

Cognitive Behavioral Therapy for Suicide Prevention

Gregory K. Brown, Ph.D.

VA/DoD Clinical Practice Guideline for Suicide
Prevention Webinar Series

April 27, 2021

Penn Center for the Prevention of Suicide



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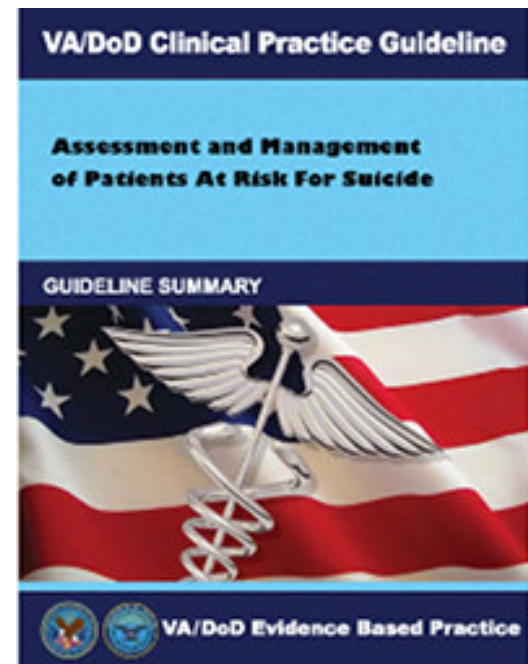
- ◆ Dr. Brown's views and opinions expressed in this presentation do not necessarily state or reflect those of the United States Government including the Department of Veterans Affairs and the Department of Defense.
- ◆ Dr. Brown receives royalties from the Research Foundation for Mental Hygiene for the commercial use of the Columbia Suicide Severity Rating Scale.

Learning Objectives

- 1. Describe the general approach, rationale and evidence supporting Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)**
- 2. Describe specific cognitive and behavioral strategies for reducing risk**
- 3. Describe a competency-based training for learning CBT-SP**

VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide (2019)

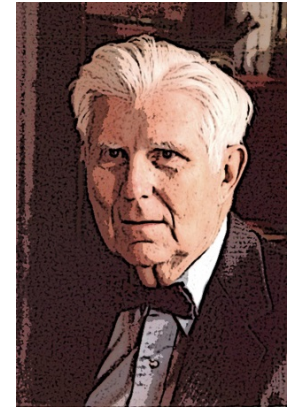
Strong recommendation for “using cognitive behavioral therapy-based interventions focused on suicide prevention for patients with a recent history of self-directed violence to reduce incidents of self-directed violence” (p 27).



Conceptual Underpinnings of CBT-SP

- ◆ Suicidal behavior is viewed as the **primary** problem rather than a symptom of a disorder
- ◆ Cognitive therapy for suicide prevention is viewed as an **adjunctive** treatment
- ◆ Suicidal behavior is viewed as a problematic **coping** behavior
- ◆ Treatment is **brief** and **focused** (10 to 16 sessions)

Suicidal Thoughts and Behaviors as Primary Targets



Cognitive Therapy for the Prevention of Suicide Attempts A Randomized Controlled Trial

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Thomas Ten Have, PhD

Gregg R. Henriques, PhD

Sharon X. Xie, PhD

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IN 2002, SUICIDE WAS THE FOURTH leading cause of death for adults between the ages of 18 and 65 years with approximately 25 000 suicides for this age group in the United States.¹ As recommended by the *National Strategy for Suicide Prevention*, one public health approach for the preven-

Context Suicide attempts constitute a major risk factor for completed suicide, yet few interventions specifically designed to prevent suicide attempts have been evaluated.

Objective To determine the effectiveness of a 10-session cognitive therapy intervention designed to prevent repeat suicide attempts in adults who recently attempted suicide.

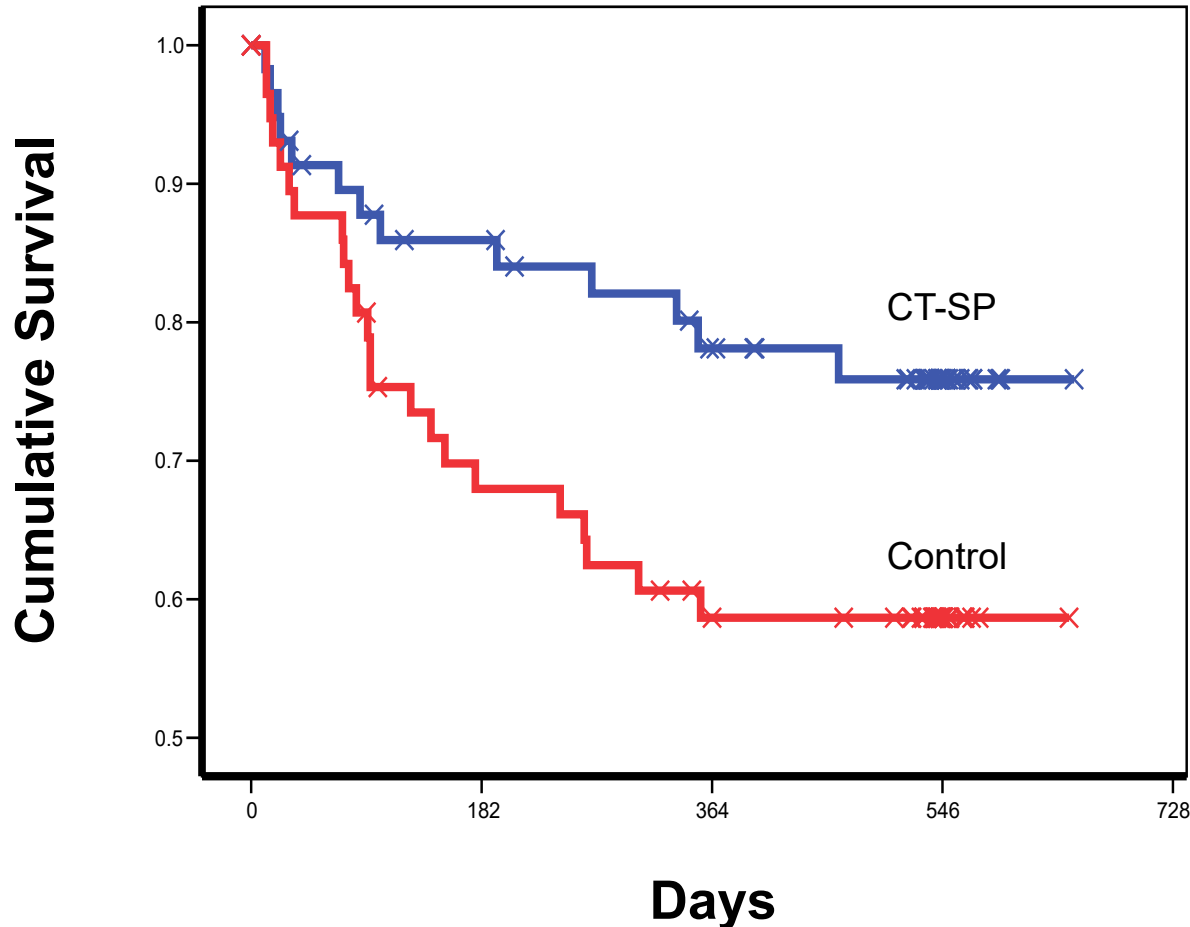
Design, Setting, and Participants Randomized controlled trial of adults (N=120) who attempted suicide and were evaluated at a hospital emergency department within 48 hours of the attempt. Potential participants (N=350) were consecutively recruited from October 1999 to September 2002; 66 refused to participate and 164 were ineligible. Participants were followed up for 18 months.

