Cognitive Behavior Therapy for Suicidality: Getting to the Eye of the Storm

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Day 1 Agenda
CBT for Suicide
1. Review of CBT Fundamentals
2. Cognitive Theory of Suicide
3. Suicide Risk Assessment
4. Early Phase of Treatment
Summary and Q&A

Day 2 Agenda
CBT for Suicide
1. Early Phase of Treatment, cont.
2. Intermediate Phase of Treatment
3. Later Phase of Treatment
4. Treating Suicidal Adolescents
5. Practice
Summary and Q&A

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The best predictor of completed suicide is a history of attempted suicide.

Glatto & Rai (1999)

Coping Card

**Situation:** Client expresses suicidal intent

**Automatic Thoughts:**

Objectives

• Describe a CBT protocol for the treatment of suicidality
• Conceptualize suicidal thinking and behavior from a CBT perspective
• Apply specific CBT techniques for the treatment of suicidality
The Problem with Suicide Research

- Only 49 RCT focusing on suicidal behavior (attempts)
- Lack of operational definitions
- Infrequent use of validated measures
- Infrequent use of blind assessment
- Exclusion of high-risk (suicidal) subjects

Rationale for Suicide-Focused Treatment

What do we know from the literature about preventing suicide?

- Hospitalization does not work
- Pharmacotherapy does not work
- No-suicide contracts do not work


Rationale for Suicide-Focused Treatment

- Suicidal clients are unavoidable
- Treatment of suicide is seldom taught
- Suicidality is usually addressed in the context of treating an Axis I or II disorder; needs to be the focus of treatment
- Standard care means risk assessment and hospitalization, “shame and blame”


Dr. Beck Discusses Landmark Study
Cognitive Therapy for Suicidal Patients

- Goal: To reduce the likelihood of future suicidal acts
- 10 sessions (approximately)

CBT for Suicidality

- Adaptive coping strategies
- Identify reasons for living and instilling hope
- Problem solving skills
- Increasing social connections
- Compliance with other treatments

Efficacy: Repeat Suicide Attempts

![Graph showing efficacy of CBT for repeat suicide attempts](chart.png)

### Efficacy: Beck Depression Inventory-II

<table>
<thead>
<tr>
<th>Follow-Up Month</th>
<th>BDI Score CT</th>
<th>BDI Score Control</th>
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<td>Intake</td>
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<td>30</td>
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<td>25</td>
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<td>3</td>
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<td>15</td>
<td>10</td>
</tr>
<tr>
<td>18*</td>
<td>10</td>
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</table>


### Efficacy: Beck Hopelessness Scale

<table>
<thead>
<tr>
<th>Follow-Up Month</th>
<th>BHS Score CT</th>
<th>BHS Score Control</th>
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<td>8</td>
</tr>
<tr>
<td>18</td>
<td>8</td>
<td>7</td>
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Cognitive Theory of Suicide

**Suicide Schemas**

- **MDD**: Hopelessness, Perfectionism, Trait Impulsivity
- **BPD**: Unbearability, Trait PS Deficit, Impulsivity

**Dispositional Vulnerability Factors**

Research has found some trait-like cognitive constructs that are more common in suicidal individuals. These constructs may help explain the association between risk factors, suicidal thinking, and suicide behavior.
Cognitive Theory of Suicide

Dispositional Vulnerability Factors:

- **Hopelessness (Trait)**
  - Very strong predictor of suicide (years)
  - Not typically seen in BPD

- **Impulsivity**
  - When an impulsive person starts to view their situation as unbearable, risk increases
  - May be more active in BPD

Dispositional Vulnerability Factors:

- **Information processing biases**
  - Attentional bias
  - Memory bias

- **Problem solving deficits**
  - Trait deficit may activate hopelessness schema
  - State deficit may activate unbearable schema

- **Perfectionism**
  - Socially-prescribed more of a risk factor than self-oriented (teens)

