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Notes to Accompany Videotape: Helping People at Risk of Suicide or Self-Harm
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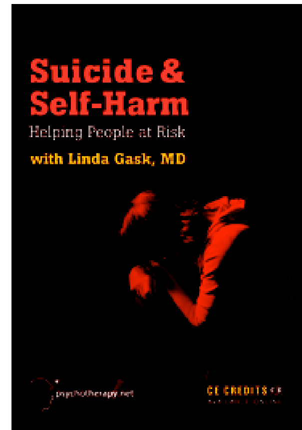

Viewer's Manual for the Video SUICIDE AND SELF-HARM: HELPING PEOPLE AT RISK

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*This manual is part of Psychotherapy.net's video program entitled *Suicide and Self-Harm: Helping People at Risk*. One copy only may be printed for personal reading; otherwise this manual may not be distributed or reproduced in any form.

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I. Course Objectives

- Build confidence and hope in dealing with people who are suicidal
- Apply effective interviewing skills to elicit suicide risk
- Help people in crisis develop survival strategies

II. Some Factors Affecting Suicide Risk and Prevention

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 than among those with an expectation of continued employment.
- Suicide is 40-60 times more frequent in people who are recently discharged from hospital with psychiatric disorder, compared to the general population. 70% of suicides occur in depression. Other psychiatric disorders associated with suicide include schizophrenia, bipolar disorder and personality disorder.
- 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 catastrophic or stigmatised illness 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 medial 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 death—1/3 gave a clear indication of suicide intent at 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.

III. Assessing the Problem

General Interviewing Skills: *These should be employed throughout the interview*

Establishing Rapport

- Introduce yourself by name.
- Explain the purpose of the interview.
- Preferably interview the patient in a quiet setting.
- Assure the patient of confidentiality.
- Ask permission to take notes.
- Maintain eye contact (beware of looking at notes or computers).
- The interview should be unhurried and non-challenging.

Questioning Style

- Start off with open questions.
- Do not ask 'why' questions at first, which require opinion rather than fact.
- Do not ask questions which can simply be answered 'yes' or 'no,' since these shut the patient up.
- 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 'directive' questions which specify what the assessor wants to speak about but cannot be answered 'yes' or 'no.'
- Closed questions which are answered 'yes' or 'no' are only used to clarify facts.

Pick up 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").

Pick up non-verbal cues

- Pay attention to signs of possible emotional disorder:
    - tearfulness; sighs; agitation; restlessness; pacing; lack of eye contact; 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 what patient says (paraphrasing).

- Sympathise—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 exposure—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.

Clarification of Current Problems

- Specify problems over the last few months and the last 24 hours.

Checklist of current problems

- The assessor should check if there are any problems relating to the following that s/he has not spontaneously mentioned:

  Relationship with partner, other family members, friends
  Social isolation
  Bereavement
  Separation
  Employment
  Studies
  Financial
  Housing
  Legal, including current court/police proceedings
  Physical health
  Use of illicit drugs/alcohol
  Mental health

Specific Questioning about Suicidal Intent

Myth: Talking about suicide increases the risk

- Asking a person about suicidal thoughts will not plant an idea which was not there before.
- Most people who are contemplating suicide feel relieved to be able to talk about it.
- You cannot assess suicide risk without specific questioning.
- If you need to refer on to other agencies, 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 characterised 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 feels that anybody can help to improve the current situation.
- Does the patient have anything to look forward to?
- Whilst the patients who are looking forward to a future event are less likely to commit suicide in the immediate future, <u>beware</u> of patients who plan to live until they have seen through a particular event, e.g. a birthday before committing suicide.
- 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.

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

- Beware of patients who have thought about measures to prevent detection (i.e. who have planned to commit suicide when their partner is at work, children at school, etc.).

BEWARE OF ASKING 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 get offended.

- Patients who are feeling suicidal are more likely to feel comfortable talking about it if you are comfortable asking them.

- Ambiguous questioning may result in your interpretation of the person's response being inaccurate—e.g., "Have you thought about getting away from it all?" A 'yes' response may be interpreted as suicidal ideation, when in fact the patient may simply feel s/he needs a break away from the source of distress.

Myth: People who are serious about committing suicide do not tell anyone else

- Whilst some suicides are unpredictable, many people who go on to commit suicide have been in contact with helping agencies in the previous month.
- Most reveal suicide intent under direct questioning from a sympathetic interviewer.
- Only a minority of people deny suicidal intent when in fact they are planning suicide.