Intervention Cognitive therapy or enhanced usual care with tracking and referral services.

Main Outcome Measures Incidence of repeat suicide attempts and number of days until a repeat suicide attempt. Suicide ideation (dichotomized), hopelessness, and depression severity at 1, 3, 6, 12, and 18 months.

Results From baseline to the 18-month assessment, 12 participants (7.4%) in the

Survival Functions for Repeat Suicide Attempt by Study Condition



CT-SP was associated with a 50% reduction in suicide attempts in a severe sample with a high rate of repeat attempts.

* $p < .05$

Source: Brown et al. (2005). *JAMA*, 294, 563-370

Brief Cognitive-Behavioral Therapy Effects on Post-Treatment Suicide Attempts in a Military Sample: Results of a Randomized Clinical Trial With 2-Year Follow-Up

M. David Rudd, Ph.D., A.B.P.P., Craig J. Bryan, Psy.D., A.B.P.P., Evelyn G. Wertenberger, Ph.D., L.C.S.W., Alan L. Peterson, Ph.D., A.B.P.P., Stacey Young-McCaughan, R.N., Ph.D., Jim Mintz, Ph.D., Sean R. Williams, L.C.S.W., Kimberly A. Arne, L.C.S.W., Jill Breitbach, Psy.D., A.B.P.P., Kenneth Delano, Ph.D., Erin Wilkinson, Psy.D., Travis O. Bruce, M.D.

Objective: The authors evaluated the effectiveness of brief cognitive-behavioral therapy (CBT) for the prevention of suicide attempts in military personnel.

Method: In a randomized controlled trial, active-duty Army soldiers at Fort Carson, Colo., who either attempted suicide or experienced suicidal ideation with intent, were randomly assigned to treatment as usual (N=76) or treatment as usual plus brief CBT (N=76). Assessment of incidence of suicide attempts during the follow-up period was conducted with the Suicide Attempt Self-Injury Interview. Inclusion criteria were the presence of suicidal ideation with intent to die during the past week and/or a suicide attempt within the past month. Soldiers were excluded if they had a medical or psychiatric condition that would prevent informed consent or participation in outpatient treatment, such as active psychosis or mania. To determine treatment efficacy with regard to incidence and time to suicide attempt, survival curve analyses

were conducted. Differences in psychiatric symptoms were evaluated using longitudinal random-effects models.

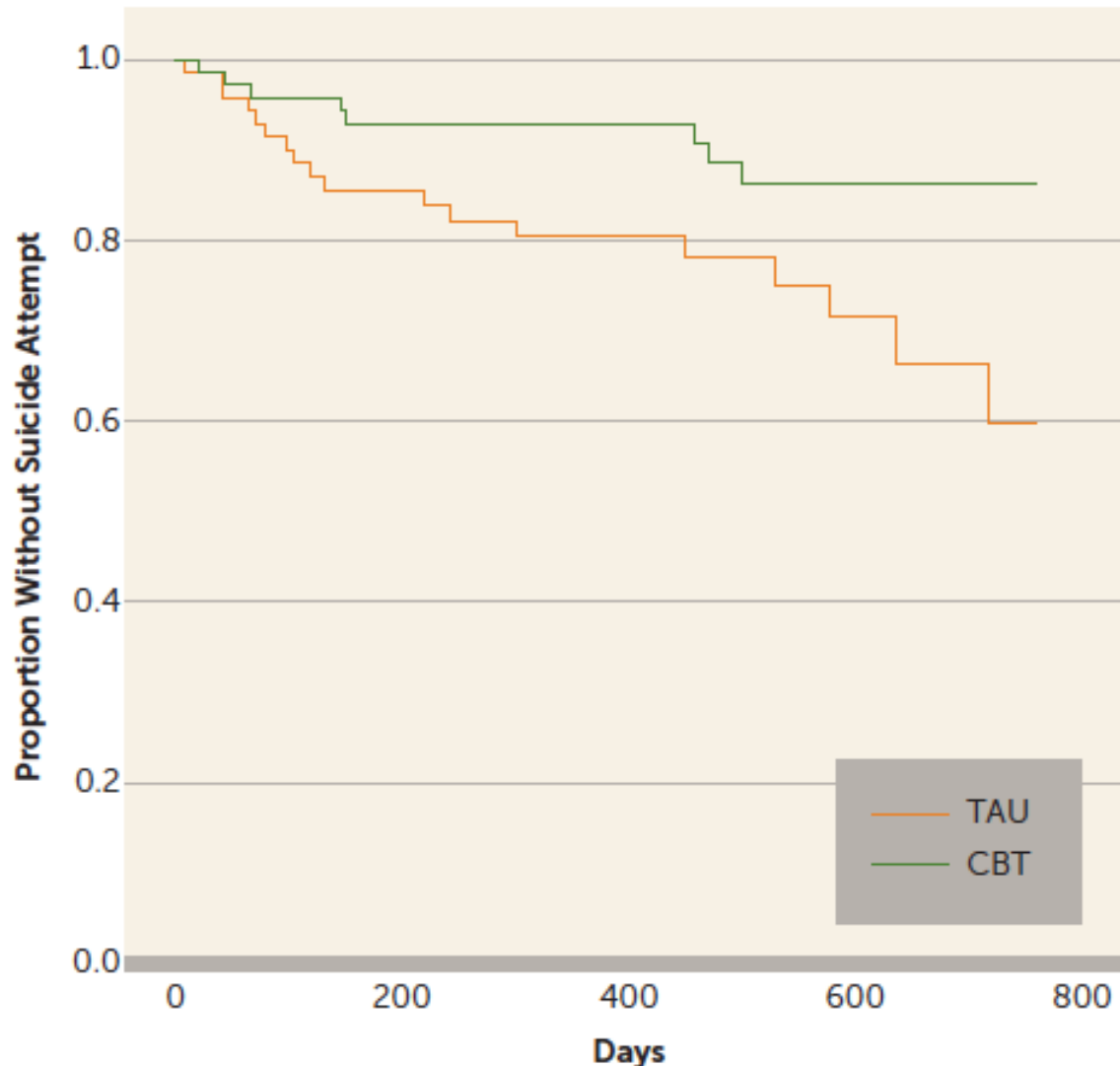
Results: From baseline to the 24-month follow-up assessment, eight participants in brief CBT (13.8%) and 18 participants in treatment as usual (40.2%) made at least one suicide attempt (hazard ratio=0.38, 95% CI=0.16–0.87, number needed to treat=3.88), suggesting that soldiers in brief CBT were approximately 60% less likely to make a suicide attempt during follow-up than soldiers in treatment as usual. There were no between-group differences in severity of psychiatric symptoms.

Conclusions: Brief CBT was effective in preventing follow-up suicide attempts among active-duty military service members with current suicidal ideation and/or a recent suicide attempt.