Cognitive Theory of Suicide

- **Attentional Fixation =**
  - **Cognitive Constriction**
    - Decreased ability to reflect on what is happening and problem solve
  - **Preoccupation with suicide as a solution**
Cognitive Theory of Suicide

Attentional Fixation

- Looks like desperation (anxiety + agitation)
- Dispositional impulsivity may bring attentional fixation on faster
- Individuals who are not normally impulsive may appear to make an impulsive decision to attempt suicide due to attentional fixation
- Individuals with high trait hopelessness may have cognitive AF only, without the desperation (planners)

Cognitive Model of Suicide

Adapted from Wenzel et al. (2009)
Cognitive Model of Suicide
Suicide schemas & dispositional factors:
Dr. Beck with Depressed Patient

Cognitive Model of Suicide
Dispositional Vulnerability Factors

EARLY PHASE OF TREATMENT
### Early Phase

1. Informed consent & socialize to CT
2. Engage client
3. Suicide risk assessment
4. Safety plan
5. Convey hope
6. Narrative of suicidal crisis/Conceptualization
7. Treatment Planning

### Treatment Engagement

Only 20-40% of patients who attempt suicide follow through with outpatient treatment after hospitalization.

**Help patients commit to treatment**

- Build therapeutic relationship
- Emphasize benefits of treatment
- Address cultural differences and practical barriers to treatment
  - Help patients get to treatment
- Use cognitive model to address negative beliefs about treatment
Risk Assessment

**Rationale:**
To protect patient’s safety and aid in treatment planning.

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**Risk Assessment**

**Risk factors**
- Empirically supported risk factors
  - (previous attempt, hopelessness, intent, plan)
- Factors most distressing to patient
+ **Protective factors**
= **Determination of risk** (Clinical judgment)

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**Risk Assessment**

**1. Demographic Risk Factors**
- Male
- White
- Older
- Unemployment (!)
- Lower SES
- Less educated
- Social isolation: single/widowed/divorced
- Veteran
- Medical illness
- Native American
- Same-sex partner

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Risk Assessment

2. Fixed Psychiatric Risk Factors
   - Psychiatric diagnosis; Substance Abuse
   - Previous attempt (!)
   - Family history of suicide
   - Treatment noncompliance
   - Sad reaction to failed attempt
   - Wish to live vs. wish to die
   - Hopelessness
   - Shame

3. Proximal Risk Factors
   (Precipitants/triggers)
   - Recent life stressor or loss
   - Firearm
   - Lethal rx drugs
   - Teens: peer suicide
Risk Assessment

4. Cognitive Vulnerability Factors
   • Hopelessness (trait and state)
   • Unbearability
   • Attentional fixation
   • Impulsivity
   • Perfectionism

Risk Assessment

Scales
   • Beck Hopelessness Scale
   • Beck Scale for Suicide Ideation (self-report)
   • Scale for Suicide Ideation (SSI and SSI-W; clinician-administered)
   • BDI-II #9
www.becksciles.com

Beck Hopelessness Scale

<table>
<thead>
<tr>
<th>Question</th>
<th>True</th>
<th>False</th>
</tr>
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<tbody>
<tr>
<td>1. I look forward to the future with hope and enthusiasm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I have enough time to accomplish the things I want to do.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. In the future, I expect to succeed in what concerns me most.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Scale for Suicidal Ideation

1. Wish to Live
   0 None
   1 Weak
   2 Moderate to Strong

2. Wish to Die
   0 None
   1 Weak
   2 Moderate to Strong

"When you made your suicide attempt, were you sad or glad that it didn’t work?"
Risk Assessment

Also assess for:

- Suicidal behaviors such as planning, organizing, obtaining means, writing note, etc.
- Frequency, duration, and intensity of suicidal thoughts
- Ego-syntonic or ego-dystonic

Risk Assessment

Does talking about suicide increase the likelihood of attempt?

What does it mean if a client is reluctant to disclose his/her plan?

