

Cognitive Behavioral Therapy for Suicidal Behavior

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Donna M. Sudak, MD

Funding and Disclaimer



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About SPRC

The Suicide Prevention Resource Center (SPRC) is the only federally funded resource center devoted to advancing the implementation of the *National Strategy for Suicide Prevention*. SPRC is supported through a grant from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration.

SPRC builds capacity and infrastructure for effective suicide prevention through consultation, training, and resources for state, tribal, health/behavioral health, and community systems; professionals and professional education programs; and national public and private partners and stakeholders.

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We acknowledge that the land that now makes up the United States of America was the traditional home, hunting ground, trade exchange point, and migration route of more than 574 American Indian and Alaska Native federally recognized tribes and many more tribal nations that are not federally recognized or no longer exist.

We recognize the cruel legacy of slavery and colonialism in our nation and acknowledge the people whose labor was exploited for generations to help establish the economy of the United States.

We honor indigenous, enslaved, and immigrant peoples' resilience, labor, and stewardship of the land and commit to creating a future founded on respect, justice, and inclusion for all people as we work to heal the deepest generational wounds.



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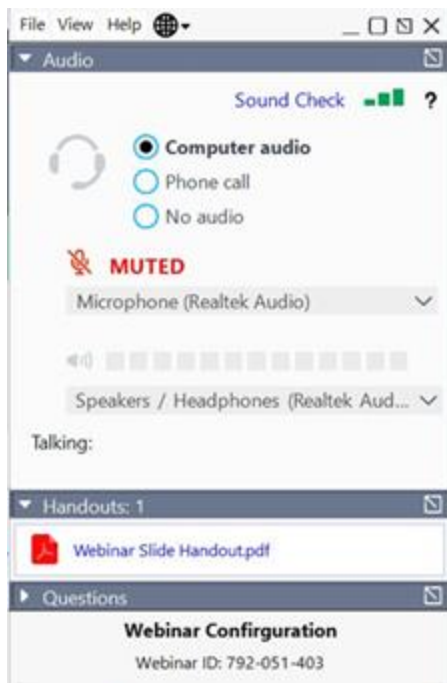
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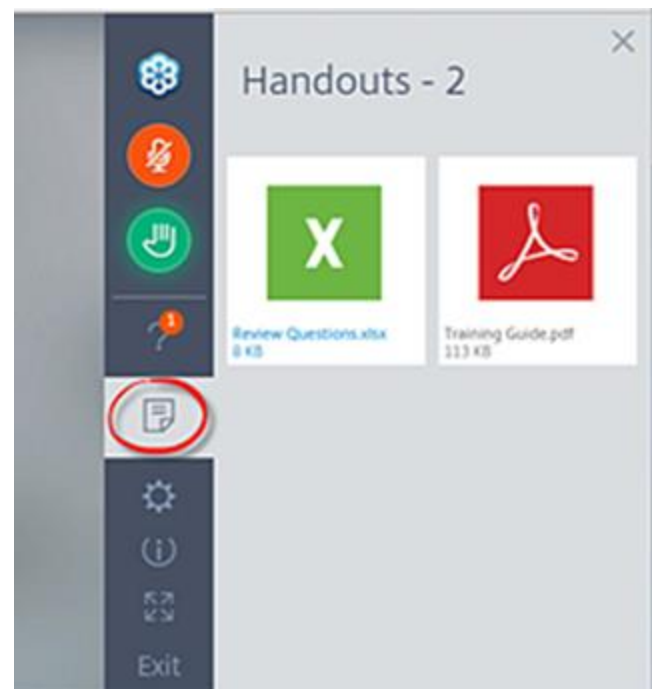
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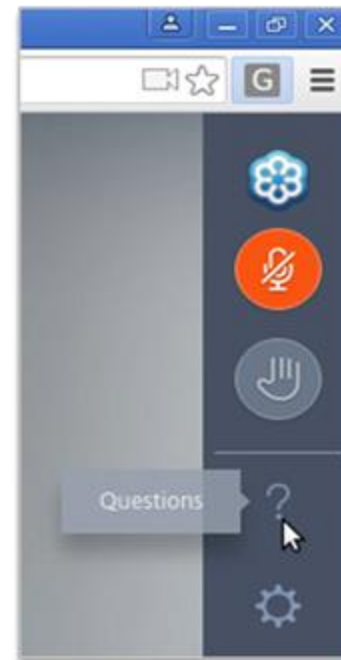
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CBT for Suicidal Behavior

Donna M. Sudak, MD

Disclosures

- Book Royalties - American Psychiatric Publishing, Wolters Kluwer, Wiley and Sons
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Overview



- Why Cognitive Behavioral Therapy (CBT) for suicidal behavior?
- Evidence for CBT in patients with suicidal behavior
- Basic principles of CBT
- The CBT conceptualization of suicidal behavior
- Risk assessment generates preliminary conceptualization of suicidal behavior
- Treatment planning and safety planning
- Specific techniques useful for patients with suicidal behavior



Why CBT for Suicidal Behavior?