Am J Psychiatry 2015; 172:441–449; doi: 10.1176/appi.ajp.2014.14070843

Brief Cognitive-Behavioral Therapy

FIGURE 2. Survival Curves for Time to First Suicide Attempt^a



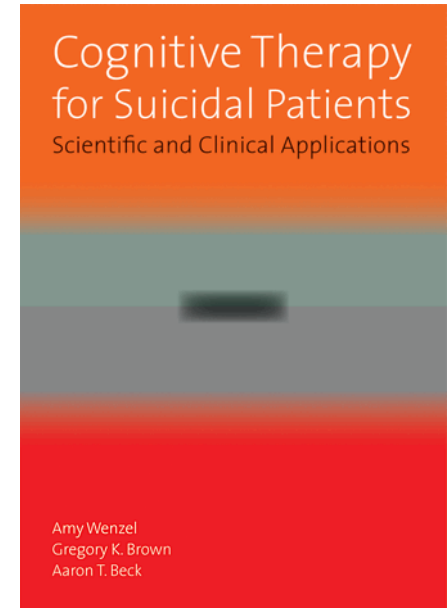
Soldiers in brief CBT were approximately **60% less likely** to make a suicide attempt during follow-up than soldiers in treatment as usual.

^a CBT=cognitive-behavioral therapy; TAU=treatment as usual (log-rank $\chi^2=5.28$, $df=1$, $p=0.02$).

Source: Rudd, Bryan, et al. (2015). *AJP*, 172, 441-449.

Cognitive Therapy for Suicide Prevention

- **Initial Phase**
 - Informed Consent
 - Motivational Enhancement
 - Suicide Risk Assessment and Narrative Timeline Interview
 - Safety Planning Intervention (Stanley & Brown, 2012)
 - Reasons for Living & Dying and Hope Kit
 - Treatment Goals and Case Conceptualization
- **Middle Phase**
 - Cognitive & Behavioral Strategies
 - Case Management Strategies
- **Final Phase**
 - Skill Consolidation
 - Relapse Prevention Task
 - Treatment Planning



Wenzel, A., Brown, G. K., & Beck, A. T. (2009). *Cognitive therapy for suicidal clients: Scientific and clinical applications*. Washington, DC: APA Books.

Problems with Treatment Engagement

- ◆ **Individuals hospitalized for suicide attempts often do not attend outpatient treatment. Potential reasons include:**
 - Poor economic resources or practical barriers
 - Negative attitudes toward treatment
 - Feels hopelessness about getting better, won't be helpful
 - Culturally-based beliefs about mental health treatment (e.g., don't talk about things like that; help should be found within family/church/community, etc.)
 - Mistrust of mental health treatment
 - Belief is common and **valid** among Black, Indigenous, people of color (BIPOC) populations due to discrimination and racism

Assess Treatment Expectations

- ◆ **Assess attitudes and expectations for therapy:**
 - “What do you expect therapy to be like?”
 - “Do you think therapy will be helpful?”
 - “How willing are you to attend a few therapy sessions to see if it would be helpful?”
- ◆ **Discuss previous experiences in therapy and how it contributed to any negative attitudes and expectations:**
 - “What happened the last time you went to therapy? How was it helpful? How was it unhelpful?”

Address the Risks of Treatment

- ◆ **Possibility of emotional discomfort**
 - Discuss potential strategies that can be implemented should the client feel upset following a treatment session
- ◆ **Potential negative effects of breaching confidentiality**
 - Collaborate around involving others (including emergency services) as a general rule
 - Keep clients informed if confidentiality is broken in emergency situations where you were not able to discuss this first

“Case Management” during CBT-SP

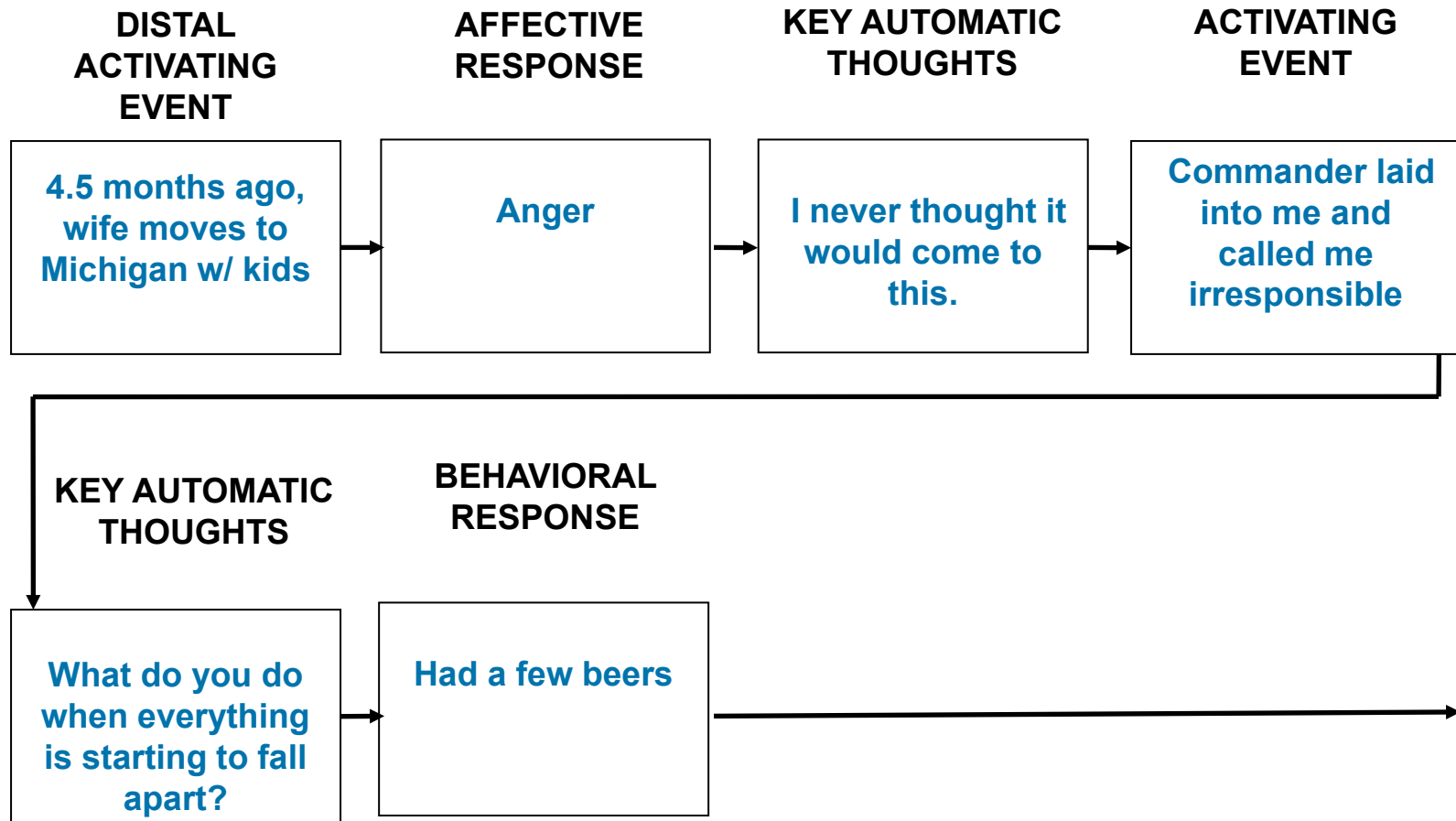
- Go the “extra mile” and reach out to patients
- Be flexible in scheduling appointments
- Make reminder and check-in calls
- Send birthday and holiday cards
- Discuss cases in regular team meetings; frequent use of consultation (“huddles”) to receive support



