan
- Some evidence of mental disorder
- Some evidence of drug/alcohol abuse
- Unstable psychological situation but no immediate/impending crisis
- Infrequent dangerous behavior

**Action for medium risk**
- Diffuse emotional distress as far as possible
- Follow-up required in 72 hours – one week
• Once safety is established, requires a full assessment of mental health, psychosocial problems and crisis prevention strategies

Medium-high risk
• Frequent/fixed suicidal ideas
• May have considered different methods but no specific plan/immediate intent
• Significant mental illness
• Unstable psychological situation with impending crisis

Action for medium-high risk
• Diffuse emotional distress as far as possible
• Remove/restrict lethal means of suicide
• Follow-up required next day
• Once safety is established, requires a full assessment of mental health, psychosocial problems and crisis prevention strategies

Very high risk
• Definite plan of suicide
• Access to means of suicide
• Significant mental illness
• Significant drug/alcohol misuse
• Unstable psychological situation with impending crisis
• Escalating dangerous/Russian Roulette behavior

Action for very high risk
• Immediate attempt to assure safety after interview, 24-hour support group and follow-up
• Remove/restrict lethal means of suicide
• Diffuse emotional crisis
• Once safety is established, requires a full assessment of mental health, psychosocial problems and crisis prevention strategies
CRISIS MANAGEMENT

OBJECTIVES

• To calm the patient down
• To reduce the immediate risk of suicide
• To enhance hope and confidence
• To improve effectiveness in tackling problems
• To arrange treatment of mental disorder

ALLOW EMOTION TO BE RELEASED

In suicidal patients, you usually cannot diffuse a crisis without the patient releasing some of their emotion. Show that it is all right if a person wants to cry or shout. When intense emotion accompanies a topic of conversation, you can be pretty sure that it is related to the underlying problem. Crying can be a release that may give the distressed person some relief from suffering, and in this way can slightly reduce the immediate risk of suicide.

Do not tolerate aggression towards yourself, other people or furniture. Firmly discourage this and encourage the person to tell you what is wrong. Aggression is a way of testing you out; people will usually say afterwards that they do not feel in control of themselves and they remain suicidal unless they find someone who can be both assertive and supportive.

Do not let the suicidal patient leave the interview without ensuring that s/he is calm and there is a safe and practical plan of what they are going to do in the next 24 hours. If you cannot reach this stage, you will need to call in other professional staff or ensure that s/he is not out of sight of a competent caregiver until s/he can be re-evaluated later.

TAKE CHARGE OF THE INTERVIEW

While it is desirable for the suicidal patient to express emotion, patients can get too distressed and overwhelmed by their problems and decide to leave while still distressed and suicidal. It is important for the interviewer to take control of the situation by distracting
the patient. Ask the patient more about aspects of his life that are positive or not upsetting to talk about. Alternatively, talk about issues unrelated to the patient to distract from their distress.

You may need to calm the patient down by teaching them slow, deep breathing exercises if they start to hyperventilate.

**ADDRESS IMMEDIATE PROBLEMS**

You should be aware of these from the assessment, but you may need more information either from the patient or from other sources before immediate problems can be addressed. Use the following questions as guidelines:

- What exactly has happened?
- What is the discrepancy between what has happened and what would be acceptable to the patient?
- Does the patient’s view of the problem sound accurate and plausible?
- Is the patient’s position realistic and achievable?
- Would the patient accept some form of compromise that is realistic and achievable?
- Does the patient require more information to check the accuracy or practicalities of his/her viewpoint?
- What practical problems stop the patient from achieving an acceptable compromise to achieve his/her goal?
- Who else needs to be involved?

Look at past solutions the patient has employed in solving similar problems. Could these solutions be used again (possibly with some modification)? You do not need to solve the patient’s problems. In most cases, all you need to do is persuade the patient that there is something realistic that s/he could do to help their situation—i.e. their situation is not entirely hopeless.

**PROVIDE IMMEDIATE SUPPORT**

The vast majority of problems can be helped to some extent in the way
outlined above; e.g., terminal AIDS will mean death but help can be given with pain relief, putting affairs in order, etc. However, sooner or later, you will be faced with problems that cannot be helped, e.g. the inevitability of death from terminal AIDS. Even so, patients often feel more able to cope when they have an opportunity to discuss their emotional problems with someone who is supportive.

Look to see if there is a friend or family member who could take this role. If not, look for health professional or others, e.g. priests, who could take this role in the near future. You may have to discuss how a person could introduce their concerns into conversation with their future source of support without embarrassment.

BOLSTER SELF-ESTEEM

It is important to compliment the suicidal patient on sharing their thoughts and feelings with you (they have done something well at last), to encourage them to get support in the future. Express the view that discussion of private and painful issues with a stranger requires some bravery. Remind the patient that they have succeeded in this difficult task, got some relief from their distress, and further discussion with the right people can lead to some of their problems being resolved and a wish to live.

IMPROVE HOPEFULNESS

Discuss the final and irrevocable nature of suicide. Explore the effects of the suicide on significant others. Also, explore whether suicide is compatible with religious or humanistic values the patient may have. Assure patients that they still retain the right to carry out suicide at a later date—you are just asking at this stage to postpone the suicide (however, beware of setting deadlines, etc.).

Discuss problems from a more realistic perspective. Does the situation really have to be entirely hopeless or entirely satisfactory? Is there anything at all that they can look forward to, e.g. happy family events or times of the year they enjoy? Explore whether there have been any small successes in the patient’s life and what prospect there is of repeating them, even just a little bit. Do not trivialise a person’s problems or deny that problems exist, but do emphasise that problems
can be dealt with in a way other than suicide. Whatever the current problems, it does not mean that the future will also be filled with problems—it is possible to break the pattern.

Nearly all suicidal people have in common an illogical sense of hopelessness. They may believe that they have never succeeded at anything worthwhile in their life and that they are unlikely to do so in the future. It is important to expose this irrational kind of thinking before any real progress can be made.

Get the person to write down/verbally list things s/he has achieved, no matter how small it may seem. You may need to help the patient with this based on previous contact/info from others. People in crisis are good at disqualifying the positive and focusing on negative events in their life. Role-play (and role reversal) is a useful way of exposing patients to think about their strengths and accomplishments, as well as exposing the lack of logic behind their feelings of hopelessness.

**ATTEMPT TO ENSURE SAFETY**

The majority of suicidal people have second thoughts about suicide over a 24- to 48-hour period; therefore, it is crucial that safety is maintained over this time. Ensure immediate safety by asking:

- Who can s/he confide in?
- What support is available?
- Does s/he still have access to any potentially fatal methods?
- Are they currently using any drugs or alcohol?

**USE FAMILY AND FRIENDS**

It is important to clarify with the patient what is going to be the most effective kind of support and who is best able to provide it. Family and friends can offer better support than professionals if they are available and empathic. They should be informed of risks and what to do if the situation gets worse. Teenagers and immature people become distressed by being with suicidal patients and should not be relied upon.
USE OTHER PROFESSIONALS
Sometimes offers of emergency telephone access to either the therapist or other professionals might be considered. Crisis telephone lines are available 24 hours a day and are staffed with people specially trained to provide support for those in crisis situations. Do not offer emergency access numbers unless you are fairly sure that the patient will get a hold of someone when they call; the disappointment of being let down could lead to a further suicide attempt.

PROBLEM SOLVING

OBJECTIVES OF PROBLEM SOLVING

• To help patients identify problems as a source of distress
• To help patients identify their psychosocial resources
• To provide patients with a framework to think through problems logically
• To enhance patients’ control over current and future problems

WHY USE PROBLEM SOLVING?

• It is easily learned
• It has a wide application for many psychiatric disorders
• It can be used in addition to medication
• It is popular with patients
• It is more accurate, as patients generate their own solutions
• It is less stressful for health professionals

SUITABILITY FOR PROBLEM SOLVING

Failure to meet the following criteria will preclude problem solving:

*Patient’s problems can be specified.* Sometimes, pinpointing the specific problems that have led up to the overall distress can be a difficult task in itself and may take more than one session.
Patient’s goals are realistic. If the patient has unrealistic expectations, this is likely to result in further disappointment, which could deepen the despair and loneliness.

Absence of severe acute psychiatric illness. Although problem solving can be a useful approach with patients suffering from a wide range of disorders, it is important that the patient is not in an acute phase of a major psychiatric illness.

Patient is no longer in crisis (suicidal) situation. Safety must be ensured and some degree of hopefulness should be present before the patient can engage in problem solving.

Patient able to take some responsibility for self. Problem solving is a collaborative effort between the therapist and the patient, with a particular emphasis on enhancing patient control over problems.

STEPS IN PROBLEM SOLVING

1. **Decide which problem to be tackled first**
   Focus on one problem at a time. It is helpful to deal with the most solvable problem first, not necessarily the most serious. Although the patient must ultimately decide on which problem to tackle first, s/he needs to gain some self-confidence by achieving something. The therapist should help the patient choose a problem that is likely to be manageable at this stage.

2. **Generate options for dealing with problems (brainstorming)**
   Encourage the patient to suggest as many possible options in dealing with problems as possible, no matter how unlikely or extreme they may seem. Extreme solutions can often lead the patient to unexplored avenues and thus produce other novel solutions. Sometimes a solution that at first seems highly unlikely may, on closer examination, become a potentially valuable one.