Beck's Contribution to Suicide Research

- Separated intent, degree of intent, attempt, and perceived medical lethality as risk factors
- Developed Suicide Intent Scale (*Beck, Schuyler, & Herman, 1974*)
- Developed Scale for Suicide Ideation (*Beck, Kovacs, & Weissman, 1979*)
- Identified hopelessness as a key intervening variable (*Beck et al., 1985; Beck, 1986*)
- Recognized role of mitigating circumstances (e.g., substances)
- Developed brief CBT for suicide (*Brown et al., 2005*)



Evidence for CBT in Suicidal Behavior

Safety Planning

A large-scale comparative cohort study of safety planning interventions coupled with structured follow-up reduced the risk of suicidal behavior by 50% and achieved a two-fold increase in the odds of treatment engagement over a six-month period.

www.suicidesafetyplan.com

50%

Source: Stanley, Brown et al., 2018

www.sprc.org

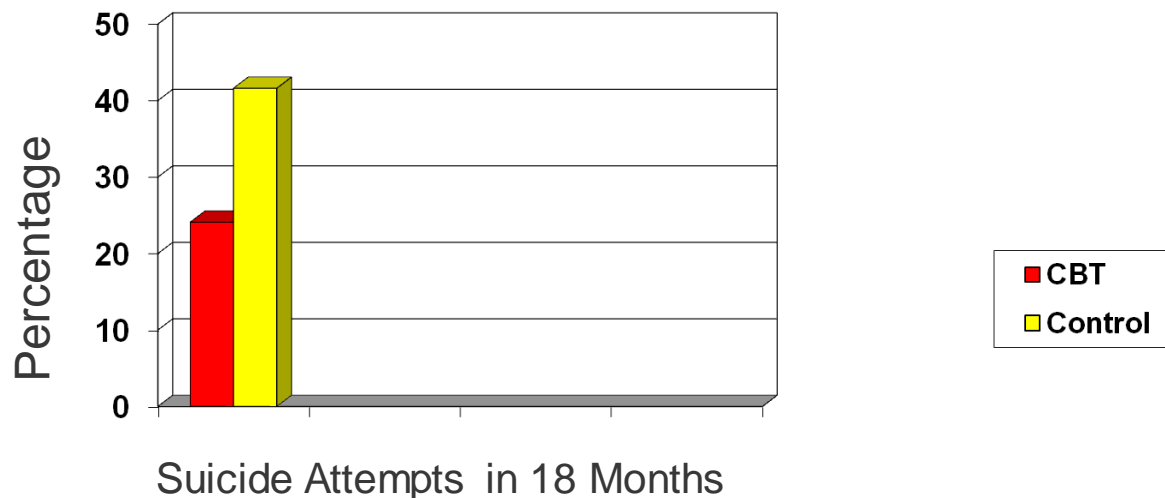
CBT Approaches and Suicidal Behavior

- **Tarrier, Taylor, & Gooding (2008) meta-analysis**
 - 28 studies
 - Highly significant effect of CBT interventions on suicidal behavior
 - In adults in individual therapy
 - Compared to minimal treatment or treatment as usual (TAU)
- **Mewton & Andrews (2016) meta-analysis**
 - Treatment is more effective when directly targeting suicidal thoughts and behavior
- **Hawton et al. (2016) meta-analysis**
 - CBT decreases percentage of people with repeat self-harm
 - DBT decreases the frequency of self-harm but not the percentage of people who self-harm

CBT for Suicide

Brief CBT intervention (10 sessions) specifically focused on hopelessness, problem solving, impulse control, treatment compliance, and social isolation.