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)
- Access to means of suicide
- Plans for death (e.g. will changes, family farewells)
- Recent escalation of:
  - Suicidal behaviour (e.g. self-harm)
  - Maladaptive behaviour (e.g. drug/alcohol abuse)
  - Help-seeking behaviour (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

- A statement from patient ensuring s/he 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").
- Looking forward to future events
- Being afraid 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

- 95% of suicides occur in individuals suffering from a mental disorder

a) 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:
    - Loss of interest or pleasure for at least 2 weeks + at least three of the following:
        - Alterations in sleep pattern (decreased or increased sleep)
        - Changes in appetite (increased or decreased)
        - Little energy or motivation
        - Poor concentration
        - Self-neglect
        - Social withdrawal
        - Restlessness, agitation
        - Slow speed of thinking or movement
        - Loss of self-confidence
        - Suicidal thoughts or hopelessness
- Depressed people can have:
  Anxiety symptoms
  Delusions (fixed false beliefs, not amenable to reason)
  Hallucinations (false sensory experiences)
  A history of mania (excessive cheerfulness)

b) Schizophrenia

- 10% of patients with schizophrenia commit suicide.

- Schizophrenia is characterised by:
    - Bizarre delusions
    - Hallucinations
    - Thought interference
    - Personality change (apathy, loss of emotion)

- Suicide is particularly likely in cases characterised by:
    - Prominent symptoms of depression, particularly hopelessness
    - Recent discharge from inpatient psychiatric care
    - Social isolation

- Measures that will help include treatment of depression & uncontrolled symptoms of schizophrenia, and measures to reduce social isolation, such as involvement in daytime activities.

c) Personality disorder

- 10% of suicides have a personality disorder.
- A personality disorder is present when a person consistently behaves in a way which causes harm to him/herself or others, and this damaging behaviour has been consistently present since the late teens.
- A personality disorder does not explain antisocial or suicidal behaviour in people who are depressed or have schizophrenia and do not exhibit these types of behaviour when their mental illness subsides.

- Common personality problems leading to suicidal behaviour 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)

d) 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.

- Drugs and alcohol have profound effects on mood and increase disinhibition, which may result in people acting on suicidal thoughts which they had previously resisted.

- Some people may self-harm or attempt suicide whilst intoxicated and later regret it when sober.

- However, for some patients, the act is fatal and regret too late. Beware of patients who have taken an overdose of tablets 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).

- Males who abuse alcohol/drugs and have a history of self-harm are at particular risk.

- In the majority of cases, depression is also present.

Assessment of Suicide Risk After Self-Harm or Attempted Suicide

Myth: People who self-harm are just attention seeking and are not at risk of suicide

- The risk of suicide following a suicide attempt is 100 times that of the general population.
- 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.
- It is important to be aware of factors associated with suicide after self-harm:
    - Male sex
    - 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

- 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.

- 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)

Myth: There is no way of knowing who is going to commit suicide

The previous section will help you identify risk 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 suicide risk
- Diffuse emotional distress as far as possible
- Screen for evidence of mental disorder. If present, arrange for treatment, usually through the primary care provider

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 behaviour

Action for medium risk
- Diffuse emotional distress as far as possible
- Follow-up required in 72 hours – one week
- Once safety obtained, 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 obtained, requires a full assessment of mental heath, 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 behaviour

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 obtained, requires a full assessment of mental health, psychosocial problems and crisis prevention strategies

IV. 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

- In most instances, crisis management follows naturally from assessment and often starts before assessment has been completed, to prevent the subject from getting too depressed.
- Use the general interview skills described earlier. Specific techniques are described below,

Allowing 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 which 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 remain suicidal unless they find someone who can be both assertive and supportive.

- Some people discourage the release of emotion in suicidal subjects, even though they may find it acceptable in distressed physically ill subjects. Others discourage the release of emotion entirely because they are embarrassed, have no confidence in dealing with distress, or view the release of emotion as time consuming.

- 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.

Taking 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 which are positive or not upsetting to talk about. Alternatively, talk about issues unrelated to the patient to distract from their distress. Professionals are often quite good at doing this with other types of patients, but are often unnecessarily afraid to do this with suicidal patients.

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

Addressing 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.

Providing 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 by the 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.

Improving hopefulness

- Discuss final and irrevocable nature of suicide.

- 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 which 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 is there any prospect of repeating them, even in a mall way?

- *Explore*: effects of the suicide on significant others. Also, explore whether suicide is compatible with religious or humanistic values the patient may have.

- 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.

- 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.

- Try to talk to the subject freely. Sometimes, staff are reluctant to talk in their normal sympathetic manner with a mentally ill subject when they would have no qualms about being sympathetic to a physically ill subject. Both benefit from an empathic, warm approach.