   It is important that the patient, rather than the therapist, generates the list to enhance the patient’s ownership of the solution. However, if the patient is not forthcoming with options, it is sometimes useful for the therapist to suggest something outlandish to provoke further thought and discussion.
3. **Examine the pros and cons of each option and then choose the best one**

It may be useful for the patient to give relative weightings to each ‘pro’ and ‘con’ to help clarify the most appropriate option. The therapist may ask the patient to complete this as a homework task, to be reviewed in the following session.

Although the therapist can guide the patient, the final choice must ultimately rest with the patient. Sometimes the patient chooses an option that the therapist disagrees with. This is okay, as long as the patient’s solution is not dangerous to him/herself or others.

4. **Avoid a common mistake in problem solving: giving advice.**

There are a number of problems associated with therapist advice giving. When the solution comes from the therapist, the patient does not “own” it, so confidence in his/her own ability to solve problems is not enhanced. The patient may become reliant on the therapist to solve his/her problems, instead of developing skills to face future problems. And, if the solution fails, the patient may hold the therapist responsible, which could be damaging to the therapeutic relationship.

There is an important difference between giving advice and giving information. It is okay for the therapist to give information that the patient may need to pursue an option (e.g., details of support agencies, etc.).

5. **Rehearse the option in imagination**

Work out in imagination with the patient all the steps required to carry out the chosen option. Predictability gives the patient a sense of control and thus s/he is more likely to carry out the task. The patient may think of possible snags that were not apparent before or identify worries about how their actions may be perceived. Help the patient prepare for these risks by practicing role-plays.

6. **Carry out the option**

Have a contingency management plan—e.g., the patient might agree that if a task is completed within a certain time, s/he will buy something as a reward.
7. **Review what happened**
   Any positive efforts should be praised, even if the results have been disappointing. Difficulties can be used to provide further understanding of the patient’s problems, which can then be used to formulate tasks more likely to succeed. It may become apparent that the initially agreed task was too difficult, and that a smaller step may need to be tried or a new approach to the problem may be necessary.

**REASONS FOR FAILURE**

Low self-esteem/self-confidence can make any task appear daunting and indeed impossible to the patient. Some patients may give up easily. Patient unwillingness to take responsibility for resolution of problems can also be a major reason for failure. The therapist cannot solve problems for patients but rather helps patients find solutions for themself.

The patient may have an underlying psychiatric disorder that was not apparent at the outset or may have become more severe. Psychiatric conditions may need to be properly treated before problem solving can proceed. Some problems reflect long-standing personality difficulties that the patient needs to understand before s/he can attempt to change.

**CRISIS PREVENTION**

The aim is to devise a plan of action if a future crisis occurs, especially to prevent suicide attempts in the context of recurring crisis situations. It is less applicable if a recent crisis occurred in a highly unusual set of circumstances that have now been resolved. Either way, crisis prevention should only occur once the immediate crisis is diffused.

By its nature, crisis prevention has to be a collaborative effort between the patient and therapist. Although people who have recently gotten over a crisis may not be at immediate risk of suicide, it is important to have a plan of action in place to avoid any further crisis situations.
STAGE 1
Explore in detail the exact circumstances which led up to the current crisis—you will probably already have a good idea of this from the assessment. Consider if one of several life problems have contributed to the crisis:

- Was the person already distressed by some other problems, fatigued, overworked, developing a mental health problem?
- Was the person drunk or taking drugs?
- Was a specific person or situation involved?
- Are current problems long standing?
- If the problems are long term, what has kept the person from coping at present?
- Were the person’s usual coping mechanisms available or adequate?
- Was the person already angry or over-aroused? (Arousal and anger at others are associated with an increased likelihood of self-directed aggression.)

STAGE 2
Assess the likelihood that the exact circumstances leading to the crisis will be repeated in the short/medium term (i.e. have the difficulties been resolved?). If the chances are reasonably high, then a specific plan needs to be devised with the person to prevent the subsequent crises to lead to further suicide attempts.

STAGE 3
Help the patient to recognise early warning signs of a crisis. The three systems model provides a useful framework to identify maintaining factors in crisis situations. The three response systems are:

**Autonomic:** What happens to the person physically?

**Cognitive:** What thoughts go through the person’s mind at the time? What does s/he think is happening? What does s/he think might happen?

**Behavioral:** What does the person do at the time? Does s/he
try to avoid the situation or escape from it (e.g. using alcohol)? The patient will need to monitor key situational factors that are likely to cause difficulties (e.g. relationship breakup, job loss).

STAGE 4
Devise alternative coping strategies once the person recognises the crisis and encourage the patient to adopt the problem-solving approach. Help the patient learn to distract him or herself from distress as a way of averting crisis. Encourage the patient to become more involved with other aspects of life, i.e. be with the family more if there is a problem at work, or get involved in hobbies, as a compensatory diversion. Help the patient learn to shift focus by using breathing exercises and relaxation tapes.

Prevent risky behavior, like substance abuse. Drugs and alcohol lead to disinhibition, low mood and careless behavior that could be dangerous and potentially fatal. Look at ways of dealing with alcohol or drug misuse that people tend use to reduce distress. Try to get the patient to agree to have no alcohol in the house, or have someone else take charge of pills, firearms, etc.

Work with the patient to develop a system of support. Patients should not try to handle difficult life events on their own. It is very important that the patient has three alternative sources of support including: family, friends, health professionals, social worker, community volunteers, etc. The therapist should check out with the patient who the support people are, where they are and when they are available.
Reaction Paper for Classes and Training

Video: Suicide and Self-Harm: Helping People at Risk

- **Assignment:** Complete this reaction paper and return it by the date noted by the facilitator.
- **Suggestions for Viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards, or use the questions as a way to approach the discussion. Respond to each question below.
- **Length and Style:** 2-4 pages double-spaced. Be brief and concise. Do NOT provide a full synopsis of the video. This is meant to be a brief reaction paper that you write soon after watching the video—we want your ideas and reactions.

**What to Write:** Respond to the following questions in your reaction paper:

1. **Key points:** What important points did you learn about helping people at risk of suicide or self-harm? What stands out in Gask’s approach?

2. **What I found most helpful:** What was most beneficial to you as a counselor about the model presented? What tools or perspectives did you find helpful and might you use in your own work? What challenged you to think about something in a new way?

3. **What does not make sense:** What principles/techniques/strategies did not make sense to you? Did anything push your buttons or bring about a sense of resistance in you, or just not fit with your own style of working? Explore these questions.

4. **How I would do it differently:** What might you have done differently than the clinicians did in different scenes in the video? Be specific in what different approaches, strategies and techniques you might have applied.

5. **Other Questions/Reactions:** What questions or reactions did you have as you viewed the therapy in the video? Other comments, thoughts or feelings?
Related Websites, Videos, and Further Readings

WEB RESOURCES

Interview with Lisa Firestone on Therapy with Suicidal Patients

www.psychotherapy.net/interview/Lisa_Firestone_Suicide_Interview

Linda Gask’s webpage at the University of Manchester

www.medicine.manchester.ac.uk/staff/lindagask

The Glendon Association: suicide risk research, assessment and treatment

www.glendon.org

The National Institute for Mental Health

www.nimh.nih.gov

The US Department of Health and Human Services, National Strategy for Suicide Prevention

http://mentalhealth.samhsa.gov/SuicidePrevention/

The Suicide Prevention Resource Center

www.sprc.org

The STORM Project at the University of Manchester, School of Medicine

www.medicine.manchester.ac.uk/storm/

RELATED VIDEOS AVAILABLE AT
WWW.PSYCHOTHERAPY.NET

Voices of Suicide: Learning from Those Who Lived

– The Glendon Association

Understanding and Preventing Suicide

– The Glendon Association
BOOKS


Discussion Questions

Professors, training directors and facilitators may use a few or all of these discussion questions to address participants’ personal reactions.

1. **Personal Experience:** What personal experience have you had in dealing with people who have been at risk of self-harm or who have committed suicide? What worries or fears do you have about working with this population? What awareness or learning have you taken away from your past experiences that may be helpful to you in counseling people at risk of suicide?

2. **Counselor Qualities:** What do you notice about the counselors and healthcare workers in these different scenarios? What stands out for you in terms of how they interact with their patients? If you had been one of the patients in the video, do you think any of these counselors would have been effective with you? How so?

3. **Techniques:** What specific interviewing techniques did you observe that impressed you, or that you thought were especially effective? Was there anything a counselor did or said that you found off-putting? What stood out for you in terms of how the counselors adapted different styles in the different scenarios?

4. **Personal Reactions:** Acknowledging your emotional and physiological reactions to this work is an essential step in preparing to be an effective counselor for people in crisis. What reactions did you notice in yourself as you watched these scenes? Describe any feelings, thoughts and/or body sensations you experienced when you imagined yourself as the counselor, or when you played the counselor role in a crisis scene? What have you found that helps you stay calm and focused in these kinds of anxiety-provoking scenarios?

5. **Increasing Effectiveness:** What do you see as your own strengths and challenges in working with patients like these? What do you need to do to increase your own sense of effectiveness in working with patients who present with the potential for suicide? What specific qualities or skills did you observe in the counselors in the video that you would like to develop in yourself?
Complete Transcript of Suicide and Self-Harm: Helping People at Risk

Note to facilitators: Some of the onscreen text is included in this transcript. The rest has been incorporated into the previous sections of this manual, “Some Factors Affecting Risk and Suicide Prevention,” and “The Four-Stage Model of Suicide Prevention.”

INTRODUCTION

Commentary: This videotape is aimed at all front-line health workers who come into contact with potentially suicidal people. This includes general practitioners and practice nurses, accident and emergency staff, prison staff, mental health and social service workers, probation workers, and certain voluntary agency staff, particularly those working with drug and alcohol abuse.