Repeat Attempts 24.1% vs. 41.6% TAU



Dialectical Behavior Therapy (DBT)

DeCou, Comtois, & Landes (2019) meta-analysis

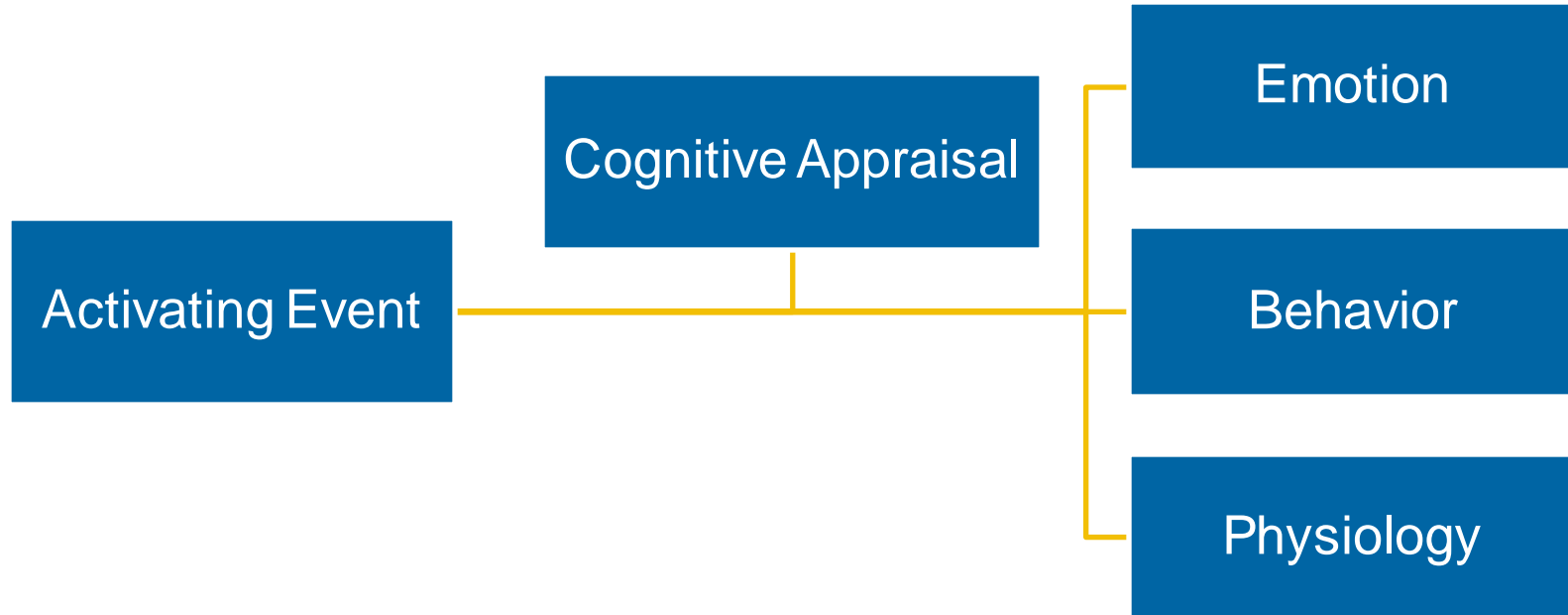
- 18 randomized controlled trials (RCTs)
- DBT reduces:
 - Self-directed violence
 - Suicide attempts
 - Non-suicidal self-injury



Basic Principles of CBT

Cognitive Behavioral Therapy

- Pragmatic
- Problem- and solution-oriented
- Based on information processing model and learning theory
- Highly collaborative
- Adaptable to many conditions and applications
- Compatible with pharmacotherapy and other approaches
- Empirically tested



Individual Case Formulation in CBT

- Key component of treatment
- Synthesizes patient's biopsychosocial history and a framework for the understanding of a specific psychological disorder—"working hypothesis"
- Explains current symptoms—thoughts/emotions/behaviors/physiology—in the context of personal history/current triggers/skill deficits
- Accounts for perpetuating and protective factors
- Attempts to explain how the patient learned to think about the world

Treatment Modalities Used in CBT

- Cognitive restructuring
- Behavioral activation
- Exposure
- Contingency management
- Stimulus control
- Skill deficit remediation
- Psychoeducation



Learning Theory and CBT

- Skill development and psychoeducation vital to durable recovery
- Structure of the session facilitates learning and efficiency
- Practicing tools outside of the session critical to generalize skills to patient's everyday life

Structure of CBT Session

- Mood/symptom check
- Agenda
- Bridge from last session
- Work on today's agenda items
- Capsule summary
- Action plan
- Patient feedback



Therapist and Patient Are a Team

- Common factors
- Socratic questioning
- Feedback
- Skill training
- Collaboration