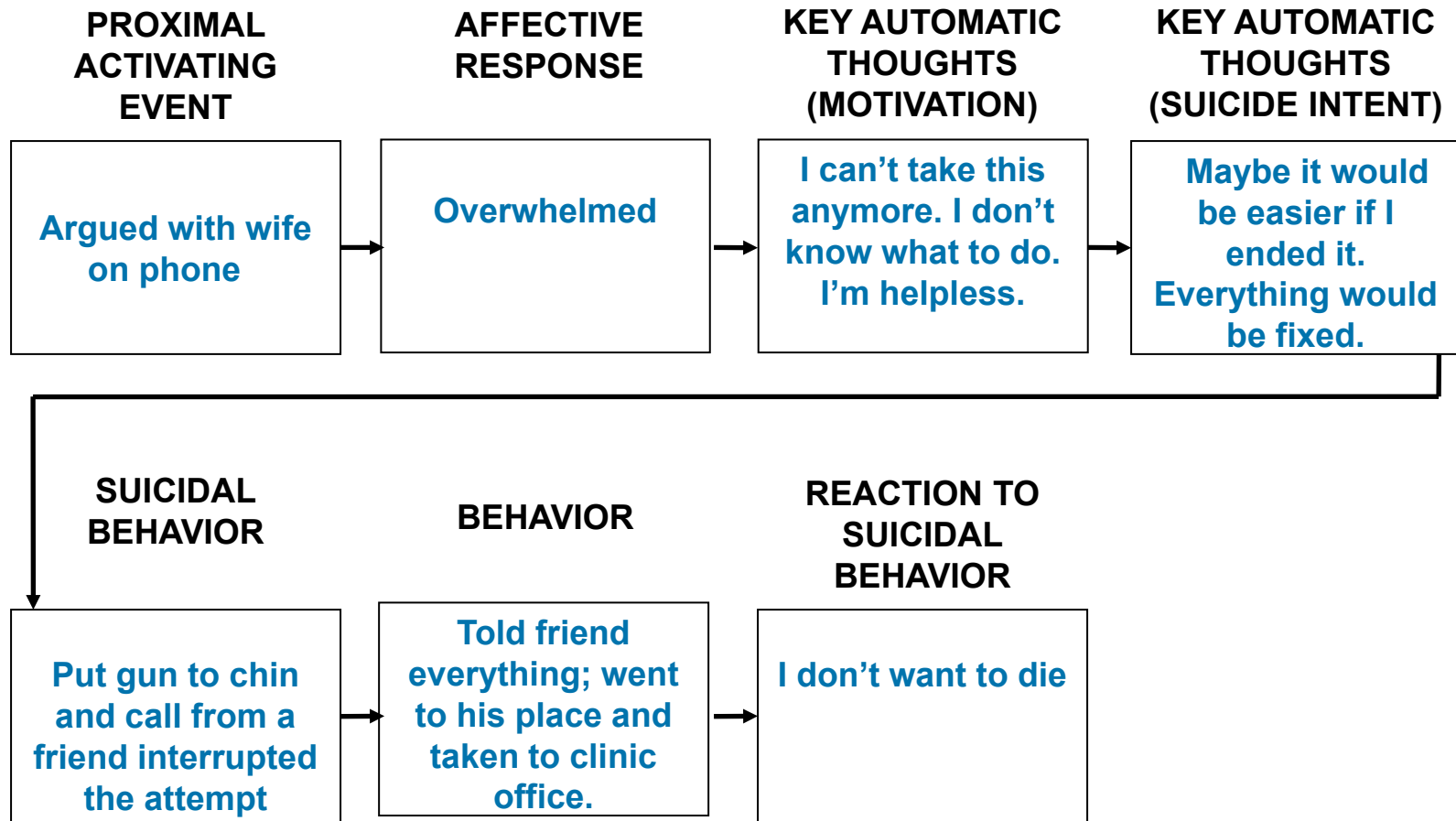
Narrative Interview of Suicidal Crisis

- ◆ Obtain a **detailed description** of a suicidal crisis (e.g., recent attempt or recent moment when suicidal ideation increased)
- ◆ Patients are asked to recall the suicidal crisis in **as much detail** as possible, including the activating events and reactions to the events.
- ◆ Construct a **timeline** that indicates the major external events and cognitive, emotional, and behavioral factors proximal to the crisis
- ◆ Forms the basis of the **case conceptualization**
- ◆ **Understand** that suicidal thinking and behavior “makes sense” to the individual in the context of his or her history, vulnerability, and circumstances.

Timeline of Suicide Attempt: Example



Timeline of Suicide Attempt: Example



CBT-SP Focuses on Modifiable Risk Factors

- ◆ **Case Conceptualization and Selection of CBT Strategies:**
 - Each treatment session addresses thoughts, beliefs, and behaviors that are most **proximally related** to the suicidal crisis and contribute to and maintain hopelessness.
 - Select CBT-SP strategies that are perceived by **both** the clinician and patient to be the most helpful in preventing a future suicidal act.

Hope Kit

- ◆ Identify and discuss reasons for dying and reasons for living
- ◆ Construct a **Hope Kit** or Survivor Kit to create a representation of reasons for living
 - Pictures
 - Letters
 - Poetry
 - Prayer Card
 - Coping Cards
 - Meaningful mementos or tokens



Common CBT-SP Strategies

◆ Behavioral Activation

- Used to increase meaningful or purpose-driven activities, strengthen or enhance reasons for living, increase social connectedness, etc.

◆ Cognitive Restructuring

- Used to help individuals to identify and evaluate suicide-related thoughts; increase cognitive flexibility.

◆ Coping Cards

- Used to remind individuals of important conclusions from therapy that can be easily used in a crisis.

Thought Record Example

Date	Situation	Automatic Thoughts	Feelings	Alternative Response	Outcome
	What event led to the unpleasant emotion?	What thoughts went through your mind?	What emotions were you feeling?	Use questions to evaluate the thought.	What emotion do you feel now? What will you do?
12/18	Checked the mail Nothing but bills No holiday cards	No one would care if I was dead (95%)	Sad (80) Lonely (90)	Not many people send cards anymore. It doesn't mean people don't care. I got a call from my cousin the other day and Carlene invited me to Christmas dinner. They would take it really hard if I killed myself because they really do care.	I believe the original thought 20% now. Not so down, actually, more optimistic (50) Still a little lonely (30) I'll call a friend and make plans.

Sample Coping Card

- ◆ ***Automatic Thought:*** “It’s too much; it’s over, there’s nothing you can do about it.”
- ◆ ***Adaptive Response:*** “Things have been bad before. You always come out of it better in the end.”

Common CBT-SP Strategies

◆ Planful Problem Solving

- Used to help individuals brainstorm and evaluate potential solutions to solve problems without resorting to suicide.

◆ Examine Pros and Cons

- Used to help individuals resolve ambivalence and make important decisions.

