The Rational Management of Self-Harm Risk

A Cognitive-Behavioural/Problem-Solving Approach

Wayne Froggatt

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What causes a wish to self-harm?

There are many reasons why human beings develop self-harm intentions. One question we need to address is: do people become suicidal because of *external* factors (e.g. their circumstances), or because of *internal* factors (their psychological state).

The best answer to this question is: 'both'. It is clear that environmental factors such as social isolation, poor family support, sudden loss or abusive relationships increase suicide risk. However, not everyone exposed to such events and circumstances wishes to die. Factors internal to the individual, for example, high expectations of oneself, or a tendency to suppress emotions, play a key role in the development of suicidal ideation.

A psychological explanation with considerable research backing is provided by cognitive-behaviour therapy (CBT). According to the two main variations of CBT – *Rational Emotive Behaviour Therapy* (REBT) developed by Albert Ellis, and *Cognitive Therapy* (CT) developed by Aaron Beck – suicide contemplation results from certain dysfunctional beliefs and attitudes.

Two key motivations

Writing from a CT perspective Williams & Wells (1989) state that there seems to be two main motivations for self-harm/suicide:

1. ***Communication****:* the wish to send a message to someone or others who are perceived as not listening.
2. ***Escape****:* the wish to escape from life*,* usually reflecting a perception that there are no more options left.

Because each requires a different approach to intervention, it is important to identify which motivation predominates.

Two types of disturbance

REBT (Ellis, 1987) suggests there are two common themes which may lead to disturbed emotions and behaviours – *self-hatred* (known as ego disturbance) and *low discomfort-tolerance* (discomfort disturbance).

Ego disturbance involves an upset to the self-image resulting from demands about how one should be or behave, followed by global self-evaluation for not meeting these demanding standards. In relation to self-harm ideation, it is characterised by self-talk like: 'Nobody cares about me, which shows that I'm no good' / 'I'm a failure / I deserve to die'. Coupled with: 'I'll never be able to improve' this leads to: 'I may as well kill myself'. Underlying these ideas will be core beliefs like: 'I *need* to achieve / have the approval of others;' 'I *can't stand* failure / lack of approval;' 'If I was not able to satisfy my needs for achievement/approval, life would not be worth living.'

Discomfort disturbance involves a person's perception of threat to such things as their safety, quality of life, emotional or physical pain and so on, coupled with excessive evaluations of the badness of negative events or circumstances and demands that they not occur. In the case of self-harm ideation, it will result from self-talk like : 'My life is so bad / I feel so depressed / I can't bear this pain'. Coupled with: 'There is no way out' this leads to: 'I may as well kill myself.' Underlying these ideas will be core beliefs like the

following: ‘Discomfort and misery are awful;’ ‘I can’t stand bad feelings and must avoid them at all costs;’ ‘If I was helpless to do anything about bad feelings, the only solution would be to kill myself.’

There are four types of thinking that potentially underlie each disturbance. The most basic is *demandingness:* the individual believes that they or the world ‘should’ or ‘must’ be a certain way. Deriving from demands are the other three types: *awfulising* – believing that something is awful, terrible or horrible because it is not as it ‘should’ or ‘must’ be; *discomfort intolerance* – viewing certain things as unbearable (known as ‘can’t-stand-it-it is’), and *self-rating* – viewing oneself as totally bad, stupid or incompetent.

For most people, ego and discomfort disturbance will co-exist, but one or the other will tend to predominate. It is important to identify which is uppermost, because each requires different treatment.

Note that ego and discomfort disturbance will not by themselves lead to suicidal inclinations – what is needed, as we shall see in a moment, is the added component of *hopelessness:* some kind of belief that oneself or one’s circumstances are unlikely to ever improve.

Three directions of negative thinking

Beck (1967) points out that depressed people typically engage in highly negative thinking focussed in three directions. It may directed toward the *self* (‘I’m no good’) – this appears to be identical to Ellis’ concept of ego disturbance; or toward the *world* (‘The world is no good’) – this would equate to discomfort disturbance.

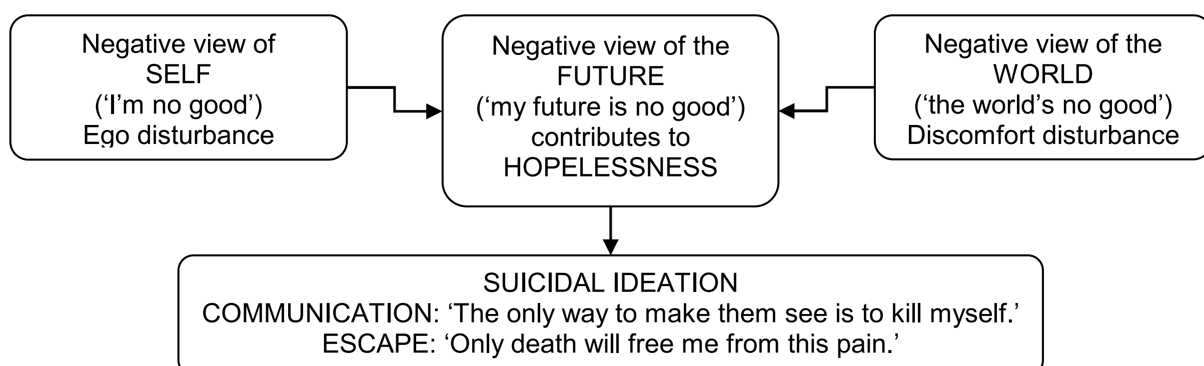
The third direction is toward the *future* (‘My future is no good’). Whichever of the first two is emphasised, a negative view of the future is the decisive element in depression and suicidality. A person may regard themself or the world (or both) as no good, but they are less likely to become depressed or suicidal if they believe things can improve. If, though, they see little or no hope for improvement, this provides fertile ground for the idea that the only solution is to terminate one’s unworthy existence or presence in an unworthy world. It can be hypothesised that the degree of hopelessness determines the degree of suicidal ideation.

