The Specialist Academy

Cognitive Behavioural Therapy (CBT)

Course Manual

Course Contents

The Specialist Academy

Module 12:

CBT for those at risk of suicide

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Overview

This module aims to address the use of CBT for people at risk of suicide. Overall, the objectives of this module are to examine the use of CBT in this instance including specific intervention techniques for this client group.

Background and theory

When working with clients who have experienced or are experiencing suicidal thoughts or who have a history of attempted suicide, great care must be taken to ensure that CBT is delivered in a manner which is tailored to these individual circumstances.

Key theorists in the area of application of CBT for clients experiencing suicidal ideation or with a history of attempted suicide are Beck et al. (1974, 1976), Robins et al. (1959) and Roy (1982) to name a few. In terms of questionnaires which have been found to be of use to CBT practitioners for clients presenting with this symptomatology, the following are most commonly implemented across the field:

Reasons for living scale (Linehan, 1985)

This scale is usually utilised when working with clients for whom the practitioner wants to gain an understanding of adaptive characteristics in suicide.

Hopelessness scale (Beck et al., 1971)

The hopelessness scale is most often used to assess the degree of suicide risk in clients at the beginning stage of CBT, additionally, this scale can be useful as an interim and follow-up measurement to assess the effectiveness of the treatment.

Additionally, the Scale for suicide ideation (Beck et al., 1971), the Prediction of suicide scale (Beck et al., 1974), the Los Angeles suicide prevention scale (Los Angeles Centre for Suicide Prevention, 1973) and the Beck depression inventory (Beck, 1978) have been found to be of use when working with clients affected by suicidal ideation.

Factors associated with increased risk

Many factors have been found to have an association with an increase in the risk of both generations of suicidal thought processes, attempted and completed suicide. These risk factors include:

- Making intention to complete suicide clear to another party
- Being male – increased risk in males over females, particularly young men
- Being older – the risk of suicide increases with age, peaking for those who are single, widowed or divorced in later life
- Those who focus on cognitions associated with past suicide attempts.
- Those with a previous suicide attempt
- Those who attend to current suicidal thoughts and impulses
- Cognitions of hopelessness – found to be one of the strongest indicators of suicide
- An individual believes that they are caught in a cycle whereby death is viewed as a more viable option than living
- If an individual has a clear suicide plan to be implemented in the next 24-48 hours – this indicates a high risk of suicide completion and the patient should be hospitalised or moved to a safe location as soon as possible
- Clients who have a chronic or life-limiting condition, including both physical or mental illness are considered high-risk
- Misuse of drugs or alcohol
- Social isolation

Therapeutic intervention

Most importantly, if placed in a positon whereby a CBT practitioner is made aware that a client is at risk of suicide, this should always be taken seriously. The manner in which a client may convey their suicidal ideation can vary greatly dependent upon the individual but may include behaviours such as lack of appetite (both eating and drinking), giving away personal possessions, organising personal affairs, written

messages, pictures or symbols of suicidal thought. It is also important to understand that speaking with a client about the potential for suicide does not increase the risk that they will attempt or complete suicide.

The guidelines which are suggested when working with clients who present in this way is as follows:

1) Target thoughts of hopelessness
2) Focus on strengthening thoughts and desires to live and weakening thoughts/urges to die
3) Teach problem-solving techniques and abilities such as:
    - Awareness of change in mood
    - Awareness of unhelpful thought processes
    - Introduction of cognitive and behavioural experiments
    - Assisting the client to draw up helpful action plans as an alternative to suicide
4) Set aside time and allocate your full attention to suicidal thoughts or attempts
5) Help the client to see life crisis in a non-catastrophic manner
6) Help the client to bring about hope for the future by equipping them with alternative to suicide

Multiple choice questions

1) *Which is a questionnaire used primarily for those with suicidal ideation*
    a) *Hopelessness scale*
    b) *Mood rating scale*
    c) *Negative thought process questionnaire*

2) *Males are more at risk of suicide*
    a) *True*
    b) *False*

3) *If a person has a suicide plan to be implemented in the next 48 hours, they should:*
    a) *Be hospitalised*
    b) *Go to a quiet place*
    c) *Be left alone*

4) *If a client presents with suicidal ideation, the practitioner should:*
    a) *Always take them seriously*
    b) *Take them seriously if they have self-harmed*
    c) *Ignore them*

5) *A client can communicate suicidal thoughts by*
    a) *Pictures*
    b) *Words*
    c) *Actions*
    d) *All of the above*

6) *Which of the following is a suicide-specific CBT intervention?*
   a) *Assisting the client to draw up helpful action plans as an alternative to suicide*
   b) *Positive behaviour support*
   c) *Medication*

Bibliography

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