Locking firearm in safe and giving key to Keats

Pros	Cons
Staying on track in treatment; If I kill myself, treatment won't help	I would be giving in to what others tell me
It would make my family feel better	I won't have it for protection
It might make it more "out of sight, out of mind"	

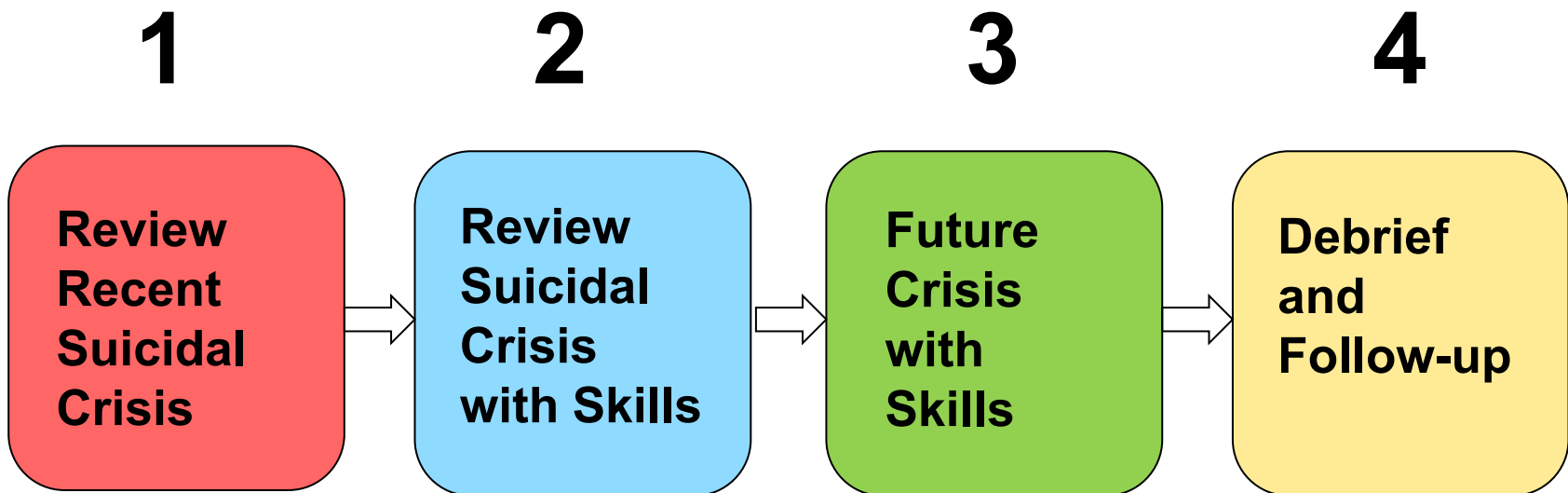
Review and Consolidate Skills

- ◆ **Reviewing coping skills:**
 - “Which skills were most helpful in reducing your suicidal ideation and desire for suicidal behavior?”
 - “What have you learned through this experience?”
 - “What further goals do you have for yourself?”
- ◆ **If the patient has difficulty generating a list of specific CBT coping strategies, then they may not be ready for the later phase of treatment**
- ◆ **Preparation for the Relapse Prevention Task**

Relapse Prevention Task

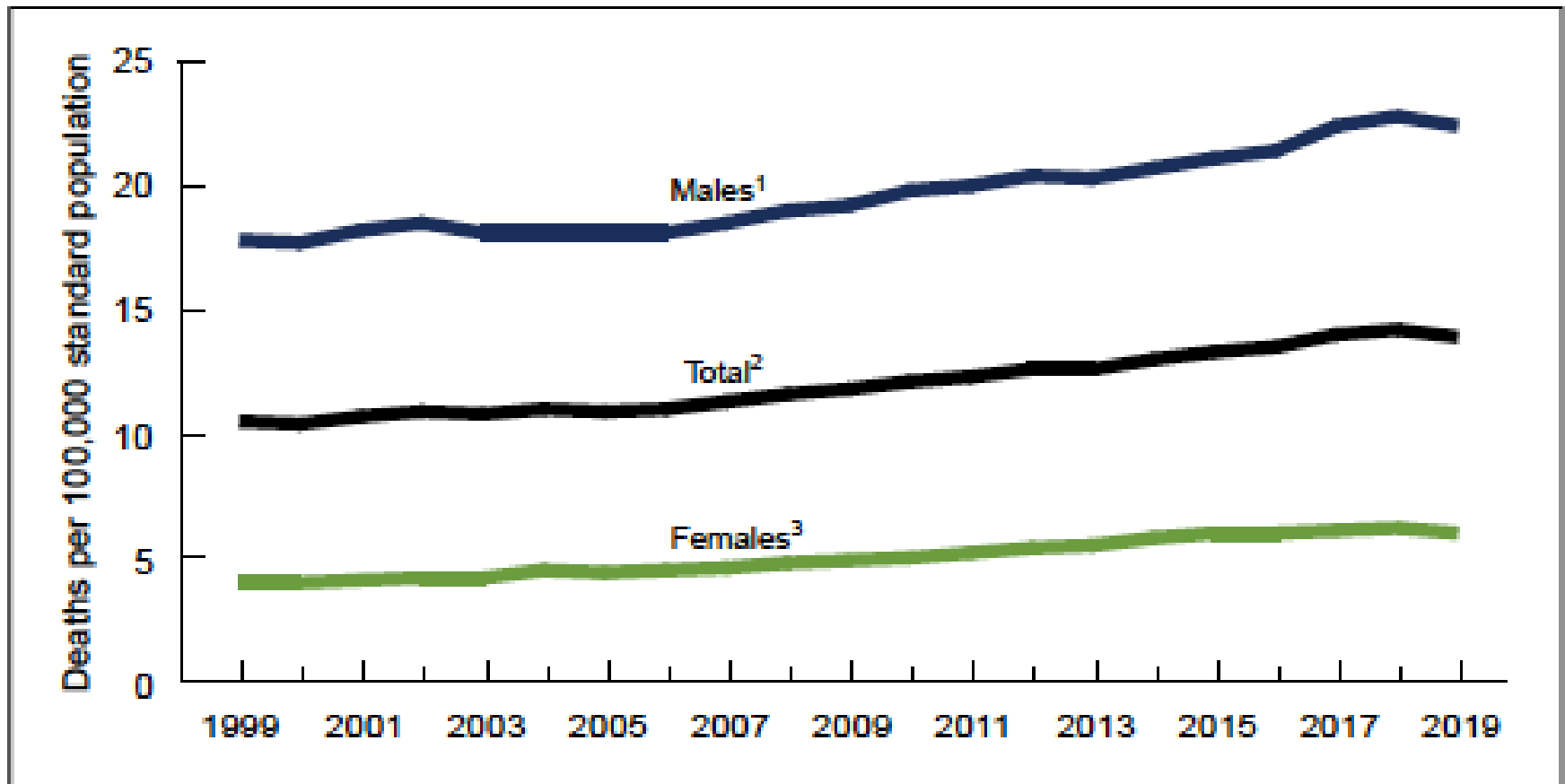
◆ Goals

- Rehearse coping with future crises.
- Assess treatment progress.
- Determine if additional sessions are warranted.