The teaching package has the following aims: to develop a more positive attitude towards potentially suicidal patients, to increase confidence, to develop skills for the assessment of suicide risk, and to help improve your techniques in managing situations in which people are at risk of harming themselves.

Suicide is one of the major causes of death, accounting for 1 percent of all deaths annually. It is rising in young males in the 15- to 35-year age group. Unemployment has a complicated relationship with suicide. Suicide is more common in those under threat of redundancy or who’ve recently lost their job than where there is an expectation of continued unemployment.

It’s more common in those who are socially isolated or who have no particular aims in life, and also in those who’ve been recently separated or bereaved. Ninety-five percent of suicides occur in people suffering from a mental disorder, most typically depression, and alcohol and drugs are also implicated, both in deliberate self-harm and in completed suicide.
Contrary to what is popularly believed, only a minority of people commit suicide without any prior warning. Most have been in contact with helping agencies shortly before the act, putting front-line health workers in a prime position to help prevent suicide. Research indicates that an awareness of risk factors and management strategies can significantly help to reduce the number of suicides.

**MYTH: THERE IS NO WAY OF KNOWING WHO IS GOING TO COMMIT SUICIDE**

This videotape is divided into four sections: assessment; crisis management; problem solving; and crisis prevention. The professionals that you are going to see are played by real health workers. The patients are played by actors. We think it is important that you have opportunities to practice skills in between looking at each of these sections. This tape isn’t designed to be looked at all the way through in one sitting.

In the booklet which accompanies the videotape, there is a more detailed description of the skills. We also think that it is important that you have an opportunity to discuss any personal experiences you’ve had in dealing with people who have been at risk of self-harm or who have committed suicide, at that same time as practicing new management skills.

**ASSESSMENT**

Now let’s look at the skills required in the assessment of patients who may be suicidal. We are going to look at general interviewing skills, the need to clarify current problems, specific questioning about suicidal intent, exploration of the background, and inquiry about symptoms of mental disorder.

There are a number of key general interviewing skills that are required in assessment. We are going to be looking at how an assessment is carried out in three different settings, by a general practitioner, a police surgeon in a police station, and a community psychiatric nurse. You may look at all three of these or select the one which is most appropriate to you and your place of work.

Now let’s look at a GP employing some of the general interviewing skills that we have discussed. The first consultation that we are going to look
at involves a teacher who has gone to see her GP to asking for sleeping tablets.

Barry: What can I do for you?

Teacher: All right, well, I have not been sleeping very well recently and I’ve been under some pressure at work, and I wondered if you would give me some, something to help me sleep. It’s only—I only need, I suppose, about 10 days’ supply. I don’t want a massive amount.

Barry: Can you tell me a little bit why?

Open question
Teacher: Well, yeah, it’s… I don’t know if you know, I’m a teacher, and we’ve got an inspection coming up.

Barry: Right.

Teacher: And I have not been sleeping well.

Barry: It’s very stressful.

Empathic comment
Teacher: Yeah.

Barry: Have you got specific responsibility for it?

Teacher: Well, I know that I’m going to be looked at, yeah, and I’m worried how it’s going to go. So it’s, like, constantly on my mind.

Barry: Really constantly on your mind—is it taking over?

Pick up verbal cue
Teacher: I suppose so, yeah. Yeah.

Barry: How long have you felt like?

Teacher: God. A long time.

Barry: How long?

Teacher: Months and months and months.

Barry: Really? How long have you known about the inspection?

Teacher: Last few, few weeks, about a month.
Barry: So it sounds as though you’re saying that you have had something on your mind long before the inspection was coming up.

Teacher: The job, yeah. Yeah.

Barry: Right. In what way?

Teacher: I don’t think I’m very good at it anymore. And I’m having problems with other members of staff, particularly the head.

Commentary: Barry goes on to uncover a number of problems relating to work and home. She feels that she isn’t coping with school and expresses some negative thoughts about how badly she is coping. She has also got problems in her relationships at home.

Barry: What about you and your husband?

Teacher: We don’t spend much time together really, now.

Barry: You said now, again. Is this all something that has gone on over the last few months or is it longer?

Clarify ambiguities

Teacher: Longer.

Barry: How long do you think, altogether?

Teacher: I don’t know, it seems like ages. A long time. Longer than a few months, I think.

Barry: Right. So there are problems at school. It sounds like things aren’t wonderful at home, as well.

Summarise

Teacher: No, they’re not.

Commentary: Now let’s move on to look at specific questions.

There is no evidence to suggest that asking people about suicide will plant an idea in their mind which wasn’t there before. Most people who have thought about suicide feel relieved to talk about it. Most importantly, you can’t assess suicide without specifically asking about it.

MYTH: ASKING PEOPLE ABOUT SUICIDE WILL INCREASE THE RISK

When determining suicide risk, there are certain key factors that you
need to consider. You need to explore the following: hopelessness; wishes to be dead; specific plans for suicide; measures to prevent detection; factors which might make suicide more likely; and factors which might make suicide less likely.

Let’s rejoin the interview you’ve just watched to see how the general practitioner determines whether the teacher is at risk of suicide. He starts off by assessing hopelessness, which is the single most important predictor of suicide.

Barry: So how have you been feeling?
Teacher: Pretty low.
Barry: Desperate?
Teacher: Yeah.
Barry: Anything to look forward to?
Teacher: No.
Barry: So you can’t tell me how you will feel or what things will be like in a few months’ time?
Teacher: Same as this—worse. It’s not getting any better.
Barry: Then is there anything in your life that lifts that feeling, that alters it?
Teacher: No, not anymore.
Barry: You imply that there was.
Teacher: I used to enjoy lots of things.
Barry: Do you want to tell me what?
Teacher: I used to enjoy going out.

Commentary: At this point, the patient starts to talk about feeling low again. Watch how Barry picks up on this verbal cue and assesses suicide risk.

Barry: How low is low?
Teacher: Really low.
Barry: Desperate?
Teacher: Yeah. Yeah, I am desperate.

Barry: Does that mean that you’ve thought about harming yourself or killing yourself?

Thoughts of suicide
Teacher: Yeah, I’ve thought about it.

Barry: Have you?
Teacher: I don’t think anybody would miss me.

Barry: How long have you been thinking about it?

Fleeting or persistent thoughts?
Teacher: Off and on for a bit now.

Barry: Does it frighten you?
Teacher: Sometimes.

Barry: Have you made any plans?

Specific plans for suicide
Teacher: Yeah.

Barry: You’re smiling about it. How… Is it a detailed plan?
Teacher: I don’t know if it’s detailed or not.

Barry: What were you thinking of doing?
Teacher: Take some tablets—paracetamol.

Barry: Is that where the sleeping tablets came into it?
Teacher: I wasn’t sure how many… how many paracetamol to take, really. I mean, I don’t know how many—how many does it take to, to work?

Barry: Difficult to say, isn’t it? They do an awful lot of damage before they work. When were you going to do it?

Teacher: Quite soon if this—if this inspection doesn’t—if it goes how I think it will go.

Barry: So when is the inspection due—when are they arriving?
**Teacher:** End of the week.

**Barry:** Right. And what if the inspection went okay?

**Factors which make suicide less likely**

**Teacher:** I don’t think it will. But I expect I’ll not do it, then.

**Barry:** Right. So you really think this is going to be a major crisis, this inspection, and that would push you over?

**Teacher:** I know the head wants to get—I know he wants to get shot of me. It’s the only way he can do it, really.

**Barry:** Does the family know? Does your—is your husband aware of how you are feeling?

**Teacher:** Oh, God, no. No. I don’t talk to him, really, about stuff now. Used to. He’s sick of hearing me moaning.

**Barry:** So what was going to happen in this plan? How were you going to avoid him being involved?

**Measures to prevent detection**

**Teacher:** Oh, he’s—he goes away quite a bit doing—you know, climbing with kids and stuff. They’ve got a thing on this weekend. And my son will be at his mates.’ He practically lives there anyway.

**Barry:** So you’re spending quite a bit of time on your own and that would be an opportunity.

**Teacher:** Yeah. They won’t miss me.

**Barry:** What about your friends, people around you otherwise?

**Teacher:** How do you mean?

**Barry:** Well, they’ve—obviously your husband is involved in a lot of activities. Have you got friends of your own that you’re involved with when he is away or out?

**Teacher:** No. I’ve got friends, but I’m not seeing much of them.

**Commentary:** Ninety-five percent of suicides occur in people suffering from a mental disorder, most typically depression, and it is important to try and distinguish depression from sadness. When people are depressed,
they experience a number of different symptoms which affect their functioning and ability to cope with everyday life.

The key symptoms they experience are loss of interest or pleasure, which should have gone on for at least two weeks, plus, at least three of the following: alteration in sleep pattern; change in appetite; reduced energy or motivation—a feeling that they just don’t have the same go; poor concentration; either being restless or agitated, or the opposite, feeling very slowed up; feelings of guilt or worthlessness; and thoughts of death, which may be suicidal thoughts.

It’s important to say, as well, that depressed people can also have symptoms of anxiety, and in severe depression, people can become deluded and actually have beliefs of guilt or worthlessness and have hallucinations, such as voices actually telling them to harm themselves.

Now let’s look at a different interview set in the police station, involving a young man with multiple social and interpersonal problems who’s just been arrested for fighting. We join the interview at the point where the police surgeon explores mood, depression, and suicide risk.

**Police Surgeon:** The police are actually quite concerned—I’ll, you know, lay full cards on the table. The police are quite concerned that they thought you were quite down and you were quite depressed. What do you say about that?