Beck also outlines a further seven types of disturbed thinking (in addition to Ellis’ list of four) that contribute to negative emotionality:

- *Black & White thinking:* ‘I either do it perfectly or it’s not worth doing at all.’
- *Filtering:* ‘I can’t see any positives in my life.’
- *Overgeneralising;* ‘Everything is going wrong in my life.’
- *Mind-reading:* ‘They think I’m worthless.’
- *Fortune-telling:* ‘Things can only get worse.’
- *Emotional reasoning:* ‘I know I’m a failure – otherwise I wouldn’t be feeling this way .’
- *Personalising:* ‘It must have been me that made her feel bad.’

A unified CBT model of Suicidality

Ellis and Beck, the two main CBT theorists, are often saying similar things, but using different words; further, where they do differ (for example, regarding the types of irrational thinking on which to focus) they tend to be complementary rather than contradictory. Here is a model that combines their thinking in a unified understanding of why people become suicidal, incorporating as well the two key motivations for self-harm.

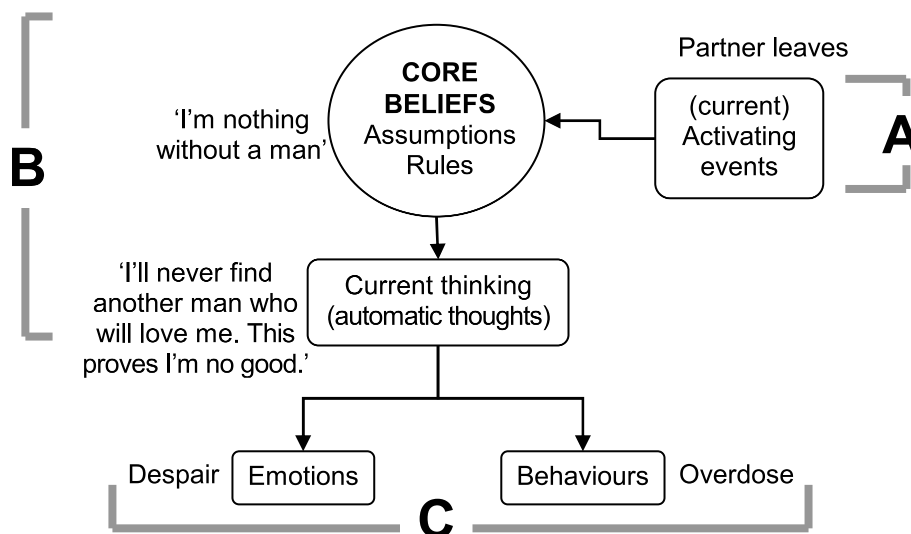


How does suicidal thinking come about? Both REBT and CT agree that dysfunctional thinking has its origins in a combination of inherited biological temperament and learning that begins at birth and continues throughout the life cycle. This combination leads to the development of core beliefs or ‘schema’, which are enduring assumptions and rules about oneself, the world and how things ‘ought’ to be. They are usually held subconsciously. When an individual is exposed to a triggering event or circumstance, one or more of their

core beliefs are activated, leading to current thinking. These ‘automatic’ thoughts, as they are called in CT, then create emotional and behavioural consequences.

What follows is a model that illustrates all of the components referred to thus far. This is a version of Ellis’ well-known ABC model, modified to reflect a broader CBT perspective. ‘A’=Activating or triggering events, ‘B’=Beliefs, and ‘C’=Consequences.

The example used is that of Anna, who was seen in hospital following an overdose of paracetamol. Anna had been moderately depressed for some months, following conflict in her relationship with Warren who was expressing dissatisfaction and a desire to leave. Anna believed that she had to have a man for her life to have any meaning, but, because she had a very low opinion of herself, simultaneously believed that few men would ever want her. One afternoon she arrived at their flat to discover that Warren’s clothes and belongings were gone. She took a number of paracetamol tablets, but shortly after reconsidered and rang the ambulance service, whereupon she was brought to hospital. Here is this experience shown in the framework of the modified ABC model:



To summarise, when Anna’s partner left, this *activated* a long-held core *belief* ‘I’m nothing without a man’. She was not conscious of this belief, but was more aware of the current thinking that it stimulated: ‘I’ll never find another man who’ll love me’ followed by: ‘This proves I’m no good’. These ‘automatic’ thoughts in turn created her *consequence:* a feeling of despair and the act of taking an overdose.

Managing risk: Overview and principles

Now we turn from theory to practice. The process of self-harm risk management can be summarised as follows:

1. Identify any background suicide risk factors;
2. Assess current risk;
3. Develop and implement a plan to reduce the risk level or protect the person if necessary;
4. Attend to underlying problems when the client is ready.

Before we look at each of these steps in detail, here are some general principles to keep in mind when working with suicidal clients:

Be as collaborative as possible, given the client’s mental and emotional state and level of risk. Don’t take over any more than is necessary – this may only reinforce the client’s belief in their inability to cope. As far as possible, involve the client in a dialogue about the assessment and proposed management. Model the approach of therapist and client working together as a team to problem-solve.

While remaining collaborative, *be prepared in the early stages to supply initial energy* for a client who may be depressed and sees no options available to them. Avoid, for instance, aimlessly restating the client’s problems, or vaguely discussing hopeless thinking without proposing any options. It is possible to combine appropriate directiveness with client involvement and collaboration. With suicidal clients, Socratic questioning is usually more appropriate that reflective listening.

Consult, as appropriate, family doctor, other helping professionals already involved with the client, specialist practitioners (e.g. psychiatrist), or other people significant to the client, including family members. Try to avoid acting alone with high-risk clients.

Assessment

Identify the presence of possible general risk factors

The initial 'screening' phase involves identifying the presence of *general/demographic risk factors* – by reading previous notes, observing the person, and talking with them and with significant others. A list of key factors to look for, culled from statistical research, is on page 20 (see 'General Risk Screening'). Especially watch for the presence of *clinical depression*.