Age-adjusted Suicide Rates, by Sex: US, 1999-2019

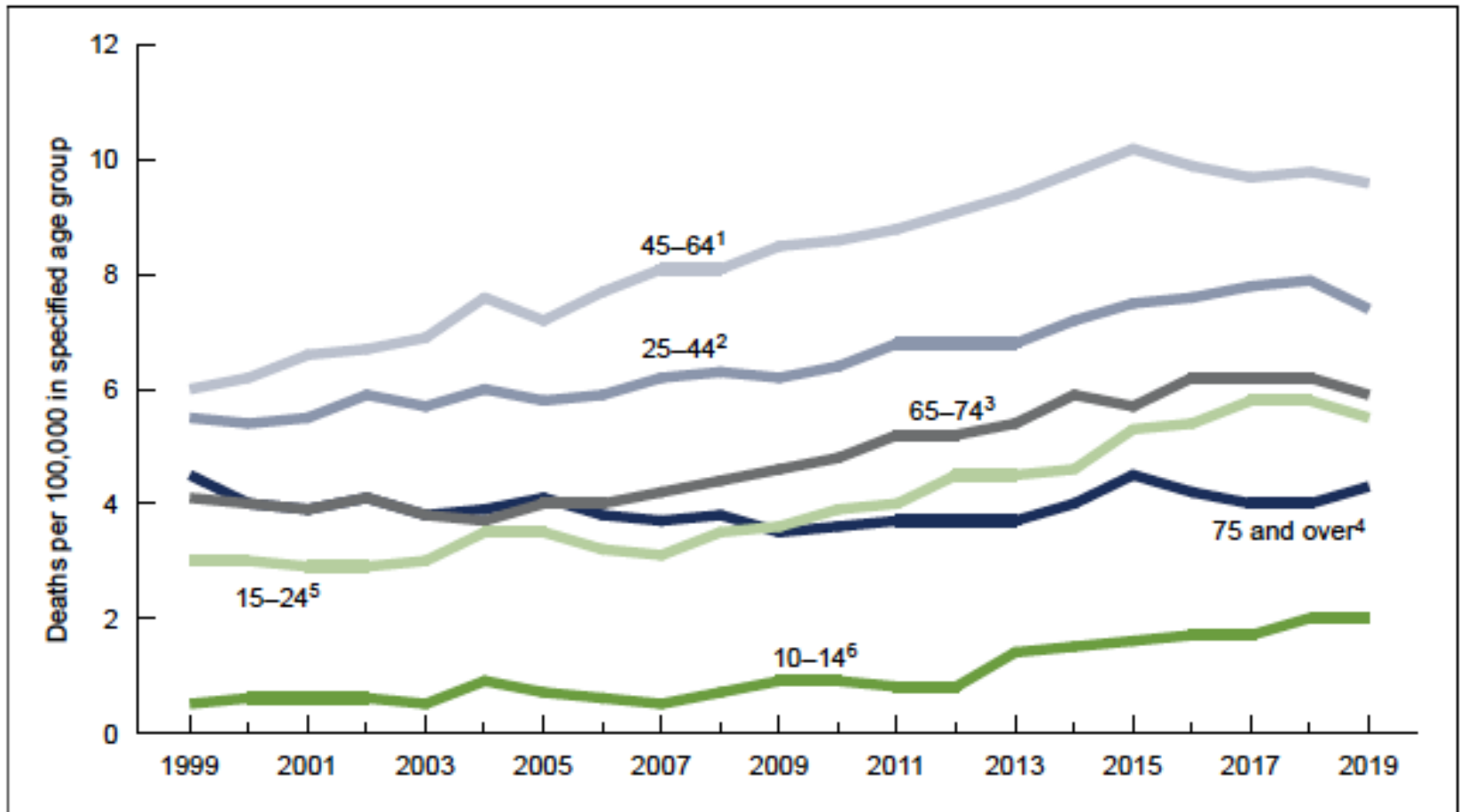
Figure 1. Age-adjusted suicide rates, by sex: United States, 1999–2019



Hedegaard et al. NCHS Data Brief. 2021 Feb;(398):1-8.

Suicide Rates for Females by Age Group: US, 1999-2019

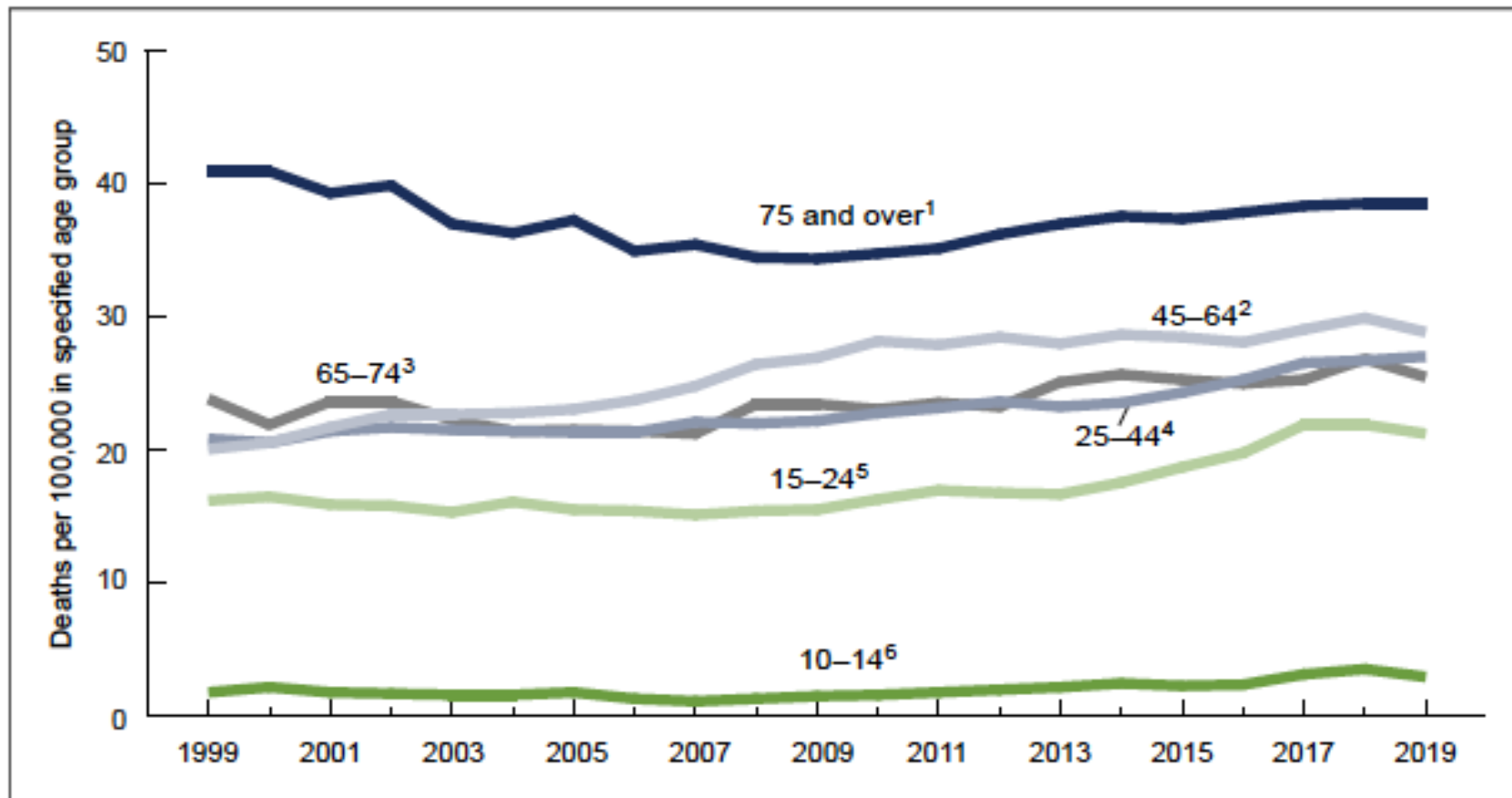
Figure 2. Suicide rates for females, by age group: United States, 1999–2019



Hedegaard et al. NCHS Data Brief. 2021 Feb;(398):1-8.