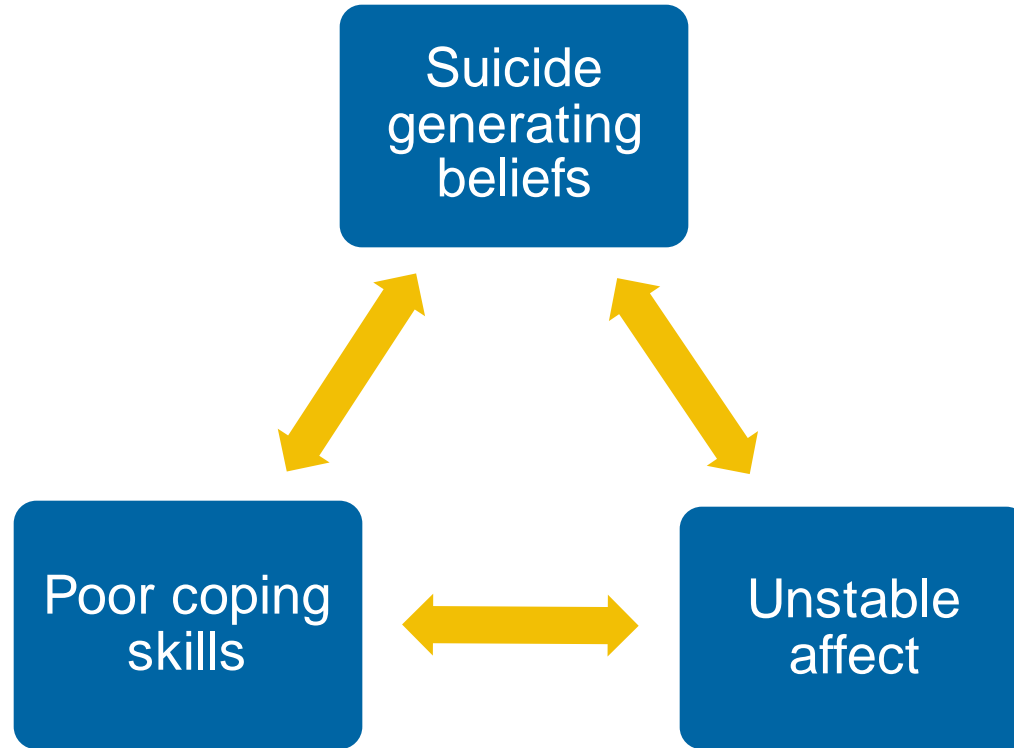
The CBT Conceptualization of Suicidal Behavior

Suicide Diathesis

- More severe suicidal ideation and emotional pain (heritable)
- Cognitive distortions—negative social signals amplified; positive signals discounted (demonstrated even when euthymic on fMRI)
- Decision-making leads to suicide attempt instead of seeking help
- Problem-solving deficits result in perception as trapped with no other options

Source: Mann, Michael, & Auerbach, 2021

CBT Conceptualization of Suicidal Behavior



Source: Wenzel, Brown, & Beck, 2009

Cognitive Model as Applied to Suicide

- Ability to be flexible in the presence of negative affect diminished
- Highly impaired problem-solving and perspective-taking
- High degree of hopelessness
- Deficient autobiographical memory
- Biased attention toward losses, failures, and suicide cues
- Eventual preoccupation with suicide as a solution
- Ideation and attempts often perpetuated by subsequent decrease in negative affect

Source: Wenzel, Brown, & Beck, 2009

www.sprc.org

Suicidal Behavior as Problem-Solving Behavior

- Problem-solving deficits are significant in patients with suicidal behavior
 - Patients approach problems, experience anxiety, and often avoid solving the problems
- Problem-solving styles
 - **Avoidant:** Avoids confrontation, neglects the problem, avoids negative emotion
 - **Impulsive:** Engages in substance use, rash decisions, other self-destructive activity (e.g., gambling, sex)
 - **Ruminative/brooding:** Worries, repeatedly contemplates past hurts and failures



Risk Assessment Generates Preliminary Conceptualization of Suicidal Behavior

Key Components of Risk Assessment

- Demographic/diagnostic – Age, **sex, medical**, psychiatric
- Environmental – **Weapon in home**, means available, recent change in level of care
- Psychiatric/psychosocial history – Hospitalization, **prior attempts**, child sexual/physical abuse/neglect, family history, current psychosocial stressors, history of psychosis
- Process and content of thinking – **Hopelessness**, impulsivity, problem-solving deficits, perfectionism, over-general/deficient autobiographical memory
- History of suicidal behavior and intent