**Patient:** Yeah. Yeah, I would say I was.

**Police Surgeon:** So how long have you been feeling like that?

**Patient:** Well, me and my girlfriend have been, like, rowing for a few weeks. We’ve just been building up, and like just eventually had a big row. She says I’m too jealous.

**Police Surgeon:** Really? Why is that?

**Patient:** Well, it’s what she says.

**Police Surgeon:** Well, do you think you are?

**Patient:** Maybe, yeah.

**Police Surgeon:** Has that affected the things between you at all?

**Patient:** Yeah.
**Police Surgeon:** In what way?

**Patient:** It just causes a lot of arguments.

**Police Surgeon:** You said things have been going on over a few weeks, things have gradually been building up and winding you up. Has there been any other way in which they’ve been affecting you?

**Patient:** No.

**Police Surgeon:** Because very often when people feel down or fed up, low, hassled, stressed or whatever, there is a number of things which keep coming back to them or keep bothering them. Any particular thoughts or problems keep coming back to bother you? Nothing you feel particularly worried about or guilty about, or…? No? Okay. I’m going to ask you a whole series of questions here, okay? Some of them sound daft, but just humor me because we’ve more or less got to go through the whole thing for this. Okay? Now, what’s your appetite been like?

**Explores worries**

**Patient:** Fine.

**Police Surgeon:** No different? You sleeping okay?

**Patient:** Some nights, not always.

**Police Surgeon:** Do you do anything to help you get to sleep? No?

**Symptoms of depression**

**Patient:** No.

**Police Surgeon:** You don’t tend to drink a lot to get you to sleep or take any tablets to get you to sleep?

**Patient:** No.

**Police Surgeon:** When you get to sleep, can you stay asleep?

**Patient:** I don’t know. I’m quite a light sleeper anyway.

**Police Surgeon:** When was the last time you actually enjoyed doing anything?

**Patient:** I can’t remember.
Police Surgeon: Really? What do you do to relax? What winds you down?

Patient: Watch telly.

Police Surgeon: Anything else? No? Have you ever actually thought about harming yourself in any way?

Explores suicidal ideation

People often do when they are feeling down. People often feel like hurting themselves, taking tablets. Some people even contemplate killing themselves. Have you ever thought about that?

Patient: Yeah.

Police Surgeon: Really? How long have you been thinking about it?

Asks about specific plans

Patient: Not long.

Police Surgeon: No? And what’s brought that on, do you think? It’s okay. Often if we talk about it, okay, get it out into the open, it’s sometimes easier to look at it. Because when you have these feelings, sometimes they don’t seem that logical, they don’t seem that rational, but they do tend to come to you. Have you actually thought about what you would do?

Patient: Yeah.

Police Surgeon: How would you do it, then?

Patient: You know, probably like jump off a bridge or something.

Police Surgeon: Gosh, awful. Have you done anything, you know, to, like been on bridges or gone near them or anything like that?

Patient: Yeah.

Police Surgeon: Which bridge would you use?

Explores degree of risk

Police Surgeon: It’s okay. Things have obviously reached a fairly awful stage for you, if you’re actually thinking about doing this. What do you actually think about the future? How would you actually see
things going for you?

Explores view of future

**Patient**: Nowhere, you know.

**Police Surgeon**: Why is that?

**Patient**: I’ve got nothing to look forward to.

**Police Surgeon**: Nothing at all? What would make you more likely to harm yourself or to kill yourself?

**Trigger factors**

**Patient**: If my girlfriend didn’t want me back. There’d be no point in living.

**Police Surgeon**: Certainly one thing. But if you got some help and support, you think that would—that would make you feel better, would it? It’s just that what you are telling me is that things have got to such a bad stage that you can’t see anyway forward. What—you’re 18, is it?

**Commentary**: Sometimes—for example, in cases of enduring mental illness—suicide risk may be ongoing. In the next excerpt, Robby, who is a community psychiatric nurse, assesses a patient who has been referred to the mental health services by his general practitioner. Nigel is hearing voices telling him to kill himself.

**Robby**: Your GP asked you to come through and see me. You’d gone to him because you had headaches, but he was obviously a bit worried about you and he asked me to come through.

**Nigel**: Yeah.

**Robby**: What was happening?

**Nigel**: Well, I’ve been having dreadful headaches, and just make me feel terrible, really. And, you know, I went to him to try and find if he could find some way of stopping it.

**Robby**: What have you tried yourself before you came to your GP?
Past coping attempts

**Nigel:** Well, I’ve tried taking tablets from the chemist—paracetamol, some of it was called Co-codamol.

**Robby:** Ah, you have tried the usual things and they haven’t worked.

**Nigel:** They won’t work, they won’t.

**Robby:** What happened when you saw the GP? He was obviously worried about you or thought something was unusual, which is why he asked me to see you.

**Nigel:** Yeah, well, I suppose it’s, I told him that I thought the headaches were due to people, people that are after me. They’re causing my headaches. He then kind of talked to me a bit about the people that are after me and suggested I come and see you.

**Robby:** Right, right. Who is after you?

Clarify current problems

**Nigel:** It’s Secret Service, KGB. I think it’s them that are making my head ache, I’m sure it is; sure.

**Robby:** I’m not sure that I really understand. Why would the KGB be after you?

**Nigel:** Well, years ago, my brother and me, we used to putter around and we discovered something that the KGB wanted.

**Robby:** What was that?

**Nigel:** They still want it. They’re still after me for it.

**Robby:** So sounds like it’s been going on for quite a long time now, yeah?

Duration of problem

**Nigel:** Yeah.

**Commentary:** Nigel explains that for about 15 years, on and off, he’s been experiencing the sensation that people are following him and talking about him. He believes people watch him and signal to each other using their car horns. He goes on to describe hearing a voice.
Nigel: And I hear, hear this man talking.

Robby: What does he say, do you know? Can you hear it distinctly?

Nigel: He says things like, “We’re going to get you, we’re going to get what you’ve got. We won’t let go, if you don’t, we’ll kill you. We’re going to kill you.” And recently it’s got that, “We’re going,” you know, “we’re going to kill you for not giving us these things.”

Robby: So part of it… Well, it seems to be getting worse recently.

Nigel: Yeah, they’re now saying they’re just going to kill me, whereas before they used to say, “We’ll get it off you, we’ll get that trigger off you.”

Robby: Right, and that sounds quite frightening. I’m wondering how it makes you feel.

Demonstrates empathy & checks mood

Nigel: It makes me feel terrible. The last couple of weeks they’ve been—they’ve been saying, well, you know, “We’re going to get you, you might as well do it yourself. We’re going to get you.” And saying, “We’re going to hang you; you might as well hang yourself.”

Robby: I’m not quite sure how to put it. Did he say it strongly enough to make you think that that maybe you should carry it out? Is it that frightening?

Explores severity of symptoms

Nigel: Yeah, yeah, it is that frightening. I’m—when I’m by myself, it just happens all the time, and I even when, you know, I’m out sometimes. I’ll be going down the road and it’s, “We can see you, go and do it, kill yourself.”

Robby: Right. So it’s worse if you’re by yourself?

Nigel: Yeah.

Robby: It’s almost constant then?

Nigel: Almost, yeah. I’ll try and watch telly and I just can’t concentrate; it happens then.

Robby: Is there anything that gives you relief from it or you can
distract yourself?

Factors which lessen symptoms

**Nigel:** When I’m with friends, it’s not too bad then.

**Robby:** What changes?

**Nigel:** I don’t hear the voices and I still feel that people are watching me and I still hear the pips and I think that’s them and... but I don’t hear the voices so much. I suppose it’s a little—I don’t know why, but when someone’s talking to me and I’m, you know, we’re in conversation, I just don’t hear the voices.

**Robby:** Right, so company makes it better?

**Nigel:** Yeah, yeah, company makes it better.

**Robby:** What I’m still not really sure about is, what distresses you most: the voices saying the bad things or the belief that you, you might have to act out yourself—that you might have to carry it out?

**Nigel:** Yeah, I feel, at times when it gets really bad, I feel that I should go and do it and then that’ll—that will shut them up. I won’t have to do it—listen to it anymore.

**Robby:** Right. Has it ever gotten to the stage where you thought “I must go and do it now; I can’t take anymore”? Has that happened?

**Nigel:** I’ve got a rope. I’ve kind of been thinking, “Where shall I put it, should I tie it?” When I’m in my room by myself, I’m thinking, “I’ll tie it around, the curtain rail and do it there,” but then I think, “No, that’s not going to hold me.”

**Robby:** So you are beginning to have some kind of plan. Is there a bit of you that ever wanted just fight against that?

Specific plans

**Nigel:** Yeah, now, now, and again, I kind of think that some day, “I’m not doing what you said. I’ve had—you know, you’ve been at me 15 years and I’ve gone through it that long, I’m not—I’m not going to listen to you.” But there again, it gets so bad sometimes, I can’t sleep. I think it’s like a combination of them saying, “Go on, you might as well kill yourself, go on, do it now,” and the not being able to sleep and
wanting to get rid of it.

**Robby:** Are you more at risk at night when you’re on your own, then?

**Factors which increase risk**

**Nigel:** Yeah, yeah, definitely—it’s definitely worse at night. Because there is no one around then, I’m in the flat, you know, and you can’t kind of bang on your friends’ doors at three o’clock in the morning.

**Robby:** When you’ve thought about harming yourself, has it been an impulsive thing—“I’ve got to go and do this because I’m really upset”—or has it been more of a planned thing—“This would be a good time, this would be a good place”?