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. Occasionally, a person is suicidal for longer than 24-48 hours, in which case qualified mental health professionals should be contacted to assess the person contemplating suicide.
    - Who can s/he confide in?
    - What support is available?
    - Does s/he still have access to any potentially fatal methods?
    - Check on use of drugs and alcohol

Use of family and friends

- Family and friends can offer better support than professionals if they are available and empathic.
- 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.
- Teenagers and immature people become distressed by being with suicidal patients and should not be relied upon.
- It is important that friends and families of suicidal people are informed of risks and what to do if the situation gets worse.

Use of other professionals

- Sometimes offers of emergency telephone access to either the therapist or other professionals might be considered. However, do not offer them unless you are fairly sure of being able to get hold of them; the disappointment of being let down could lead to a further suicide attempt.
- Crisis telephone lines are available 24 hours a day and are staffed with people specially trained to provide support for those in crisis situations.

Myth: Since unemployment and poverty are the main causes of suicide, there is little an individual can do to prevent it.

- Whilst these factors do contribute to the overall crisis situation, the single most common predictor of completed suicide is hopelessness.

- Front-line health workers are in a prime position to improve hopefulness using some of the techniques described earlier.

- All of the management techniques described here are derived from evidence-based research—i.e., they have been proven to work.

V. Problem Solving

Objectives of problem solving
- To help patients to identify problems as a source of distress
- To help patients to 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 which 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 ranger of disorders, it is important that the patient is not in an acute phase of a major psychiatric illness.

- *Patient 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
- It is best to focus on one problem at a time.

- The therapist should ensure the patient chooses a problem which is likely to be manageable at this stage. The most serious problem is therefore not necessarily dealt with first.
- The patient needs to gain some self-confidence by achieving something.
- The patient must ultimately decide on which problem to tackle first.

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.
- It is important that the patient, rather than the therapist, generates the list to enhance the patient's 'ownership' over 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.
- Extreme solutions can often lead the patient to unexplored avenues and thus produce other novel solutions.
- Sometimes a solution which at first seems highly unlikely may, on closer examination, become a potentially valuable one.

3. Examine the pros and cons of each option

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

4. Choose the best option

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

IMPORTANT! THE MOST COMMON ERROR MADE BY HEALTH PROFESSIONALS IN PROBLEM SOLVING IS GIVING ADVICE.

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

- There are a number of problems associated with therapist advice giving:
    - The patient does not 'own' the solution, 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.
    - The patient does not develop skills to use when faced with future problems.

  - Repeated contact with the therapist (or other health professionals) will continue until the patient is able to take some responsibility for the solution of problems (i.e. 'revolving door' patient).
  - If the solution fails, the patient may hold the therapist responsible, which could be damaging to the therapeutic relationship.

5. Rehearse the option in imagination

- Work out in imagination with the patient all the steps required to carry out the chosen option.
- The patient may think of possible snags which were not apparent before.
- Predictability gives a patient a sense of control and thus s/he is more likely to carry out the task.
- Role-play is occasionally useful when patients are worried about how their actions may be perceived.

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

- Psychiatric disorder
  - May not have been apparent at outset
  - May have become more severe
  - May have been poorly assessed

  The psychiatric conditions must be properly treated before problem solving can proceed.

- Low self-esteem/self-confidence
  - Any task appears daunting and indeed impossible.

- Problems reflect long-standing personality difficulties
  - Patient must understand these before s/he can attempt to change.

- Patient unwillingness to take responsibility for resolution of problems
  - The therapist cannot solve the problems for the patient but rather help the patient find solutions for him/herself.

VI. 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 which have now been resolved.

- Although people who have recently got 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.

- 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.

Myth: Crisis prevention is not my responsibility

- All front-line health workers coming into contact with people in crisis have a role to play in the prevention of suicide.

- Whilst crisis prevention skills are particularly relevant for health professionals working in community or other long-term settings, they can also be used in other settings—for example following self-harm in the emergency room (although underlying psychiatric disorder should be treated).

- Depending on how much time you have or how well you know the patient, you may only get as far as stage one or you may be able to move straight to stages three or four.

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 led the person to not coping at present?
  - Were the person’s usual coping mechanisms available or adequate?

Myth: Suicide prevention measures are a drain on resources which would be better used elsewhere

- The suicide prevention skills described here can be used in a variety of situations providing the patient's safety has been ensured.

- Teaching patients these specific techniques will not only have short-term benefits but also long-term benefits for both patients and health workers—patients will be more resourceful in coping with difficult situations and less reliant on helping agencies in the future.