Patients with History of Attempts

- More severe psychopathology
- More significant suicidal ideation, interpersonal impairment, past trauma (sexual, emotional)
- Attempt earlier in life
- Family history of suicidal behavior

Obtain a Detailed Picture of Suicide Relevant Behavior

- Assess reaction to attempt/ideation.
- Assess lethality and perceived lethality of suicidal behavior.
- Do a careful behavioral analysis of the most severe or most recent event, looking for common themes and triggers—the narrative of emotions, images, behaviors, thoughts, and beliefs at the time.
- This chain provides material for safety planning (looking for warning signs) and future interventions (intervening to change maintenance factors) to protect the patient.

Obtain Reasons for Living

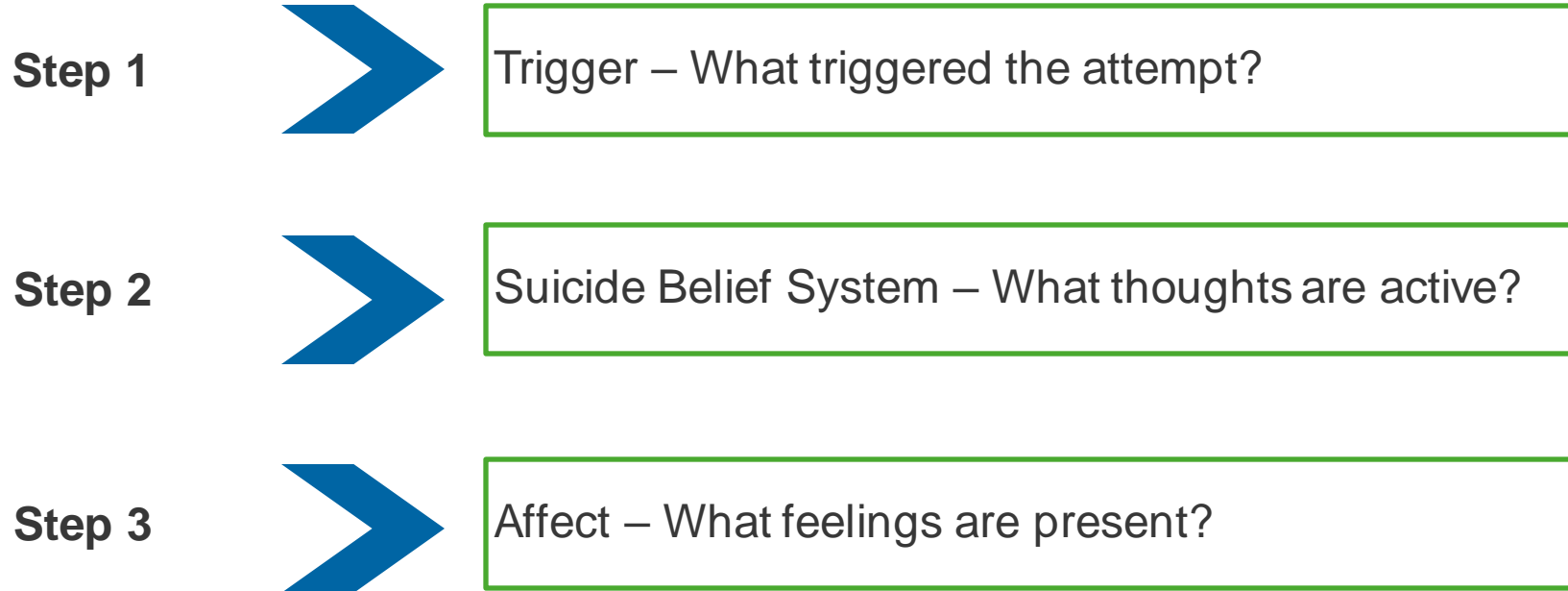
Six sets distinguish non-suicidal from suicidal

- Survival and coping beliefs
- Responsibility to family
- Child-centered concerns
- Fear of suicide
- Fear of social disapproval
- Moral objection to suicide