If there have been previous self-harm episodes, ascertain (1) when was the last attempt? (2) how frequent have they been? (3) what were the circumstances triggering or surrounding the attempts? (4) in the case of family self-harm history, have any attempts been successful?

Assess current risk

Ascertain whether the person is likely to harm themselves in the near future:

- Are they thinking of suicide now?
- How lethal is the proposed method (and what is the client's *perception* of lethality)?
  Higher ← firearms–hanging–gassing–cutting–wrists–pills → *Lower*
- Are there any preparations (giving away valued possessions, making a will, etc.)?
- What situations tend to trigger the suicidal ideation?
- What positives and alternative options can the person see in themself or their circumstances?
- Watch especially for thoughts and feelings around the theme of *hopelessness*, including the client's perception that there are no options for solving their problems.
- Find out what the person is trying to achieve (their *motivation*) – is it escape or communication? If the person says they would like to die, clarify this: do they just want to escape from their responsibilities for a while – or do they want to end their life?.
- Note the presence or absence of *protective* factors. How much hope does the client see? Is good mental health care available? Would the client comply with this? Does the client consider they are needed by and have responsibility for children or other dependents? Does the client perceive they have strong social supports? Are competent caregivers available (parents, friends, etc.)?

How do you find out about suicidal thinking?

Don't be afraid to ask if the client is thinking about suicide – talking about it is likely to be a relief. This can be done sensitively. Start with general, minimally-intrusive questions; moving, as necessary, to more specific queries, like the following example: (1) *'How does the future seem to you?'* (2) *'Does it sometimes seem that life isn't worth living?'* (3) *'Have you ever thought of ending it?'* (4) *'How would you go about it?'* (5) *'Have you ever made moves toward doing this'* (6) *'Are you likely to at this point?'*

Clients who have already self-harmed

The same assessment process as described above applies with clients who have already self-harmed, with the addition of some questions designed to ascertain their intentions (see the *Self-Harm Attempt Assessment Form* at the end of this article):

1. What did they do? When? Where?
2. Who was around? Did they expect to be found? Did they tell anyone before or after?
3. Was the act planned or impulsive?
4. What did they think would happen?
5. What did they want to happen?
6. What do they think/feel about what they did, and about being still alive?

Anna was seen by a mental health nurse from the crisis team shortly after her physical condition was stabilised in hospital. A number of background risk factors were identified: she was currently depressed, she had already made one attempt, she had experienced what to her was a significant loss, she viewed herself quite negatively and did not see much hope that she would ever improve in the future. There were, though, some positives: she had support from her parents and several friends, there were no attempts previous to the current one, and she was willing to accept medication and psychological therapy for her depression.

The assessment of current risk (which also included detailed questioning about her overdose) revealed that though she lacked significant hope for the future, she was relieved to be still alive and embarrassed

about what she had done. Although thoughts of death had been present for some weeks, there was no clear plan or consideration of the consequences prior to the overdose.

Anna’s suicide risk was assessed as moderate. The most appropriate course of action was considered to be appraisal of her depression by a psychiatrist, followed by discharge from hospital with supervision and referral for psychological therapy.

Planning

As the assessment proceeds, the plan for intervention will begin to develop. There are some general principles that will increase the effectiveness of the plan and its implementation. First, as far as possible, create the plan in consultation with the client, significant others, and appropriate professionals. Second, ensure that the plan is fully documented in a way that is accessible to other key practitioners. Third, notify the plan, level of risk, and supervision required to any others who may be involved with ongoing care of the client.

The discharge plan for Anna, worked out while she was still in hospital, was first discussed with her then checked with several key supporters. Copies of the plan were given to Anna, placed on the medical file, and sent to her family doctor, psychiatrist, and the community mental health team who would allocate a therapist for ongoing work. Relevant parts of the plan were communicated verbally to her friend Debbie, who was to call on her daily, and to her parents.

Intervention

Further intervention will depend on a number of factors, such as the motivation for suicide, the ongoing risk level, and the client’s readiness for psychotherapy.

Take into account the client’s motivation

If the wish to *communicate* predominates, find out what is being communicated to whom, then consider with the client how this can be done more functionally. This may involve, for example, relationship counselling or help to develop assertive responses.

If the wish to *escape* predominates, this may indicate a higher level of risk. Consider getting a second opinion if feasible, possibly via psychiatric assessment. It may be necessary for the person to be in a place of safety. There are some ways in which these options can be assessed and, while doing so, hopefully contribute to reducing the client’s suicidal intentions:

- Discuss the pros and cons of living and dying. A useful technique to aid this is the *Benefits Calculation* (described on page 7). This technique is an example of an intervention that can both assess the level of risk and at the same time, in many cases, reduce that risk.
- As far as it is possible, make a careful assessment of the reality of the client’s life situation, and of the cognitive framework they are using to interpret and evaluate that reality. Decide whether to *problem-solve* on their circumstances (see page 10); or work on dysfunctional thinking about those circumstances using strategies like *Disputation* (page 12), *Reframing* (page 13) or the *Catastrophe Scale* (page 12).
- Initially, it will often be necessary to concentrate on hopeless thinking and lack of positive expectation. Cognitive techniques that can help here include *Identifying reasons for living* (page 9), *Identifying unfinished business* (page 9) and *Generating alternatives* (page 9).

The circumstances of Anna’s overdose might suggest, at first glance, a communication motive; however, on exploration, it became apparent that she was not trying manipulate Warren into coming back – she really believed that the relationship was over for good. Nor was it the so-called ‘cry for help’ – Anna saw little prospect for improvement, with or without help. As escape seemed to be the primary motivation, the crisis nurse assessed the level of risk by helping Anna carry out a *benefits calculation* (see the example on page 7); after this was completed, Anna decided that continuing to live was the preferable option.

Help the client problem-solve

Problem-solving, in the early stages of contact, involves helping the client to split up their various problems and look at solutions available; then plan how they will cope in the situations that lead to suicidal thoughts. *Problem-solving* is discussed on page 10. *‘Coping plans’* (page 10) may also be relevant at this stage.