Suicide Rates for Males by Age Group: US, 1999-2019

Figure 3. Suicide rates for males, by age group: United States, 1999–2019



Hedegaard et al. NCHS Data Brief. 2021 Feb;(398):1-8.

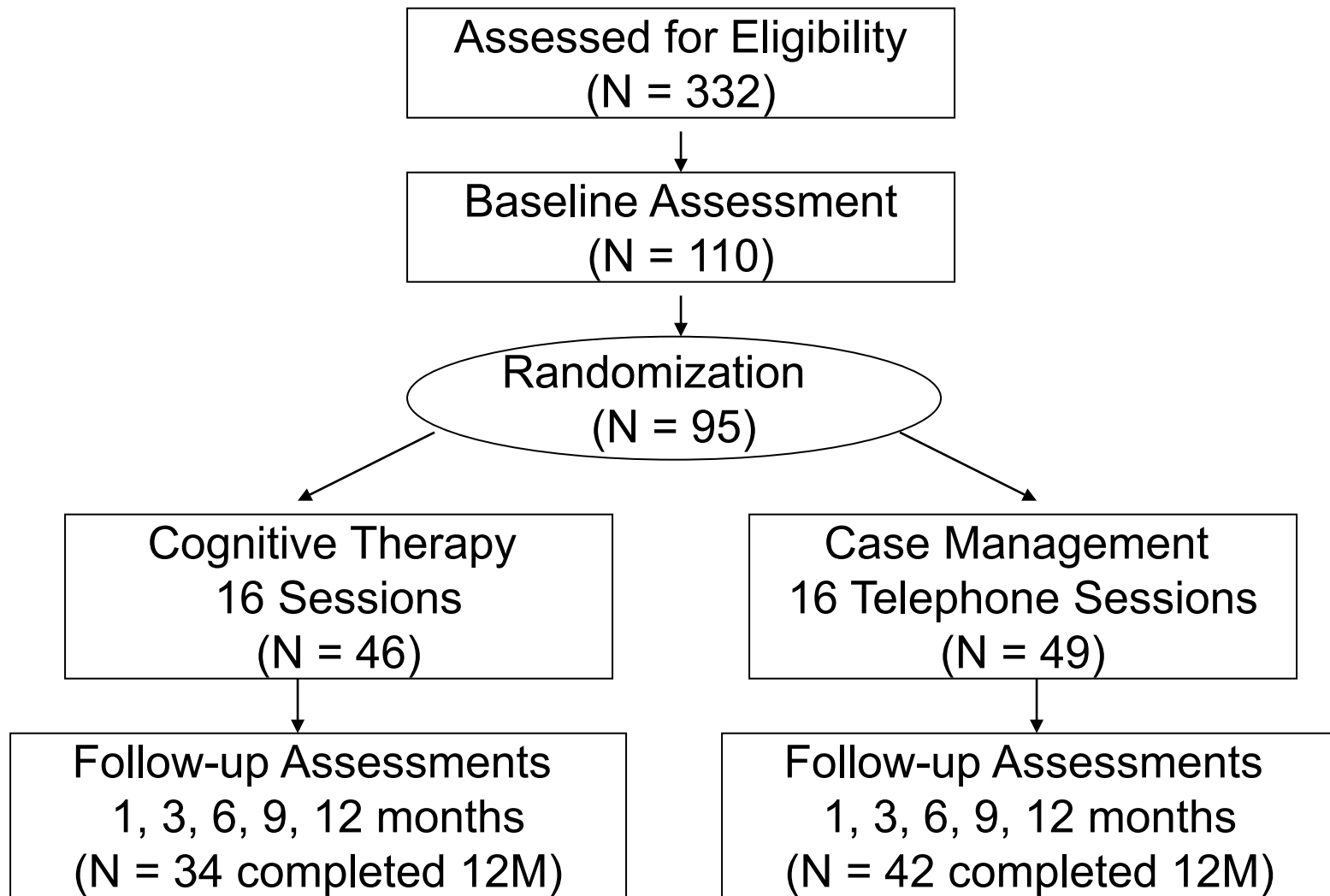
Risk Factors for Suicide Among Older Adults

- ◆ Older adults have a lower lifetime prevalence of suicide attempts than younger adults
- ◆ Suicidal ideation is a major risk factor for death by suicide for older adults
- ◆ Older adults often experience significant loss (e.g., death of partner, medical problems, independence, etc.) that increases risk
- ◆ Older men are often reluctant to disclose suicidal ideation to others
- ◆ Older men are likely to engage in “passive” suicidal behavior (e.g., failing to take prescribed medications)

Adapting CBT-SP for Older Men

- ◆ Greater focus on reducing suicidal ideation
- ◆ Treatment length was extended from 10 sessions to 16/20 sessions to address persistent ideation
- ◆ Pacing was slower. Take your time!
- ◆ Used whiteboards to stay on the agenda and prevent drift
- ◆ Used worksheets and forms with LARGE FONTS
- ◆ Used post-it notes; laminate important information such as Coping Cards
- ◆ Provided written summary of the session and written homework assignment with rationale (reminders)

Cognitive Therapy for Suicidal Older Men



Cognitive Therapy for Suicidal Older Men

Inclusion Criteria:

- 1. Suicidal desire or intent in the past month (SSI Items 4 or 5 >0)**
- 2. Male gender**
- 3. 50 years of age or older**
- 4. English speaking**
- 5. Able to provide informed consent**
- 6. Able to attend the study assessment and therapy sessions**
- 7. Provide at least 2 verifiable contacts for tracking purposes**
- 8. Cognitive Functioning: MMSE => 24 and EXIT-25 <= 14**