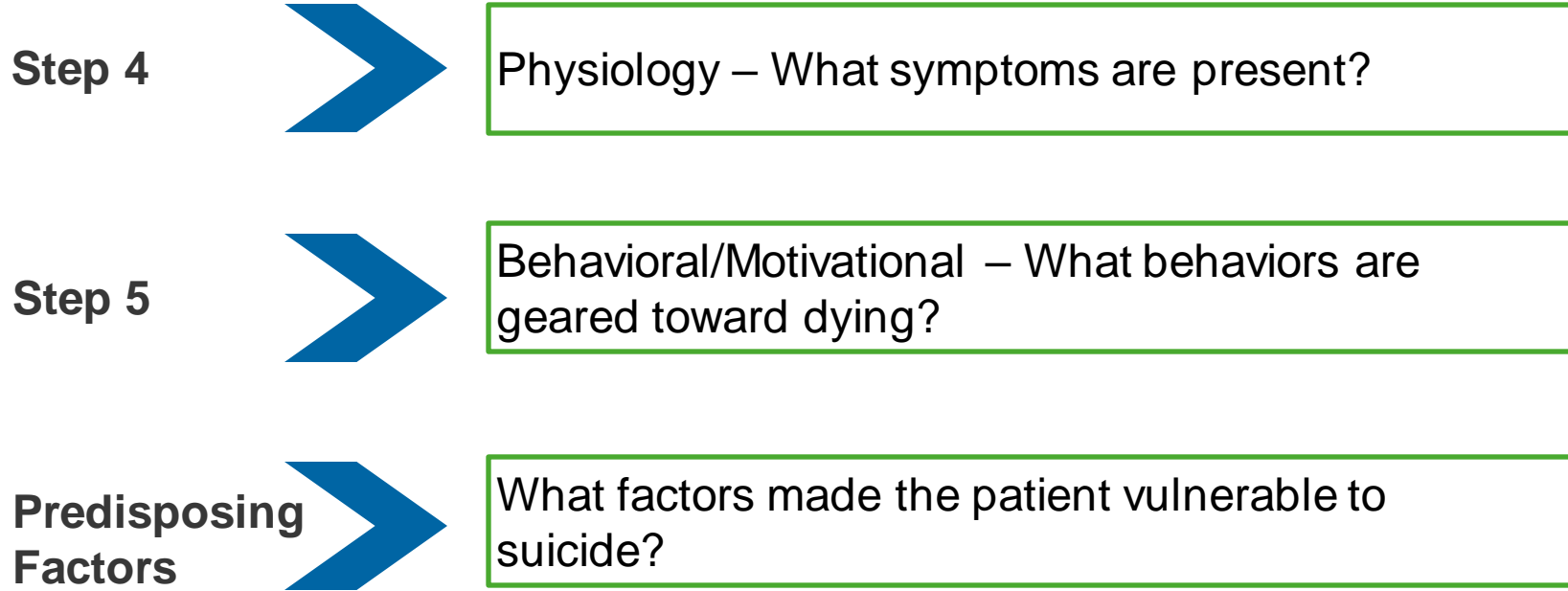
Cognitive Features Common in Suicidal Behavior

- Characteristics of thoughts and beliefs frequently activated prior to attempts
 - Rigid and absolute
 - Self as hopeless, helpless, unlovable
 - Intolerance of distress or pain
 - Suicide viewed as a desirable solution
 - Dichotomous thinking
- Impaired recall about positive memories, affects, coping behaviors