In Anna’s case, some initial problem-solving around being alone in her flat was indicated, along with attention to some practical issues such as managing the rent on one income. The crisis nurse helped her prepare a coping grid (see page 10) for when she returned home.

Continue assessing the risk

The client's ability to cooperate with developing an appropriate intervention plan will provide further information about the level of risk. In particular, note any difficulty the client has seeing options available to them.

Arrange support / monitoring as necessary

Identify a few resource people to whom they can and will turn for help when feeling suicidal: parent, partner, friend, church members, daycentre, volunteer, etc. List sources of emergency help: psychiatric emergency team, GP, telephone counselling service, police. Finally, check for and secure any substances, weapons, etc. the person had considered using.

Build a bridge to the next session

The most common way to help clients cope between contacts is to develop a personal self-harm management plan (see page 15). This may be enhanced (or replaced) by a coping plan (see page 10).

Obtain the client's agreement that (1) they will not harm themselves within a certain period, and (2) if they are feeling suicidal, they will contact specified people.

Ask the client to regard their next episode of suicidal thinking as an opportunity to record the situation, their thoughts, and their feelings; and bring this data to the next session (see '*ABC Diary*' on page 11).

The crisis nurse helped Anna prepare a management plan to complement the coping grid mentioned earlier. Although she was unable to guarantee that she would not attempt self-harm before her next contact with the worker, she doubted that she would make further attempts before that time. She was also introduced to the *ABC diary* and the nurse helped her complete several entries as examples of what to do. They discussed the appropriateness of recording negative thoughts at this early stage, but Anna considered that it would be better for her to externalise and dispute these thoughts rather than just leave them buried.

Begin dealing with the client's underlying issues

As soon as the client is ready, address the factors that may keep them at risk of overreacting to the inevitable triggering events in their lives. For ongoing therapeutic work, Anna was allocated a social worker trained in cognitive-behaviour therapy. Early sessions involved a regular reassessment of Anna's suicide risk and the use of techniques to help reduce the suicidal ideation; *Identifying reasons for living* (page 9) and *Identifying unfinished business* (page 9). Anna continued to keep the ABC diary, sharing the results at each session with the therapist, who was thus able to train Anna to more accurately identify dysfunctional thinking and increase her effectiveness in disputing it.

Within a few weeks, the focus was able to move from Anna's suicidal ideation to her underlying lack of self-acceptance, as indicated by her belief that she was 'nothing without a man'. Ongoing therapy, involving the usual range of cognitive and behavioural techniques appropriate to any CBT programme, continued for a further eight months, with session frequency progressively decreasing from weekly to monthly.

An additional note: When the risk remains high ...

If supportive and therapeutic interventions are not enough to keep the person safe, then some further options may need to be considered. One is referral for psychiatric assessment, if not already carried out. For some, admission to or retention in hospital will be wise. In extreme cases, where the person is at high risk but rejects help, compulsory assessment and treatment may be necessary. Keep in mind that the higher the risk, the more important it is to involve other professionals in the helping process.

Inpatient treatment

Although the management of clients in hospital is beyond the scope of this article, most of the techniques already described are also relevant to that setting. There is a useful discussion of inpatient treatment in the guidelines issued by the New Zealand Ministry of Health (2003).

Note that while hospitalisation will be needed for some high-risk clients, it will be inappropriate for many others. Admission may isolate them from family and support systems. Some will take on the 'patient role' and lose their sense of power and control. Placing someone in hospital when they could be managed in the community, just to 'be on the safe side', may actually retard their recovery.

Special issues

Working with clients from other cultures

When working with clients from cultural groups other than the practitioner's own, it is important to be conscious of the areas where modified approaches may be required. Be aware of differences, sometimes subtle, in meanings attached to particular words and concepts. Show sensitivity to any reluctance to disclose (which may be due to shame). For some cultures, there may be a greater expectation of and importance attached to involving the client's family in assessment and planning. Endeavour, where appropriate, to involve a specialist person such as a health worker from the person's own culture.

Repetitive self-harm

Practitioners will sometimes work with individuals who engage in repetitive self-harm for reasons other than suicide. *Histrionic* behaviour, where the individual engages in attention-seeking acts, or dangerous behaviour to self-stimulate in response to anxiety or boredom is described by Freeman & White, 1989. *Borderline personality disorder,* involving a complex set of factors including repetitive self-mutilation and threatened suicide is discussed by Linehan et al, 1991. These conditions are beyond this article's scope, but some of the techniques already described can be used with such clients, and the references quoted will lead to more detailed recommendations.

Gaining the energy to suicide

Be aware that suicide risk may actually increase as depression improves. This is because a very depressed person lacks energy and motivation to do much about anything – but as their mood lifts, they may go through a stage where they develop the energy to carry out suicidal intentions.

Fear of encouraging suicide

People are sometimes concerned that discussing the possibility of suicide may further stimulate suicidal thinking and intent. There is little evidence for this – in fact, talking about their suicidal ideation will usually be a relief to the client (as long as any questioning is done in a sensitive manner and the client is helped to see that there are valid alternatives to suicide).

Specific psychotherapeutic approaches

Now it is time to consider some of the many cognitive-behavioural strategies that can be helpful with suicidal clients. Most of the techniques that follow are described in more detail in Froggatt (2003), Freeman & White (1989) and Ellis & Newman (1996). Keep in mind that cognitive-behaviour therapy is most effective when both client and therapist are in agreement to and clear about why they are using a specific technique or discussing a particular topic.

Changing the cost-benefit ratio

Benefits calculation

Do a 'cost-benefit' analysis with the client on their suicidal intentions: (1) Discuss reasons for dying (assess both pros & cons), then (2) discuss reasons for living (again, assess both pros & cons). If the client has trouble thinking of reasons for living, ask questions like:

- 'What were your reasons for living before you became depressed?'
- 'What would be your reasons for living if you weren't depressed now?'
- 'What things have kept you going despite your problems?'