Risk Assessment

Protective Factors

- Social support network/pet
- Married
- Being a parent (mother)
- Specific reasons for living
- Religious affiliation/moral opposition
Risk Assessment

Determination of Risk: Dr. Beck's Patient

EARLY PHASE OF TREATMENT

Collaboration

Muñoz, Ghosh Ippen, Rao, Le, & Dwyer (2000)
Conveying Hope

Verbally: 
by stating you believe the patient can 
makes gains in treatment

Nonverbally: 
by modeling a systematic problem 
solving approach

Conveying Hope

Begins in the first session with the 
development of a Safety Plan, which sends 
the message that there may be more 
effective ways of managing their problems 
than they have used in the past.

Safety Plans

• Not a “no-suicide contract”
• A list of coping strategies and resources
• Rationale: to decrease risk of attempting 
suicide in immediate future
• Targets identified risk factors
• Collaborative
• Reviewed and updated during treatment
Safety Plans

- **Aim for 90% likelihood of using**
- **Readily accessible & easy to use**
  - Small crisis card
  - Smart phone note
- **Remove lethal methods**
  - Collaborate with patient to have someone remove gun/weapons from their home and store without access

Safety Plans: Warning Signs

<table>
<thead>
<tr>
<th>Type of sign</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Automatic thoughts</td>
<td></td>
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<tr>
<td>Images</td>
<td></td>
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<tr>
<td>Thought Patterns</td>
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<tr>
<td>Mood</td>
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<tr>
<td>Behaviors</td>
<td></td>
</tr>
<tr>
<td>Physical sensations</td>
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Safety Plans

- Increase hope
- Decrease impulsivity

Role Play Exercise

- In groups of 3 (with others who speak your native language, if necessary):
  - One will play the therapist, one will play the patient, and the third will be the “supervisor,”
  - After role play, supervisor reflects back what he/she observed, and provides confirming feedback.
Conceptualization of Suicidal Act

An individualized formulation that helps us:

- understand the patient’s behavior and what led to the suicidal crisis, and
- pick treatment strategies that may prevent a future suicidal act.

Timeline of Suicidal Crisis


Treatment Planning

Goals:
1. Prevent future suicide acts
2. Reduce risk factors (dispositional factors such as poor problem solving skills)

Strategies:
- Cognitive and behavioral interventions targeting the most life-threatening problems or skills deficits
INTERMEDIATE PHASE OF TREATMENT

Intermediate Phase

Goal:
• To develop cognitive, affective, and behavioral coping skills to decrease future suicidal ideation & behavior

Focus on:
1. Problems most related to suicidal crisis
2. Interventions to reduce future crises
3. Therapy-interfering cognitions & behaviors

Intermediate Phase

How it differs from CBT for Depression:
• Content is focused on suicide
• Strategies are more concrete and more easily accessible during a crisis

In each session:
• Evaluate suicide risk
• Evaluate substance use
• Evaluate other treatment compliance
• Review safety plan
Behavioral Strategies
- Increasing pleasant activities
- Improving social support
  - Consider a family session
- Increasing compliance with other treatments
  - Consult and coordinate care
  - Problem-solve obstacles

Affective Strategies
- Help patients regulate their emotions without self-harm
- Prevent onset of attentional fixation
- Decrease beliefs of unbearability
- Individualized for each patient

Affective Strategies
Three categories:
1. Physical
   - Exercise
   - Relaxation (PMR, controlled breathing)
2. Cognitive
   - Distraction (short term)
3. Sensory
   - Smell, sound, touch
Cognitive Strategies: Hope

- **Coping cards**
- **Hope Kit**
- **Modifying suicide-related beliefs**
  - Future-time imaging to increase hope
- **Enhancing problem solving skills**
- **Reducing impulsivity**

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Coping Card

Reasons for **Living**

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Hope Kit

- Physical cues of the patient’s reasons for living
- Patient creates, then reviews each item with you:
  - Items should generate positive thoughts, feelings, memories → hopeful!
- Have patient practice using the kit for homework
- Patient uses the kit when feeling hopeless or warning signs become active
Action Plans