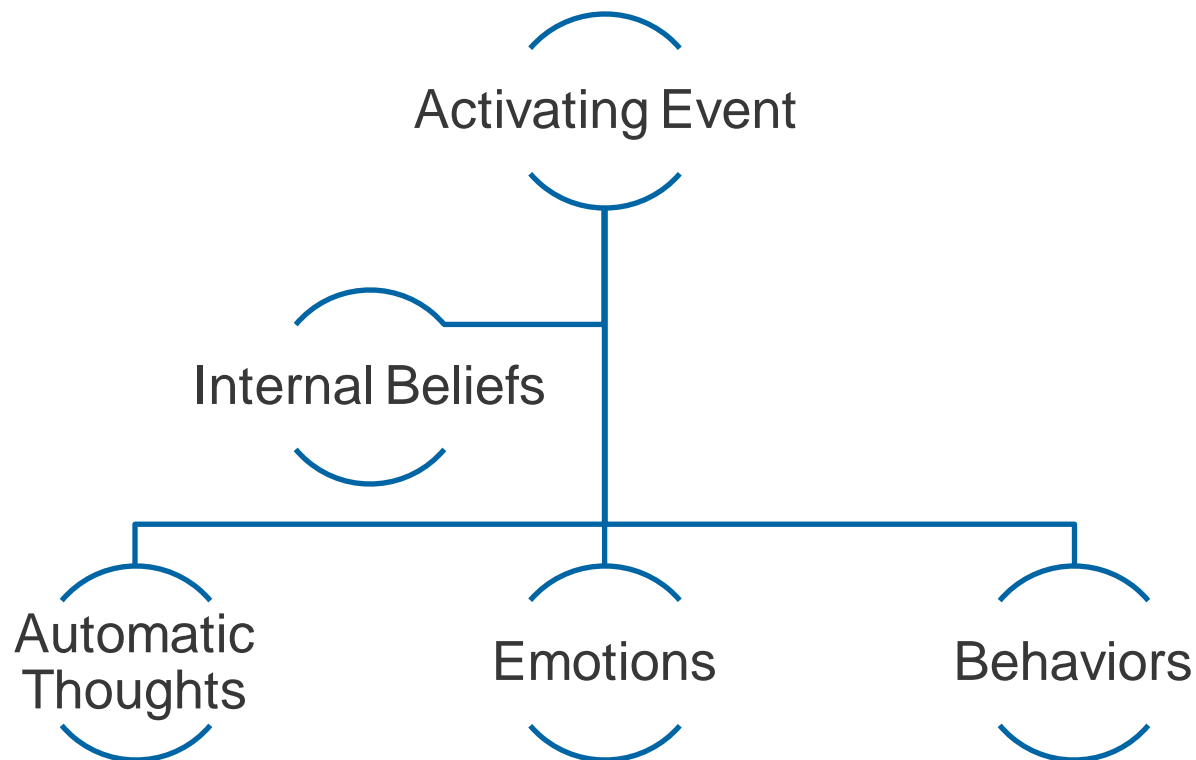
Suicide Mode in Action



Suicide Mode in Action



Cognitive Model as Applied to Suicide





Treatment Planning

General Interventions

- Obtain agreement that goal of treatment is preventing suicide
- Ensure environmental safeguards
- Assess risk in ongoing way
- Collaborate and attend to the relationship—understand suicidal behavior from the patient's point of view
- Target suicidal thinking and hopelessness with cognitive and behavioral interventions
- Write down the treatment plan
- Attend to continuity of care

Therapist Stance

- Be highly active, directive, calm, determined, empathic about pain
- Keep patient in treatment—call about missed appointments
- Maintain curiosity and interest—talk about the patient’s point of view
- Do not preempt discussion of suicide
- Proactively search for solutions
- Cope ahead

Goals of Interventions

- Develop alternatives to:
 - Suicide
 - Views of the future that are hopeless and include the idea that life is unbearable
 - Suicidal behavior during acute distress
- Fire drill mentality:
 - Patient must capably employ skills in presence of negative affect to ensure relapse prevention

First-Line Interventions

- Obtain agreement that the goal of treatment is to prevent suicide (level of care determined here)
- Safety plan – With significant others' involvement, guns and other means removed
- Tell patient you do not want them to die by suicide and that you believe life could improve and why; indicate positive regard
- Generate meaningful reasons for hope and living with the patient



Safety Planning

Key Points in Developing Safety Plans

- Collaborate, recording brief instructions in patient's own words.
- Plan is available in writing.
- Patient is instructed to follow the steps of the plan in order, stop when urges pass, and to go to hospital if acting on urges is imminent.
- Rationale
 - Emergency situations can be improved by having a plan.
 - Suicide urges go up and down; a plan to manage them can save your life.
- “Think about the last time you had an intense desire to kill yourself. Let's go back as if we were in a time machine. Describe it like a slow-motion movie frame by frame. What happened just before it started?”
- Look for components of the suicide mode—thoughts, images, emotions, actions, physiology.

Steps to Follow in Safety Plans

- Identification of warning signs
- Coping strategies that can be done alone
- People/places that can distract (include contact info)
- People who can discuss the crisis (include contact info)
- Professional help (include contact info)
- Lethal means reduction
- Reasons for living

Make the Plan Detailed, Effective, and Specific

- Provide a rationale
- Ask patients for ideas and brainstorm further solutions—do not tell them what to do
- Remind patient the goal is not to feel good—just to get through the crisis
- Elicit likelihood of follow-through
- Identify obstacles and brainstorm solutions
- Make sure the patient gets a copy of the plan
- Ask where it will be kept

Lethal Means Reduction

- Collaborate to make the environment safer
- Express your concern and that you want the patient to stay alive
- Elicit pros and cons of removal of lethal means
- Highlight brief nature of suicidal urges
- Determine what it would mean to give up access
- Include firearms even if not the patient's preferred method