Write up the calculation on a whiteboard or sheet of paper. A common format is to draw four boxes as below (alternatively, each option could have a separate sheet of paper):

	Ending my life	Staying alive
Advantages	I'll stop being a burden to everyone I will make up for all the bad things I have done	I get the chance to work on myself and my problems. I avoid causing huge pain to my family.
Disadvantages	Everyone will feel worse if I suicide I'll be dead – so I won't have the chance to behave better in the future	I will keep on being a burden to everyone. I'll feel depressed for ever.

Sometimes the calculation can be enhanced by asking the client to decide how much value or benefit each item has to them, stating these values numerically, then add up the numbers to see how the totals work out.

Note that advantages to the first option will often represent disadvantages of the second option, and vice-versa. While this may seem like doubling up, in fact it aids clarification.

Having the client articulate the pro's and con's in this way helps uncover negative thinking that can be worked on in sessions and for homework. This would involve, for example, checking out the reality of such beliefs as: 'Everyone will be better off without me' or 'I will never feel any better'. Disputation is discussed in more detail on page 12.

What if the client's calculation adds up in favour of suicide? In this case you will know that the risk level is probably higher than at first thought, so protective action may be indicated. Either way, the technique will be useful – hopefully the suicidality is reduced, if not, then a more accurate picture of the risk level is obtained.

Questioning the advantages of suicide or suicidal behaviour

This technique can be used alone, or as a follow-up to the 'advantages' of suicide the client listed in their benefits calculation. If this has not already been done, have the client list all of the perceived advantages to suicide they can think of. Then ask them to think of a catch to each 'advantage'. Here is an example (adapted from Ellis & Newman, 1996):

THE 'ADVANTAGES' OF SUICIDE	
The Plus	**The Catch**
I won't be a burden to my family any more.	They will be devastated if I commit suicide.
I've failed at everything else – at least I will succeed at one thing: ending my life.	If I'm dead, I will never have the opportunity to succeed at anything in the future.
I won't feel bad anymore.	I'll never feel good anymore, either.
After I'm dead, they'll be sorry for how they treated me	If I'm dead, I wont be able to enjoy my revenge
I can make up for my wrongdoing by taking my life	Changing my behaviour for the better is the best way to make up for wrongdoing – but I will never get to do this if I'm dead

THE 'ADVANTAGES' OF SUICIDAL BEHAVIOUR	
The Plus	**The Catch**
It will make them change their ways	They will resent being pressured, and the change won't last
It is comforting to know that I can always end my life if things get too bad	Keeping the option of suicide open stops me from pursuing more helpful options
It is the best way to get help	People are going to focus on my immediate safety, rather than the underlying issues –

	and there is always the risk that I may kill myself accidentally

Identifying reasons for living

Very depressed people tend to magnify the negatives in their lives and minimise the positives. A simple but often effective technique is to have them list reasons to live. It will usually be helpful for therapist and client to start the list together, then the client can continue expanding the list for homework. (NB: if the client is unable to find many reasons for living, using this technique still serves a purpose by showing that the risk is higher than at first thought).

Identifying unfinished business

Here is a further technique that will help identify reasons for living. Have the client list unfinished business in their lives, using headings like the following (adapted from Ellis & Newman, 1996):

- Things I have been meaning to do or complete (list 3-10 key items);
- Why it is important for me to live to do these things (list 3-10 reasons);
- Unfinished business I will attend to now (list 2-3 items).

Generate alternatives

Work with the client to develop possible alternatives to suicide. 'Brainstorming' can be helpful here. Avoid directly suggesting that suicide is not an option – the client knows that it *is* always an option, and direct opposition by the therapist will only serve to damage rapport. The aim is to generate workable *alternatives* to suicide. (See *problem-solving* on page 10).

Increasing the client's ability to cope

Imagery

The client can use the power of their imagination to challenge overly negative ways of thinking and 'practice' new ways of coping. When using any of the techniques listed below, first run through the process several times in the interview, then get the client's agreement to practice several times a day at home (the repetition is important).

Stress inoculation: ask the client to visualise a crisis situation, to generate (within the session) feelings of hopelessness they feel in their everyday life. Then help them identify and change the cognitions which create the unwanted feelings.

Replacement imagery: when the client is experiencing a repetitive dysfunctional image, have them bring the image to mind, then switch to a more functional replacement image (preferably one that you and the client have already worked out together). If, for example, the client keeps getting a picture of going to the garage and setting up the car to die by carbon monoxide poisoning, ask them to (1) experience the negative image, then (2) visualise being in the garage, looking at the car, locking it, leaving the garage and locking that too, and going for a walk or engaging in some other pleasurable activity.

Coping imagery: when the client is visualising not coping with a particular situation, help them plan an alternative scenario where they do cope. Then have them visualise the situation, for example see other people being difficult, but see themselves coping in the more functional way worked out earlier.

Behaviour rehearsal

Therapist and client together can role-play or practice coping with interpersonal situations which the client thinks they cannot manage; for example, acting assertively with a partner, employer, or friend. This can build the client's confidence in their ability to cope, and show them that there are alternatives available to deal with situations they previously saw as having no solution.

Activity scheduling

If the client thinks they are not able to cope with the demands of daily living or get motivated, help them plan how they will spend their time between sessions. The activity schedule provides a structure for this:

1. Divide a sheet of paper into seven parts, one for each day of the week, each divided into hourly blocks.
2. Help the client fill in each block with a task or pleasurable activity.

3. As the client completes each activity, they record next to it a rating of how much pleasure (P) they experienced, and the degree of mastery (M) they think they achieved (in each case using a 1-10 scale).
4. At each interview, review how the client got on with their schedule for that week.