**Degree of planning**

**Nigel:** I haven’t really thought—it’s just, it builds up and builds up throughout the night and it gets worse and worse. And I’ve got a rope, but it’s more because I can’t stand it any longer. And I’m frightened that I’m going to do it one night. And it’s all right today while I’m with you—I don’t want to do it. But at night when it’s happening...

**Commentary:** It transpires that Nigel has been in contact with the services before. Robby goes on to assess whether Nigel has made any previous suicide attempts.

**Robby:** Can I just ask, Nigel, you mentioned that this has been going on for a long time, and there was the episode with the rope where you’d thought about hanging yourself. Have you ever done anything in the past when things have been that desperate?

**Previous attempts**

**Nigel:** Yeah, I took an overdose before, when…

**Robby:** When?

**Nigel:** That’s before I last went into the hospital.

**Robby:** What happened then?

**Nigel:** It—well—they were, people were following me. It just got so unbearable. I thought that people were watching me all the time and this voice was saying, “We’ll, we’ll get that secret, we’ll get it off you.”
I couldn’t stand it, so I had some anti-depressants from the GP and I took them all.

**Robby:** Right. At that point, again, was it something that you did on impulse or had you planned to take them at a certain time? What happened?

**Commentary:** Some people use self-harm as a coping strategy with no plans to actually kill themselves. However, the risk of suicide following a suicide attempt is a hundred times that of the general population, so you should be aware of the factors associated with suicide after an incident of deliberate self-harm.

**MYTH: PEOPLE WHO SELF HARM ARE JUST ATTENTION SEEKING AND ARE NOT AT RISK**

_The factors associated with suicide risk after self-harm or attempted suicide are as follows:_

You should be particularly wary of the high suicide risk in people who make a number of suicide attempts with increasing frequency and increasing seriousness. Find out about the antecedents of the attempt; explore the attempt itself; and make sure that you try and assess the person’s mental state.

Pause the tape after this and every section of this videotape, and practice asking about suicidal risks and the symptoms of major depression. Remember to try and use the general interviewing skills that we described earlier.

**CRISIS MANAGEMENT**

_The next section of this videotape goes on to examine the concept of crisis management. This automatically follows on from assessment, and the two may take place together._

_The aims of crisis management are to calm the patient down and reduce the immediate risk of suicide, to try and enhance hope and confidence, and improve effectiveness in tackling problems, and to arrange treatment of mental disorder. There are some particular techniques, some of which we will demonstrate to you in the forthcoming sections._
Let’s go on to look at some of these in the next few interviews. First, let’s look at the interview you saw earlier with the General Practitioner, Barry, and the teacher. It’s Friday afternoon and the school inspection went as bad as she had expected. The weekend has already been identified as a crucial time. Furthermore, the teacher is convinced that her husband won’t cancel his weekend trip. Watch how Barry tries to ensure his patient’s safety.

**Barry:** If he can’t or won’t, is there anyone else?

**Assesses availability of support**

**Teacher:** I’ve got a sister. I’ve got, I’ve got two sisters.

**Barry:** Are they local? Do they live locally?

**Teacher:** Sue does, yeah. But she won’t want to come around. She’s busy.

**Barry:** Does she have any idea how you’re feeling?

**Teacher:** A bit, yeah, not, not really, no. She knows I’m having problems at school, but she doesn’t know how I really feel. She’s been going on at me about my mom, about me not going to see my mom during the week. I can’t. I can hardly cope with seeing her weekends. She wants me to go and see her in the week and she said she does. I live closer. She just—

**Barry:** Would you want Sue to be there with you?

**Teacher:** No. Not if it’s about my mom, and how I never come around. She knows what a failure I am.

**Barry:** Is she the sort of person that could help?

**Assesses appropriateness of support**

**Teacher:** No, I don’t think so. She’s, she’s tried to help in the past. She says, “Sort yourself out,” you know, “pull yourself together.”

**Barry:** Do you normally go around to see your mom at the weekends?

**Teacher:** Yeah.

**Barry:** Do you talk to her much?
Teacher: No. I talk to my other sister more, but she doesn’t—she doesn’t live close. She lives in Yorkshire.

Barry: So you phone her regularly?
Teacher: No, not regularly. I phone her when I am desperate sometimes, for somebody to talk to. I haven’t phoned her for ages.

Barry: Were you going to see your mom this weekend?
Teacher: I was going to go tomorrow morning.

Barry: And would Sue be there normally when you go around?
Teacher: No, no. I was going to go to say, say goodbye to my mom.

Barry: Are you still going to do that? And what would stop you? What would help you carry on a bit longer?
Teacher: I wish my other sister lived closer. Janet.

Barry: Got a good relationship with Janet?
Teacher: Well, all I ever do is phone her up. All I seem to do these days is just phone her up and moan.

Barry: Has she complained about that?
Teacher: No.

Barry: Do you find it’s a help talking to Janet?
Teacher: I just don’t like to keep doing it.

Barry: No.
Teacher: She’s got her own life and family. She doesn’t need me messing it up.

Barry: But you need her at the moment.
Teacher: I wish she was here.

Barry: Could she come?
Teacher: I don’t know. I’d like to see her, though. I would like to see her. She doesn’t moan at me, she doesn’t nag me.

Barry: A good person to have around.
Teacher: I’ve not seen her for ages, just occasionally talk to her.
Barry: Right. Maybe she hasn’t—has she not seen your mom for a while, either?
Teacher: No. Sue doesn’t go into her, though. I mean, she lives—she’s got young children.
Barry: Janet has?
Teacher: And the job, you know, is—got a lot.
Barry: But if for any reason your mom was seriously ill or someone else was seriously...
Teacher: Oh, she would come over then, yeah.
Barry: Don’t you think this is being seriously ill?
Teacher: I think I’d prefer to be seriously ill. This is worse.
Barry: Because someone can do something about it when you are seriously ill, or can try. I think what I am saying is that we can try and do something about this.

Improves hopefulness
Barry: And the first thing we can try is to have someone with you that you can rely on, that you can trust, that you want to be with. And maybe just get rid of the tablets that you were planning to kill yourself with, so it’s not there, available. Did you bring them with you?

Removal of lethal means
Teacher: No.
Barry: Can I make a suggestion? That I come around after surgery tonight when I’ve finished and speak to your husband before he goes away, so that...

Providing immediate support
Teacher: No, He won’t be there anyway, later. He’s going out.
Barry: What time is he going, do you know?
Teacher: About half-seven.
Barry: Okay, well, I’ll try and be there before then. Tell him I’m coming.
Commentary: In a crisis, it may be necessary to take control of the situation in order to ensure that the person gets appropriate care. In the next scenario, watch how a casualty sister takes control and employs distraction in order to ensure that a patient stays in the department to see the duty psychiatrist.

Casualty Nurse: I believe you’re not happy about waiting.

Patient: No, I’ve been here—I’ve been here an hour now.

Casualty Nurse: I know you have. I’m really sorry about that. The psychiatrist has been up on the ward seeing our patients, but I’ve just spoken to him.

Patient: Psychiatrist, I don’t need a psychiatrist.

Casualty Nurse: Well, the psychiatrist is just here to have a chat with you.

Patient: I’m not daft.

Casualty Nurse: We’re not saying that you are, but he’s here to have a chat with you and to see if he can help you.

Patient: I want—I don’t want—I don’t want to see a psychiatrist. I don’t, I don’t—I thought you could help me. I don’t—I don’t want to see a psychiatrist.

Casualty Nurse: What are you frightened of?

Clarification

Patient: I just don’t know. Fellows in white coats, and you know, straight jackets and that.

Casualty Nurse: The psychiatrist is just a doctor. He’s here to have a chat with you about your problems, like I have done already and like the casualty doctor has done. You’ve come this far.

Patient: I don’t—I don’t think he’d be any good to me, I don’t think he’d be any good at all. It was stupid coming here in the first place, I mean.

Casualty Nurse: You’ve made it this far. You are obviously very frightened about what happened before to bring you to casualty. You
can just wait a little bit longer.

Empathic comment

Patient: It’s not going to be any good. It’s daft.

Casualty Nurse: It is, you have come this far. You have been positive. You’ve come to casualty today. Do you want to tell me a bit about your daughter? What is her name?

Patient: She’s called Louise.

Casualty Nurse: Louise. You seem very proud of her. She’s at university?

Patient: Yeah, she went off a couple years ago, you know how she is.

Casualty Nurse: How old is she?

Patient: She’s 20.

Casualty Nurse: Which university does she go to?

Patient: She’s up at Hall.

Casualty Nurse: And what is she studying?

Patient: She’s doing English Lit.

Casualty Nurse: Does she graduate soon?

Patient: She is only—she is only in the first year yet, so I don’t want to bother her. I don’t want to, you know, she’s proud of... my wife would have been proud of her now.

Casualty Nurse: I’m sure she would.

Commentary: Now let’s go back to the scenario involving Nigel, the man who is experiencing psychotic symptoms. Having identified a suicide risk, Robby tries to ensure his client’s safety.

Robby: If I can just summarize it that you are distressed by all of this. Sometimes driven to do something—sometimes driven to think about hanging yourself because it gets so bad.

Summarises

Nigel: Yeah.
Robby: Yeah, but there’s a small bit of you that can still fight against it because it has been going on for so long.

Nigel: Yeah, I don’t want to kill myself, but at night, like I say—I’ve tried putting up the rope and then I’ve thought, “No, that won’t hold me.” And I suppose the delay in that kind of thing has stopped me doing, you know. I’ve thought about, perhaps I need to go out and find a tree or something like that.