Finding Reasons to Live

- Ask patients for reasons to live
- Paint an emotional picture to connect the patient to, and amplify the meaning of the reasons
- If there is difficulty identifying reasons to live, ask questions that break through hopelessness and pessimism
- Play for time

Build a Hope Box

- Pictures
- Letters
- Poetry
- Prayer cards
- Coping cards
- Meaningful mementos or tokens
- Container can be anything as long as it is easily accessible (e.g., shoebox, folder, phone app)



Virtual Hope Box: <https://apps.apple.com/us/app/virtual-hope-box/id825099621>

Mary's List of Reasons to Live

- **My children**
 - I don't want to hurt them.
 - I am very important to them.
 - I love them deeply.
- **My husband**
 - I really care about him.
 - He is sticking by me.
- **My father is back in my life**
 - He wants to do things with the kids and me.
 - This is a good opportunity for me.
- **I would like to go back to school to become a nurse**
 - I want to be a nurse and help people.

Problems/Solutions with Safety Plan

Problem	Solution
Difficulty generating reasons to live	Ask Socratic questions that draw out healthier perspectives on living. Ask “What about family...how would they react? What about spiritual beliefs? Things you still want to do? How would you have answered this question before you were depressed? What would a good friend say?”
Difficulty finding behaviors that reduce emotional pain	Be more directive, suggest behavioral strategies with high chance of success.
Ambivalence about committing to a safety plan	Get family or friends involved; admit to hospital if needed.
High stress expected	Generate plan to manage stress; put extra safety precautions in place in case of expected events.



Further Cognitive and Behavioral Interventions

Hopelessness

- Important alterations in thinking occur that are associated with suicide
 - Rigid, biased, absolute judgments, dichotomous thinking—more fixed core hopelessness
 - Errors in logic and information processing—particularly selective abstraction and overgeneralization
 - Beliefs and subsequent emotions with themes of loss, defeat, worthlessness
 - Beliefs about the self as a failure

Managing Hopelessness

- Develop a sense of the life the patient wants. What was best period of life in the past?
- Strengthen sense of connection to others, purpose, safety, competence, control.
- Provide reasons for optimism—about treatment, about coping skills you have seen in the patient.
- Spell out how treatment will work, and include a plan B.
- Attend to what went well week to week and relate it to the patient.
- Set and work toward realistic goals.

Behavioral Techniques for Acute Suicidality

- Journaling – Particular emphasis on search for positive/meaningful, make last item something that is thankful
- Crisis management cards
- Positive behavioral change – Activities, self-care, pro-social behavior
- Distraction, physical sensations, relaxation, self-soothing behaviors
- Bibliotherapy

Cognitive Techniques for Acute Suicidality

- Play for time
 - Advantage/disadvantage analysis of living and dying—for self/others, now/in future
 - Timeline regarding the finality of death and events to be missed; future time imagery regarding the life the patient wants
 - Delay tactics
 - Answer rhetorical questions
- Monitor thoughts about suicide that are problematic

Coping Cards for Suicidal Ideation

- Personalized
- Warning signs – Hopelessness, pessimism
- Concrete plan to manage ideation
- Reasons to live
- Reasons to die with reframing
- Crisis plans

Coping Card



Source: <https://sunnybrook.ca/content/?page=coping-card-mental-health>

Coping Card – Jump-Start Adaptive Thinking

“My boss humiliated me so I should kill myself.”

This is my negative belief. Even though I feel angry and hopeless I need to remember:

- My family will be devastated.
- I know I will feel better later.
- He is not that important.
- People live through work stress, and I can too.

I should call a friend. If I don't feel better, I will use my crisis card.

Resources

American Foundation for Suicide Prevention:

www.afsp.org

Now Matters Now:

www.nowmattersnow.org

Stanley-Brown Safety Planning Intervention:

www.suicidesafetyplan.com

Virtual Hope Box:

<https://apps.apple.com/us/app/virtual-hope-box/id825099621>

Suicide Prevention Resource Center:

www.sprc.org

Substance Abuse and Mental Health Services Administration:

www.samhsa.gov

National Action Alliance for Suicide Prevention:

www.actionallianceforsuicideprevention.org



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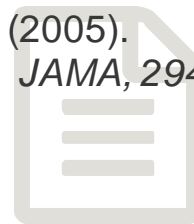
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Questions?

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Thank you!

Donna M. Sudak, MD
ds42@drexel.edu

Suicide Prevention Resource Center

1000 N.E. 13th Street
Nicholson Tower, Suite 5900
Oklahoma City, OK 73104

sprc.org



@SPRCTweets