	Daily Activity Plan & Record for week beginning: ………..……		
	Monday	**Tuesday**	**Wednesday**
7-8	Eat breakfast P4 M8 Get dressed P5 M7		
8-9	Walk round garden P6 M9		
9-10	Debbie to visit P8 M9		

Coping plans

When the client lacks confidence they will be able to cope with their suicidal thoughts in particular situations, help them develop a list of strategies they can use if and when the situation of concern occurs. There are two main types of strategy:

- *Practicing a self-help technique* such as relaxation, postponing worry, doing a rational self-analysis, etc. (develop 4-6 of these);
- *Carrying out specified activities* such as mowing lawns, painting the house, etc. and engaging in pleasant activities like soaking in the bath, telephoning a friend, reading a novel, watching a video, and so on (ask the client to list 5-15 items).

Have the client write down the strategies before leaving the session. Ensure they know specifically what to do, and emphasise that the purpose is to simply *cope* with the situation – not be skilful with it.

The coping grid

A more structured variation of a coping plan is the *'coping grid'*. This is set up as follows:

	What I can do when I am alone	**What I can do when with others**
During the day	Practice my relaxation technique. Go for a walk Ring mum	Get involved in whatever they are doing. If a close friend is there, alert them when I feel at risk.
During the evening	Watch TV or a video Ring Debbie or Jan Read a magazine	Same as for daytime
If I wake during the night	Catch up on my letter writing Do a self-analysis If I feel really bad, phone Lifeline	Not applicable

Problem-solving

Suicidal ideation, when oriented toward the 'exit' strategy, represents a perception that there is no hope of problems being solved in the future and that the only solution is to end one's life. Suicide may be seen as 'the solution to end all problems' – the therapist needs to help the client see suicide for what it really is: 'the problem to end all solutions'. Many of the techniques discussed thus far will help show that there are solutions other than suicide.

Problem-solving in general is discussed in Froggatt (1997 & 2003) and Hawton et al (1989); what follows is a brief summary of the standard process:

1. Spell out problems in concrete, specific terms.
2. Select one problem and express it in terms of a *goal*.

3. Brainstorm alternative solution *strategies* aimed to achieve the goal.
4. Consider each strategy (it's possible results, how it fits with the client's values, it's usefulness in achieving the goal), then decide which to pursue.
5. Identify any blocks to carrying out the chosen strategies.
6. Brainstorm specific *tactics* for carrying out the strategies.
7. Select the tactics to use.
8. Put the tactics into practice. Observe the results. If the desired outcome is not achieved, go through the steps again.

Increasing problem-solving confidence

Here is a strategy for helping suicidal clients regain confidence that they can solve their problems (adapted from Ellis & Newman, 1996):

1. Start by helping the client identify times when they have helped others with their problems (a) list names (it may help to list these under headings, e.g. older relative / sibling / spouse / child / friends / etc.); then (b) state the type of problem they helped that person with.
2. Next, have the client choose at least three people from the list and summarise (a) the problem they helped with; and (b) what they said or did to help solve the problem.
3. Finally, have the client list examples of how they have solved their own problems in the past (perhaps using a format like the following):

Problem situation (date/place/event/etc.)	The actions I took	The results of my actions

As this exercise progresses through each stage, Socratically assist clients to see that they do possess problem-solving skills that have been effective for themselves and others in the past. Step 3 will assist them to identify skills they can, perhaps, start using again now.

Identifying and changing dysfunctional thinking

ABC diary (also known as the Daily Thought Record)

Ask the client to record (between sessions) the following items, and bring their diary to the next session:

- The situations where they felt suicidal (the ***A***ctivating events);
- What they were thinking (their ***B***eliefs about the activating events);
- How they were feeling and/or what they did (their emotional and behavioural ***C***onsequences).

Keeping such a diary can help them see suicidal thoughts more clearly and also provide material to discuss with the therapist at the next session. (NB: use this approach only when the client is ready – if they are very unwell, writing down their negative thoughts might simply make them feel worse). Here is an example of such a diary, with the addition of a section for replacing the old suicidal thinking:

A Activating event / Situation	B Beliefs / Thoughts	C Conse-quence	D Disputation / Rational response
Woke up feeling down	I can't stand feeling depressed	Exhaust-ed 5/10	I don't like it, but it is not unbearable – I will feel better if I get myself moving.
Noticed that garden is full of weeds	I should be able to keep things up to date – I'm just useless	Self-downing 7/10	I'm not useless – I'm depressed at present. And while it is desirable to keep things up to date, it's not a Law of the Universe.

Disputation

The main strategy for disputing an irrational belief is through a verbal dialogue between therapist and client. While this can be done didactically, it is usually more successful if the client is helped to check out the rationality of a belief 'Socratically' (i.e. through a series of leading questions), using three basic *strategies:*

Pragmatic ('is this belief useful?'). The aim is to help the client see how an irrational belief leads to negative emotional and behavioural consequences. People are more likely to change a belief when they see that it is harmful to them and serves little or no useful purpose. It is often most effective to use pragmatic disputing first, before the other two strategies: 'What does telling yourself … do to you?' 'What effect does this belief have on the way you feel / behave?' 'What are the consequences for you of believing that … ?'

Empirical ('is this belief supported by the evidence?'). The goal here is to help the client see that their belief is inconsistent with reality, with little or no empirical evidence to support it: 'What evidence do you have for believing that ... must happen?' 'Where is the evidence for thinking that you need ... ?' 'What evidence is there that may contradict this belief?' 'How reliable is the source of your information?' Ask the client to be very specific about the evidence they are using. Help them develop alternative explanations for events and circumstances.

Logical ('does it follow?'). Here you help the client examine and question the logic of their belief, helping them understand why it does not logically follow from the facts: 'How does it follow that because you *want* … to happen, therefore it *must* happen?' 'How does the fact that … is *unpleasant* make it *unbearable*?'

Time Projection

This technique is ideal for helping someone get a loss into perspective. Ask the client to begin by thinking about their loss; then visualise how they will be feeling and how their life will be at increasingly distant times in the future, e.g. in five days time, five weeks, five months, five years. (This can be even more effective if, as well as positive outcomes, the client also realistically foresees some potential problems – and visualises being able to cope with them).