Robby: Right, I’m wondering if we could go the other way and think about how we might make the situation safer, where we could actually a) make it more bearable and then b) take away some of the immediate risks for you. Yeah, I guess the first thing is, it would be helpful to get rid of the rope.

Removal of lethal means

Nigel: Yeah, yeah.

Robby: Yeah? And beyond that, I think we need to look at other things. It sounds like—it sounds like the thoughts you are having might respond to medication. Maybe your GP can look at something else that could give you some relief. Sounds like the Largactil dampens things down a bit, but—

Improves hopefulness

Nigel: It does when I take it day after day after day after day.

Robby: But because of the side effects…

Nigel: Must be something better.

Robby: Yeah, sure, sure. So short term, we can look at things like getting rid of the rope, yeah? So we could go and deal with that, well, as soon as this finishes, really, when you leave here.

Ensures immediate safety

Nigel: You’re coming?

Robby: Well, I would come home with you, if that’s okay, and actually take it away, I think, yeah.

Nigel: Yeah, yeah.
Robby: I mean, it would help—it would be helpful if, I think, if we looked to other things to distract you. I mean, are there people that you could, like, phone at night until the medication kicks in? Are there friends, have you got family, are there other supports around?

Use of support network

Nigel: I’ve got—there’s my brother. He lives—although I don’t, he’s got a family. Yeah, there’s my brother and a couple of friends.

Robby: And again, I think, I’m talking very much about a short-term crisis here. So it wouldn’t be reasonable to expect your brother to support you through phone calls week after week, but over the next few days. Can we get a plan that would help support you there, and who could we use? So there is your brother, some friends?

Nigel: I’ve got a good friend who I have phoned up now and again. I feel it’s a big commitment for him, it’s a lot for him. I suppose on short term. I do feel better when I’m talking to someone.

Robby: Right, that’s the thing that comes through—that if you have company or if you are engaged somehow, that you are more relaxed.

Nigel: Yeah.

Robby: And then longer term.

Nigel: It’s almost like they protect me in some way. The voice won’t say anything while someone else is around, in case they hear.

Robby: Longer term, perhaps, look at, look at things like more suitable medication that you can tolerate okay.

Nigel: Yeah, if it don’t—because I felt dreadful when I was taking it before.

Robby: Are you happy enough to leave it at that just now and we can maybe go and have a word with your GP and just let him know what’s happening?

Nigel: Yeah.

Commentary: Family and friends can offer better support than professionals if they are available and empathic. It’s important to clarify with the patient who is going to be the most effective kind of support and
who is best able to provide it. Teenagers and immature people become distressed by being with suicidal patients, and parents may be too overprotective or judgmental. It’s important that friends and family are informed of the risks and what to do if the situation actually gets worse.

This next interview involves Don, a drugs counselor, and Jillian, a heroin user, who has recently been sacked from her job for stealing. She is having serious problems with her boyfriend, who is also a drug user and is now expressing the view that life isn’t worth going on with. Watch how Don assesses appropriate support.

**Don:** Before we go any further, I know that you say that there are very few people in your life that you can rely on or confide in, but I think it is very important that we find somebody that can offer you support through this.

**Jillian:** No, I’ve got mates, really. I just don’t know how, you know, how… not reliable, but you know, how they would be about it. I don’t know.

**Don:** What about the family?

**Explores available support**

**Jillian:** My mom would hit the roof, I think. She doesn’t know, you know, I mean.

**Don:** So you reckon she’d go—she’d go wild if she, if you told her?

**Jillian:** She would come around and start cleaning up and telling me what to do and stuff. I mean, I tried to have—I’ve got a couple of mates who might—what do you mean help me, anyway?

**Don:** I think at the moment you are feeling quite depressed and that depression isn’t going to go away just because you are in the detox. I think you are going to feel, at times, that you need somebody around just to say how you feel. Somebody, maybe, to look out for you when you’re not feeling very good. And I think there will be times when you want to go and get heroin, as well. And it’s useful, I think it’s useful to have somebody about who can help you deal with those things. You say you’ve got a couple of mates; tell me a little bit about them.

**Jillian:** Well, there’s Allison at work, when I did work there. And I’ve
got a couple of mates that I still—I still see. I know people who take heroin, but they won’t be any good, will they?

**Don:** No, I don’t think so, not in this case.

**Jillian:** I don’t know.

**Don:** Tell me about Allison. Why would she be a good person?

**Jillian:** Well, she’s—she’s not dead straight, if you know what I mean, but she’s—she’s nice. And I don’t know if she’d—yeah, she’s… I just don’t like imposing like, like that, but I think she would be all right. It’s just, it will be a pain for her, won’t it, coming around, listening to me moaning on. But we did get on really well. I mean, I’ve known her for… Did get on. It’s just that I haven’t been in to work, but I’ve known her for a couple of years.

**Commentary:** In some situations, referral to another agency may be required to ensure safety. For example, in the cases of serious mental illness, such as schizophrenia, it is important that the psychotic symptoms are treated by an appropriate health professional. Let’s rejoin the interview with Robby and Nigel. The voices are worse and Nigel is now a fairly high suicide risk.

**Robby:** That’s, what, three days since I last saw you, now. I’m just wondering how things are going?

**Nigel:** Not, not very well. The voices have got worse and I’ve been taking the tablets, but they’re still there and I just feel tired as well, now. I’m still awake at nights, and the voice is getting worse. I’m hearing it more.

**Robby:** Have you tried to harm yourself again since?

**Attempts at self-harm**

**Nigel:** I haven’t… I’ve got another rope. I put it up on the curtain rail again, but I’m beginning to think that perhaps I’ve got to go somewhere else, make sure I do it properly so it won’t do that, it won’t pull things down and that, where I can hang myself.

**Suicidal thoughts/plans**

**Robby:** So you’re actually giving a fair bit of thought to how you might
do it successfully, if “successful” is the right word.

**Nigel:** Yeah, yeah, yeah. I feel that when I—especially at night, but it’s happening as well during the day. The feeling that people are following me, as well, is getting worse and I’m tending to stay in. And the voices are getting—they’re just saying, “Kill yourself, hang yourself, go on, you’re no use to us anymore, hang yourself.” They’re just getting worse.

**Robby:** It sounds like things are so distressing now, it’s virtually impossible to keep you safe where you are, and I really think that you need to see one of my colleagues. There is a consultant psychiatrist I work with in the health center here. I think it would be really helpful if you saw her.

Negotiates referral to psychiatrist

**Nigel:** A psychiatrist, you say.

**Robby:** I know you find… Sorry.

**Nigel:** Does that mean go into a hospital?

**Robby:** It may mean going into a hospital. I wouldn’t like to second-guess what—what she will say, but between yourself, the GP, myself, your friends and family, we’ve tried to make things better, but it sounds like things are still—they’re getting worse. And it sounds like you are becoming more desperate. Is that fair?

**Nigel:** Yeah, I am. You know, I don’t really know what to do now. I was—I was just holding onto things, I suppose. I don’t know whether I can anymore.

**Robby:** And I think when things get that desperate you really need some specialist help.

**Nigel:** And she would see me here?

**Robby:** Yeah, yeah.

**Nigel:** Yeah. When?

**Robby:** If you agreed, I would try and get hold of her immediately. We could go up and see her. Either we could go and see her or she could come down to the health center here. As quickly as possible, really, I
think, because it sounds like things are quite desperate.

**Nigel:** Yeah, I prefer to see her here. I’m not very fond of—well, I know here.

**Robby:** Are you happy enough if I start that referral process then, yeah?

**Nigel:** Yeah.

**Commentary:** In the final scenario in this section, Susanne, a community psychiatric nurse, is working with a female client who has got recurring thoughts of harming herself. Watch how she attempts to challenge hopelessness and generate hopefulness in her client. She particularly tries to challenge the dichotomous nature of her thinking and help her to look for alternatives to suicide.

**Susanne:** I wondered if we could go back a little bit and maybe talk a little bit more about—you were talking before about having ideas about harming yourself and having thought of ways in which—in which you could do that. Does that—does that feel like it’s the only solution at the minute?

**Explores alternatives**

**Patient:** I can’t think of anything else, yeah.

**Susanne:** But there were also things that you said that suggested that there were reasons for staying alive, as well. I wonder if we could talk a little bit more about them. You talked about your mom.

**Final nature of suicide**

**Patient:** She’ll be all right. I just wanted to know that she was all right, really, but I don’t think she would miss me an awful lot. And she would be—I mean, if she, if she knew the mess I was in anyway, that would really—I don’t know, it would really hurt her.

**Susanne:** Because, I mean, I guess the thing that strikes me about it is that it’s a very, it’s a very final solution. It is a very, a very big thing to decide and I wonder if maybe—because it sounds like, in a sense, that all these things have happened to you. All these things have, in a sense, spun out of your control, and that can feel very overwhelming. And
I think in situations like that, it is possible for people to think, “Well, the only, the only way out is to end my life.” But I wonder if you have thought of that first, I wonder if maybe it has been so overwhelming that you haven’t thought of other possible things to explore as ways of trying to get it back under control.

**Patient:** There aren’t any. There aren’t any.

**Susanne:** What have you thought of?

**Patient:** Well, I haven’t, because I can’t—I can’t—I can’t think of anything that is going to sort it out. I can’t think of how I’m going to pay off all these things. Steve’s gone, I can’t think of about how I’ll ever work again. I can’t and I know I—I know I do it myself, I know, I can’t—you know, that I just drink more and I know it doesn’t help, but I can’t see how I’ll ever stop doing that. And I can’t think of how I am just going to get through it all. There isn’t, there isn’t anything.