- **Essential!**
- **May see lower compliance in this population**
- **Suggestions:**
  - Meaningful rationale
  - Be collaborative
  - One concrete item
  - Start in session if possible
  - Get likelihood rating, modify if necessary
## Later Phase of Treatment

1. **Summarize and consolidate new skills**
2. **Relapse prevention**
   - Practice new skills in guided imagery
3. **Review progress on treatment goals**
   - Risk assessment, goals for next phase
4. **Plan for continuation of treatment**
5. **Taper sessions & schedule boosters**

### Relapse Prevention:

1. Preparation
2. Review recent suicidal crisis
3. Review recent suicidal crisis using skills
4. Review future suicidal crisis
5. Debrief and follow-up
Adolescent Suicide in the US

- 3rd leading cause of death ages 10-19 (16-19 highest risk)
- 20% of adolescents consider attempting suicide in any given year
- 2,000,000 adolescents attempt/year
- 2,000 adolescent deaths/year

Adolescent Suicide in the US

Cognitive Vulnerability Factors:

- Hopelessness: time-limited, peaks just before attempt, less evidence for it in teens
- Impulsivity: seems to be indirect vulnerability factor, seems to play bigger role than hopelessness
Adolescent Suicide in the US

• **Research indicates:**
  • Wishful thinking
  • Lack of coping strategies
  • Perception of situation as unbearable or excessively painful

Adolescent Suicide in the US

Suicide-Relevant Risk Factors:

• Prior attempts & intent are most predictive
  (10% do not report ideation)
• 50% of teens overestimate lethality

Adolescent Suicide in the US

Social Risk Factors:

• Peer suicide
• Lack of family cohesion (remarriage, unstable housing, lack of support, conflict)
• Loneliness/social isolation
• Self-identify as gay
• History of physical or sexual abuse
Adolescent Suicide in the US

Risk Summary:
• No single predictive factor
• Look for:
  • MDD
  • Substance abuse
  • Poor coping skills
  • Lack of family cohesion

Special Treatment Considerations
Confidentiality (and Therapeutic Alliance)
• Consent vs. Assent
• Parental involvement in treatment
• Parental notification of suicidal ideation
• Reporting abuse

Special Treatment Considerations
Engaging Adolescent in Treatment
• 45% do not attend therapy after hospitalization
• Mean = 3 sessions
• Often “brought” to treatment
• Trust must be established before discussing suicide narrative; first phase of treatment may take longer
Special Treatment Considerations

Suicide Timeline/Triggers:
- Parent/child conflict < 16yo
- Romantic conflict > 16yo
- Abuse
- Legal/disciplinary problem
- Accumulation of stresses or internal trigger

Get input from family; helps identify vulnerability

CBT for Suicidality with Adolescents

Treatment Goals Emphasize:
- Behavioral interventions
  - Distress management/coping strategies
  - Problem solving skills
  - Pleasant activities
- Family issues
  - Communication training
- Decreasing nonsuicidal self-injury behavior
CBT for Suicidality with Adolescents

Teen’s Safety Plan:

- Disclosure of suicidal thoughts to a responsible adult
- Avoid social media?

Family Safety Plan:

- Family’s responsibilities
- List of observable warning signs
- Removal of lethal means
Kevin Hines Story

QUESTIONS & DISCUSSION

Working with Suicidal Patients

• Maintain treatment frame and a focus on suicide prevention

• Utilize resources
  • Supervision/consultation
  • Adjunct services/coordination of care

• Recognize and address common therapist reactions
  • Anxiety, anger, hopelessness, burnout
  • Use cognitive model for your reactions
Summary and Feedback

Model:
No single cause, many factors working together; conceptualization helps us understand the suicide act and plan treatment.

Risk Assessment:
Sad, glad, mad; worst point; hopelessness + trigger; form.

Treatment:
Focus on suicide directly; safety plan; hope kit/reasons for living; problem solving skills; relapse prevention.

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Coping Card

New Adaptive Response:

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Summary and Feedback

- Questions?
- What will you incorporate into your practice?
- What modifications will you need to make for your patient population?
References

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