Keep the imagery going for as long as it seems helpful to capture a greater mood of optimism; then ask the client to come slowly back in time to the present, and perhaps attempt to plan the next few days.

Reframing

Suicidal people may see actual or potential losses as catastrophic. Rather than try to directly contradict this, Socratically help them see that they may be exaggerating the badness of events and circumstances. One way to help the client get bad events into perspective is to re-evaluate them as 'disappointing', 'concerning', or 'uncomfortable' rather than as 'awful' or 'unbearable'.

A variation of reframing is to help the client see that even negative events almost always have a positive side to them, listing all the positives the client can think of (this needs care, though, so that it does not come across as suggesting that a bad experience is really a good one!).

Catastrophe scale

The *Catastrophe Scale* is a more elaborate way to get negative experiences into perspective:

1. On a sheet of paper draw a line down the left side. Put 100% at the top, 0% at the bottom, and 10% intervals in between. Have the client insert the event to which they are reacting at the applicable level.
2. At each level, write in something the client thinks could legitimately be rated at that level. You might, for example, put 0% - 'Having a quiet cup of coffee at home', 20% - 'Losing my purse', 40% - being burgled, 80% - being diagnosed with cancer, 100% - being burned alive, and so on. The client will progressively alter the position of their 'activating event' on the scale, in relation to the other items, until they sense it is in perspective. Here is an example of a catastrophe scale for Anna:

CATASTROPHE SCALE Event: Boyfriend left me

100	Burning alive	← original placing
90	Becoming a paraplegic	← 2nd placing
80	Being diagnosed with cancer	← 3rd placing
70	Having my car stolen	
60	Losing my job	
50	Being kicked out of my flat	
40	House burgled	
30	Boyfriend leaving me	← final placing
20	Losing my purse	
10	Catching a cold	
5	Missing my favourite TV programme	
0	Having a coffee at home	

Dealing with self-image issues

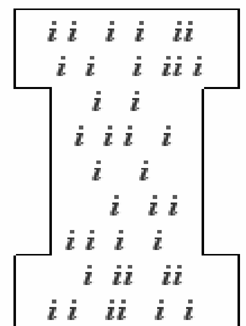
Double-standard dispute

If the client is *self*-downing because they have *behaved* in a bad, stupid or incompetent manner, ask whether they would globally rate another person (e.g. child, best friend, therapist, etc.) for doing the same thing. When they say 'No', then help them see that they are holding a double-standard – which does not make sense. This technique can also be used with the 'shoulds' and 'musts' clients place on themselves; and is especially useful with resistant beliefs.

Big I – Little I

This technique, developed by Arnold Lazarus (1977) and described in detail in Palmer (1997), is a graphical way to help the client see how illogical it is globally rate a human being:

1. Draw a 'Big I' on the whiteboard or on paper (see example).
2. Ask the client to list various things about themself, beginning with positives: 'If I asked your family or friends what are your good points, what do you think they would say?' For each item the client lists, draw a little 'i' inside the big one. Point out that these little 'i's stand for the good points they have listed.
3. Now ask the client what negative things their family or friends might list. Again, draw little 'i's for each item.
4. Then do the same for 'neutral' items.
5. Discuss the end result with the client. Socratically help them see that human beings are a mixture of many positive, negative and neutral actions and characteristics, and that it is, therefore, impossible to rate a whole person.



This technique is It is most effective when, rather than simply pointing out didactically how illogical it is to rate a human being, the client is helped to an understanding of this through a process of Socratic questioning.

When things really are bad

Sometimes the client's perception of their external problems may be based on reality. It is important that the therapist not be seen as minimising these. It is better, in such cases, to acknowledge that the client does have significant problems, then help them see that:

1. Not all people with severe problems become suicidal;
2. Suicidal feelings arise when a person adds to their original problem by self-blaming, catastrophising, or demanding the problem not exist;
3. Dealing first with such thinking will enable the individual to better solve their external problems.

Ellis & Newman (1996) present a useful discussion of so-called 'rational suicide', pointing out the problems with this concept.

For clients facing unpleasant circumstances that cannot be changed, it may be helpful to introduce the principle of *acceptance of reality* (Froggatt, 1997 & 2003). Acceptance is not the negative concept it may seem at first glance. To accept something does not mean that we have to agree with it: one can strongly wish or *prefer* it not exist, while realistically accepting there is no reason it *should* not exist. And acceptance is not 'resignation' – it does not mean we have 'give in' to things we dislike. We can continue to seek better solutions, but without the demand: 'Things must not be as they are', which induces hopelessness.

What, then, is acceptance? To accept something is to acknowledge three things: first, that it is a reality; second, that although it is unpleasant, it is bearable; and third, that even though it may be undesirable, there is no law of nature saying that it 'should' not be as it is. To increase one's tolerance for unpleasant realities that are difficult or impossible to change may be the ultimate protection from self-destruction.

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Personal Safety Management Plan

For: …………………………………………………… **Date:** ……………………

If I have thoughts about harming myself, I will do the following:

- Do something physical (e.g. go for a walk, exercise, etc.) as follows:

  ____

  ____

  ____

  ____

- Do something that is usually enjoyable (whether or not it seems enjoyable now) – like the following:

  ____

  ____

  ____

  ____

- Call and talk with a friend or someone else, such as (list names & phone numbers):

  ____

  ____

  ____

  ____

- Write down, analyse and change the thoughts about self-harm (delete if inapplicable).

If thoughts of self-harm persist, I will make contact with the following:

(list names & phone numbers)

- My counsellor: ______________________________
- My doctor: ______________________________
- Doctor's after hours service: ______________________________
- Psychiatric emergency service: ______________________________
- Telephone counselling service: ______________________________
- Psychiatric Unit: ______________________________
- Hospital Accident & Emergency: ______________________________
- Police: 111
- Other: ______________________________

  ____

  ____

Self-Harm Attempt Assessment Form

NAME: ______________________________ DATE: __________ Checked to see if client already known ?