**Susanne:** I mean, I guess, in a sense, you are right because you are thinking of a lot of problems all at the same time and it’s almost like—it’s, “I’ve lost my job, Steve has left me, my drinking, my debts, I might lose my home, my mother.” So it’s a lot of problems all lumped together. I wonder if it might be more helpful to, I don’t know, maybe try and separate them out a little. So it sounds like you are trying to deal with everything all at the same time and that is pretty difficult.

**More realistic perspective of problems**

**Patient:** It’s impossible. Yeah.

**Susanne:** Yeah, that is pretty hard.

**Empathic statement**

**PROBLEM SOLVING**

**Commentary:** In this next section, Problem Solving, we are going to look at problem solving as a means to actually help patients to identify problems as a source of their distress, to identify their psychosocial resources, to provide them with a framework to think through problems logically, and to enhance their control over current and future problems.

Problem solving is easily learned and has a wide application for many
psychiatric disorders. It can be used in addition to medication, it is popular with patients, and it’s more accurate, as patients actually generate their own solutions. It is also less stressful for health professionals than them feeling that they always have to come up with all the answers to patients’ problems.

In terms of assessing suitability for problem solving, the patient’s problems need to be able to be specified. Their goals must be realistic and there must be absence of severe acute psychiatric illness. The patient must no longer be in a crisis situation—in other words, acutely suicidal—and must be able to take some responsibility for themselves.

We’re going to take you through the steps in problem solving. First of all, you have to decide which problem to tackle first; then generate options for dealing with the problem—we call this brainstorming; then examine the pros and cons of each option; get the patient to choose the best option and then to rehearse the option in imagination before carrying out the option; then review what has happened. The crucial task is to get the patient to do the work.

You saw this patient when she was acutely suicidal. At this point in time, the woman, who is a schoolteacher, is having problems with the care of her mother. She’s having difficulties looking after her mother because of schoolwork, but her sister is unwilling to be involved in the care. She’s going to work through this particular problem with one of her general practitioner’s partners.

General Practitioner: You were telling me that—that you are already visiting your mother at weekends, and your sister visits her during the week.

Teacher: Yeah.

General Practitioner: But that you feel that, as a good daughter, you should in fact be doing more for your mother than you already are, and that your sister, in fact, is putting some pressure on you to do this.

Teacher: Yeah.

General Practitioner: Is that a fair summary?

Teacher: I think it is, yeah.
General Practitioner: Right.

Teacher: I mean, I am actually closer, you know, I live closer than my sister, really, so I do feel like I should be, you know, sort of helping out during the week, really.

General Practitioner: So you really feel under some pressure that you should be doing more. Right. What do you see as possible options for dealing with this problem?

Considers options

Teacher: Well, I have explained to her that I need to do schoolwork at nights, and it’s finding time, really, to go to my mom’s.

General Practitioner: Right, explain to who?

Teacher: My sister.

General Practitioner: To your sister, right. So one option is what you have already tried, in fact, such as explaining to her your situation. What other options can you see to help you resolve this problem?

Commentary: Two options emerge: making time to visit her mother on weekdays, or talking to her sister and explaining that this just isn’t possible because of her schoolwork. The doctor and patient here begin to explore the advantages and disadvantages of each option.

General Practitioner: And shall we start with the option of you going once or twice during the week, as well as the weekends? And I think we should look at the advantages and the disadvantage of each. Can you see advantages of doing that, for you?

Advantages

Teacher: Well, yeah, I mean, Sue will get off my back then.

General Practitioner: Right, Sue will get off your back. Any other advantages?

Teacher: I suppose my mom would be pleased to see me. Although, I mean just—she really just sort of moans whenever you go, anyway. You know, she doesn’t sort of—she doesn’t seem to appreciate that—what you’re doing anyway. I suppose that is old age.
General Practitioner: She doesn’t?

Teacher: No.

General Practitioner: Right. Okay. So you doing—the option of you going during the week as well as the weekends, you feel that it would get Sue off your back, as you put it, that although your mother might not show much sign of it, she might appreciate you going more. Now, let’s look at the disadvantages you doing that.

Disadvantages

Teacher: Is try to fit it in, you know, with what I am doing.

General Practitioner: Is trying to fit it in with the rest of your life.

Commentary: They reach agreement that talking to her sister is the favored option. Goals are then clarified.

General Practitioner: So, really, what you’d be hoping to achieve when you talk with your sister is that she would agree to the situation, that she would stop putting pressure on you—and also that you should come to an agreement about who is going to visit when, presumably. And would you be aiming to keep it as it is now?

Clarifies goals

Teacher: I think so, yeah.

General Practitioner: You think so, right.

Teacher: I’d prefer it to be.

General Practitioner: Yes, okay. So that is the—that is the two—the goals, if you like, of what, of the option that we have chosen. Right.

Work out steps

Now I think what we should do is look at the steps that we are going to need to go through or that you are going to need to go through, hopefully, to achieve that goal. And to look at some of the difficulties that might arise and how you might resolve those difficulties. What are the steps, in fact, that you will need to go through to get there?

Teacher: I need to phone her, I suppose, and arrange to meet her. Perhaps I’ll ask her up to the house or meet her.
General Practitioner: Either meet her or ask her up to the house, right.

Commentary: *It can be very helpful to work through the worst-case scenario.*

General Practitioner: Can you see what might be the worse possible response you will get from your sister? I think we should perhaps work through that.

Teacher: I think that the worse thing that, would be that she—that she’ll say that she’s done enough and she won’t—she will just say she’s not going up there. I think she will blame that on me, you know, she will say to my mom that she is not going up because of me. So my mom will blame me, then, for it.

General Practitioner: Right.

Teacher: You know, she will say that I’ve caused this row and then my mom will say that—she’ll say that she is on her own all week because of what I’ve done. And you know, I think I’ll just get—and I don’t know what I could do about that.

Commentary: *Now watch the first part of this excerpt from an interview and consider how you could set about problem solving with Jillian, the heroin user you saw earlier. Don sets out by defining that her current main problem, now her heroin use is being addressed, is her relationship with her boyfriend.*

Jillian: He takes smack as well, you see, so.

Don: And that could cause you problems, I suppose, if he came around.

Jillian: You know, it was difficult because he’d phone me up and saying well, you know, “How you going to get any more stuff if you don’t got any money?” And he didn’t have any. And it’s just—it’s just all his mates and my mates, really, they’re all—they’re all in the same crowd, you know, and… Allison is not. But I mean, she does, she takes a bit of dope and a bit of speed now and again, but I mean, you know, nothing, like, major or anything.

Don: Sounds as if you expect John to come round sometime.
Jillian: I think, yeah, I think he might. I don’t know. It depends how he is feeling, you see. He does things when he wants.

Commentary: Now try and work through this using a problem-solving approach. How can you help Jillian to decide what to do about her boyfriend?

CRISIS PREVENTION

The final section in this videotape is on crisis prevention. The aim is to devise a plan of action if a future crisis occurs, especially to prevent suicide in the context of recurring crisis situations. It is less applicable if a recent crisis occurred in a highly unusual set of circumstances which have now been resolved. We must stress that crisis prevention should be collaborative and it should only occur once the immediate crisis has actually been defused.

All front-line workers have a role to play in suicide prevention and there are really long-term benefits to be gained from trying to do some crisis prevention.

MYTH: CRISIS PREVENTION IS NOT MY RESPONSIBILITY

MYTH: SUICIDE PREVENTION MEASURES ARE A DRAIN ON RESOURCES WHICH WOULD BE BETTER USED ELSEWHERE

We are going to look at the following stages: explore the exact circumstances which led up to the current crisis—what was the situation, what were the symptoms that the person experienced, what was their behavior? Then go on and assess the likelihood that the exact circumstances will be repeated in the short or medium term—have the problems been resolved? Then go on to help the person to recognize their own personal early warning signs of a crisis—what symptoms do they experience in their body, what thoughts go through their head? And then help them to devise alternative coping strategies once they recognize the crisis.

Now let’s go back to the interview with Barry and the teacher. The school inspection isn’t going to happen for some time again, but the likelihood of her rowing with her husband is fairly high. Barry moves on to assessing early warning signs and then looks to alternative coping strategies.
Barry: How often are those really bad rows?

Assess likelihood of circumstances recurring

Teacher: We’ve had two really bad ones.

Barry: Did you know they were going to happen?

Identify early warning signs

Teacher: I thought they were going to happen on both times they did.

Barry: Why?

Teacher: Because I could feel myself getting upset, and I think, yeah, that’s what make, it starts getting really… That’s what makes him angry, it gets worse, and I get more upset, and then he just walks out.

Barry: Right, which leaves you…

Teacher: And I’m on my own. And that’s when I feel desperate.

Barry: I think recognizing that is important because those are the times that are most dangerous for you. Those are the rows that you know are going to happen that leave you feeling so bad afterwards. And so far, Janet’s been there. What if she wasn’t? What do you think would happen then?

Teacher: It had actually crossed my mind when I last phoned her that she wouldn’t be in or something. I don’t know.

Barry: Have you thought about what you could do then?

Alternative coping strategies

Teacher: No. She was, so I didn’t have to.

Three alternative supports

Barry: No. If she’s not, perhaps you would need to be able to phone someone else. And if you’ve not shared it within the family otherwise, then the Samaritans. And they are there just to contact, just to talk, just to let off steam when you’re feeling so pent up. And having their number handy can help. You can phone the duty doctor. It won’t always be me, but you’ve still got someone there that you could phone.

Commentary: Don goes through some similar steps in his session with
Jillian and looks at how she’ll cope if the problems with her boyfriend lead to her feeling once more at risk of harming herself.

Don: Right, Jillian. I guess we had better talk about what might happen and how you might feel if he did turn up.

Jillian: I don’t like thinking about it, really. It would depend on what he did, wouldn’t it?

Don: Well, if worse came to the worst and he did turn up on your doorstep and he got quite nasty with you, how do you think you would react to that?

Rehearse coping strategies

Jillian: I always try and calm him down by just sort of agreeing with him, and I don’t know what. I mean, I tried arguing with him once and it was worse. You know, he got a bit—he started chucking stuff around and he hurt my wrist and did some stuff.

Don: So are you saying you would have to go along with, with whatever he wanted? You would have to try and calm him down and...

Jillian: I don’t know what else to do because he’s—it would just depend what, I mean, if he—if he was, you know, if he needed some smack.

Don: What would happen to you, Jillian? I mean, how would you feel inside if he came around and he behaved like that?

Jillian: It would just go on and on like that, wouldn’t it, then? There wouldn’t be much point anymore would there, really, if he was going to... He’d just start taking my stuff. Oh, God. I mean, he did that to—he took his last girlfriend’s stuff and he made it his own.

Clarification

Don: You say there wouldn’t much point anymore. What do you mean by that?

Jillian: If I try and get myself out of this mess and stuff, what’s going to be the point if he keeps coming around? I think I’d be really—I think I’d want to, I would be worried about myself. I think... I’d go
down again, I think.

**Don:** So you’d start to feel pretty hopeless again, the way that you were a week or two ago?

**Jillian:** Yeah. I feel much better when he’s not around. These last couple of days I felt—I felt a bit better because he’s not been around, but then I’ve been worried that he is going to come around and start acting up again.

**Don:** So if John came round to the flat and he behaved the way that you think he is going to behave, then you reckon you would be at risk again, that you start to might feel suicidal again or so?

**Jillian:** Yeah. God, I hope he doesn’t. I hope he doesn’t.

**Don:** So there is always a possibility that he may, now, Jillian. We ought to—we ought to talk about how you are going to deal with that situation if it came along. And if he came around, well, you’d feel pretty terrible about it. You might be at risk again; you might consider killing yourself again, even.

**Jillian:** Yeah.

**Don:** So I guess we ought to think about how you are going to handle that situation again. You’ve handled things very well over the last week. I think you’ve done amazingly and I don’t think either of us wants you to slip back again.

**Encouragement**

**Don:** And let’s think about practical things you can do if John came around, practical things that you can do to put yourself less at risk. Maybe you can’t prevent him coming around—maybe, you’re not, physically, maybe you can’t prevent that. But how are you going to deal with the situation?

**Commentary:** A little further on, they start to look for potential early warning signs that Jillian is at risk of self-harm—signs of emotional distress. From this, it would be possible to move on to ways of attempting to prevent crisis: getting support, looking for alternatives to risk and behavior, controlling her arousal.
Jillian: I don’t know, I don’t know what to do, I’d feel really…

Don: How do you know when you are at risk? How do you know when you are going down again?

Early warning signs

Jillian: Because I feel—feel depressed. I start, start thinking about it and not being able to think about anything else, really.

Don: Do you start having these thoughts about—about killing yourself again?

Jillian: Yeah.

Don: And do you do anything? You know, before, you were buying packets of razor blades.

Jillian: Sometimes I sort of—I thump the wall sometimes.

Don: Because you’re really tense, yeah.

Jillian: Yeah, I kick stuff around a bit.

Don: So you get all wound up and pretty anxious, yeah.

Jillian: Yeah, and I… Yeah.

Don: I guess, maybe, Jillian, there are some things that you can do something about and other things that you can’t.

Jillian: What can I do about it, though? I mean…

Don: Maybe you can’t prevent John coming around, but maybe you can do something about the consequences of that. Maybe you can do something about the way that he makes you feel.

Commentary: This videotape has covered assessment, crisis management, problem solving, and crisis prevention. Every case requires assessment and crisis management. Some cases also require problem solving and/or crisis prevention. You need an opportunity to practice these skills now. What we would like to emphasize, finally, is that you can’t really learn how to do this by simply watching a videotape.
Video Credits

WRITTEN BY
Linda Gask
Richard Morris
Jane Battersby

PRESENTED BY
Linda Gask

PRODUCED BY
Nick Jordon for
The University of Manchester
School of Psychiatry &
Behavioural Sciences

Copyright © 1999, The University of Manchester,
School of Psychiatry and Behavioural Sciences
Notes...
Earn Continuing Education Credits for Watching Videos

Psychotherapy.net offers continuing education credits for watching this and other training videos. It is a simple, economical way for psychotherapists—both instructors and viewers—to earn CE credits, and a wonderful opportunity to build on workshop and classroom learning experiences.

• Visit our CE Credits section at www.psychotherapy.net to register for courses and download supplementary reading material.

• After passing a brief online post-test you will receive your Certificate of Completion via email. Voila!

• CE Approvals: Psychotherapy.net is approved to offer CE courses for psychologists, counselors, social workers, addiction treatment specialists and other mental health professionals.

Psychotherapy.net also offers CE Credits for reading online psychotherapy articles and in-depth interviews with master psychotherapists and the leading thinkers of our times.

To find out more, visit our website, www.psychotherapy.net, and click on the CE Credits link. Check back often, as new courses are added frequently.
About the Contributors

VIDEO PARTICIPANT

Linda Gask, MD, Featured Presenter, is Professor of Primary Care Psychiatry at the University of Manchester, and was the founder of the STORM (Skills Training on Risk Management) training initiative for suicide prevention. She is the Western European Zonal Representative for the World Psychiatric Association and has worked as a consultant for the World Health Organization. She has done extensive research on improving the quality of care for people with depression and medically unexplained symptoms, and the management of people at risk of self-harm.

MANUAL AUTHORS

Randall C. Wyatt, PhD, Editor-in-Chief of Psychotherapy.net, is Director of Professional Training at the California School of Professional Psychology, San Francisco at Alliant International University and a practicing psychologist in Oakland, California.

Linda Gask, M, See above.

Erika L. Seid, MA, LMFT, Educational Programs Manager at Psychotherapy.net, is a practicing psychotherapist in the San Francisco Bay Area, specializing in cultural issues and sexual offender treatment.
More Psychotherapy.net Videos

New videos are added frequently. Visit us at www.psychotherapy.net or call (800) 577-4762 for more information.

The Ackerman Institute  Couples and Infertility  Gender Differences in Depression
Constance Ahrons  Making Divorce Work
Ellyn Bader & Dan Wile  Couples Therapy: An Introduction  “I’d hear laughter”
Insoo Kim Berg  Irreconcilable Differences
Stephanie Brown  Treating Alcoholism in Psychotherapy  (2-DVD series)
James Bugental  Existential-Humanistic Psychotherapy in Action  James Bugental: Live Case Consultation
Tian Dayton  Healing Childhood Abuse through Psychodrama  Trauma and the Body
George De Leon  The Therapeutic Community (3-DVD set)
Pamela Dunne  Exploring Narradrama
George J. DuPaul & Gary Stoner  Assessing ADHD in the Schools  Classroom Interventions for ADHD
Bruce Ecker  Down Every Year: A Demonstration of Depth Oriented Brief Therapy
John Edwards  Tools and Techniques for Family Therapy
Stephen Feldman  Legal and Ethical Issues for Mental Health Professionals
The Glendon Association  Invisible Child Abuse  Sex, Love and Intimate Relationships  Voices About Relationships  Voices of Suicide
Kenneth V. Hardy  The Psychological Residuals of Slavery
Susan Heitler  The Angry Couple
Karin Heller & Bill Domonkos  Coming Out
Harville Hendrix  Harville Hendrix on the Healing Relationship
CHILD THERAPY WITH THE EXPERTS SERIES

Jon Carlson  Adlerian Parent Consultation
Janet Sasson Edgette  Adolescent Family Therapy
Gerald Koocher  Psychotherapy with Medically Ill Children
Terry Kottman  Adlerian Play Therapy
Stephen Madigan  Narrative Therapy with Children
Bruce Masek  Cognitive-Behavioral Child Therapy
John J. Murphy  Solution-Focused Child Therapy
Violet Oaklander  Gestalt Therapy with Children
David Scharff  Object Relations Child Therapy
Anin Utigaard  Person-Centered Child Therapy
Robert E. Wubbolding  Reality Therapy with Children

PSYCHOTHERAPY WITH THE EXPERTS SERIES

Insoo Kim Berg  Solution Focused Therapy
James Bugental  Existential-Humanistic Psychotherapy
Jon Carlson  Adlerian Therapy
Mary Goulding  Transactional Analysis
Kenneth V. Hardy  Family Systems Therapy
Allen Ivey  Integrative Therapy
Jeffrey Kottler  Integrative Counseling
John Krumboltz  Cognitive-Behavioral Therapy
Arnold Lazarus  Multimodal Therapy
Donald Meichenbaum  Cognitive-Behavioral Therapy
Natalie Rogers  Person-Centered Expressive Arts Therapy
Ernest Rossi  Mind-Body Therapy
Jill Savege Scharff  Object Relations Therapy
Lenore Walker  Feminist Therapy
Robert E. Wubbolding  Reality Therapy