INCIDENT
What did they do?
When? Where?
Who was around?
Expect to be found? Told anyone - before? - after?
Planned? Anticipated result ...
Wanted to ...
Now think - re still alive?
- re incident?

REASONS
Background
Trigger

BACKGROUND
Previous Attempts - self
- family
Psych. History - self
- family
Previous Help

DEMOGRAPHIC
Social
Family
Supports
Employment
Financial
Spends time
Other problems

PERSONAL
Physical
Alcohol/Drugs
Mental state
- Mood
- Sleep
- Appetite
- Diurnal variation
- Concentration
- Slowed down/Lethargy
- Loss of interest
- Social withdrawal
- Guilt
- Anxious
- Health concerns
- Suspicious
- Thought disorder
- View of future
- Suicidal

FUTURE
Situation returning to
Things concerned about?
Future Help:

GENERAL

At-Risk Indicators

BACKGROUND
Male
High expectations of self
Chronic physical condition / pain / disability
Alcohol & other substance abuse / addiction (self or family)
History of psychiatric problems (self or family)
Current depression
Previous suicide attempts
Family history of suicide
Preoccupation with themes of death
Suppressing emotions
Negative view of own life and future
Social isolation / poor family support
Sudden loss (bereavement, job, etc.)
Significant life changes
In abusive relationship

For Adolescents:
family breakup, conflict; parents seen as hostile, indifferent, having extremely high expectations or highly controlling; poor communication skills, peer relationships, school achievement; antisocial behaviour; sexual or physical abuse; recent suicide by friend or relative.

CURRENT
Attempt to conceal discovery
Preparation (suicide note, tidying affairs, etc.)
Knowing use of lethal method:
- firearms } higher
- hanging }
- gassing }
- pills } lower

Disability resulting from attempt
Current suicidal thinking
Interviewer unable to establish emotional contact with client

Assessment procedure

1. Check to see if client already known to agency
2. Read medical file & talk to staff
3. Interview client
   a) Minimal rapport to facilitate assessment
   b) Explain why you're there.
   c) Ask sufficient questions to get a clear picture (see checklist on other side)
4. Contact significant others (as appropriate): G.P., associates, family, etc.
5. Consider at-risk factors (see opposite) and options:
   a) Remain in hospital to enable further assessment/checking.
   b) Discharge with no follow-up
   c) Discharge with follow-up
   d) Discharge with supervision from friend or relative
   e) Refer to psychiatrist for second opinion (NB: always do so if consultant wants this)
   f) Refer for admission to Psychiatric Unit.
   g) Compulsory assessment or treatment under Mental Health Act
6. Whatever is recommended, consult duty psychiatrist (in straightforward cases send copy of your report).

Reducing suicide risk after discharge

1. Explain that it's hard to kill yourself but easy to do internal damage
2. Help client separate the problems & look at solutions available
3. Plan how client will cope in situations which lead to suicidal thoughts
4. Identify 1-3 resource people to whom they can & will turn to when feeling suicidal (family, friend, church members, daycentre, volunteer, etc.)
5. Explain sources of emergency help
6. Check for & secure any substances/ weapons etc client had considered using
7. Make an agreement:
   a) they won't harm themselves within a certain period; and
   b) if they feel suicidal, they will contact people identified in 4. & 5. above

Assessment Checklists

DEPRESSION

	MODERATE	SEVERE	SERIOUS
Depressed mood	gloomy, sad	weepy, heavy	deep despair
Loss of interest	neglects usual interests	doing little, productivity down	rejects any enjoyment or satisfaction
Social withdrawal	neglects friends and social activities	actively avoids social contact	not responding to environment
Hopeless-ness	wonders if improve-ment possible	highly pessimistic about the future	sees no future for self, world, etc.
Suicidal feelings	feels life is not worth living	considers suicide	plans or attempts suicide
Sleep problems	hard to fall asleep, restless, wakes	wakes early AM, can't get back to sleep	
Retard-ation	slow thought, speech, activity; lacks energy	apathy	complete stupor
Appetite changes	appetite reduced – or overeating	weight loss	major weight loss, or stops eating
Physical symptoms	wind, indigestion, constipation, feeling of heaviness	cardiovascular, palpitations, respiratory, pains, headaches	
Sexual / Genital	loss of interest in sex	menstrual disturbance, erectile failure	
Diurnal variation	mood same through the day, but each day may be different	mood varies through the day, same pattern every day	
Concen-tration / Cognitive	hard to read, follow TV programme, etc	gives up because of poor concentration	disordered thinking, depersonalisation, derealisation
Health concerns	worries about health	preoccupied with health	hypochondriacal delusions
Guilt	self-reproach	sees depression as a punishment	delusions of guilt
Anxiety	restless, tense, irritable	apprehensive, fears, worries over trivia	highly agitated
Suspicious thinking	suspicious of others and their motives	ideas of reference	delusions of reference or persecution

SUICIDE RISK

GENERAL RISK SCREENING

- male
-
- high expectations of self
- chronic physical health problem / pain / disability
- substance abuse / addiction (self or family)
- history of psychiatric problems (self or family)
- current depression
- family history of suicide
- previous suicide attempts
- focus on themes of death
- suppressing emotions
- negative view of life/future
- social isolation
- poor family support
- in abusive relationship
- sudden loss (relationship, redundancy, bereaved, etc.)
- anniversary/reminder of loss
- significant life changes
- intoxication
- ***for adolescents:*** family family breakup, conflict; parents seen as hostile, indifferent, having extremely high expectations or highly controlling; poor communication skills, peer relationships, school achievement; antisocial behaviour; sexual or physical abuse; recent suicide by friend or relative.

CURRENT RISK ASSESSMENT

- Thinking of suicide now?
- How lethal is the proposed method? (Higher- firearms, hanging, gassing, cutting wrists, pills -Lower)
- Any preparations? (giving away valued possessions, making a will, etc.)
- What situations trigger suicidal ideation?
- What positives/options seen in self or circumstances?

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