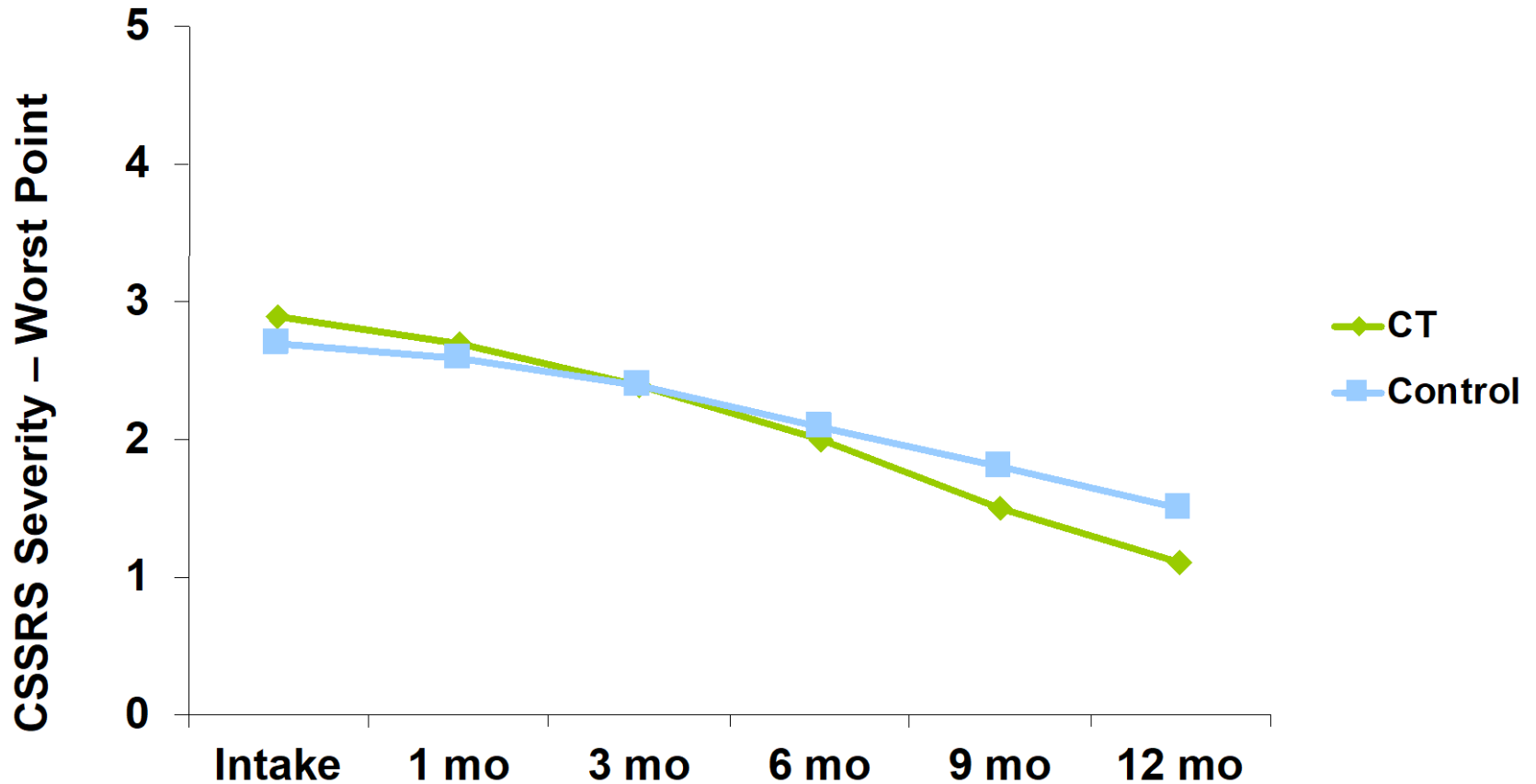
Exclusion Criteria:

- 1. Needed priority treatment for a substance use disorder or PTSD**
- 2. Taking antidepressant medication for less than four weeks or change in antidepressant medication**

Demographics

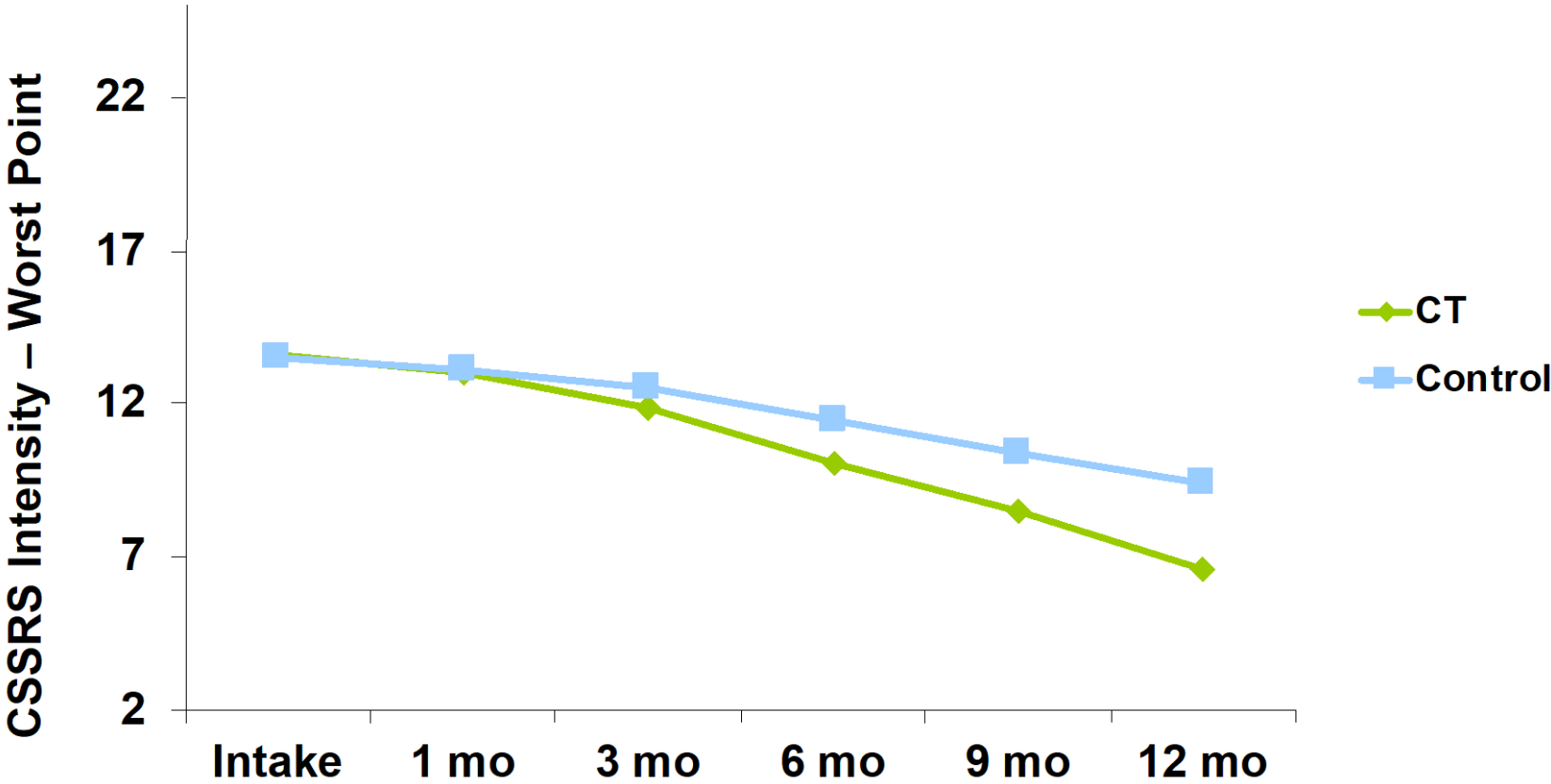
- ◆ **Mean age = 60.68** (SD = 5.68; Range = 50-80)
- ◆ **Race:**
 - 51.6% Black
 - 41.1% White
 - 1.1% Asian/Pacific Islander
 - 1.1% American Indian
 - 5.3% Other
- ◆ **Ethnicity: 0% Hispanic/Latinx**
- ◆ **95% were Veterans**

Columbia Suicide Severity Rating Scale Severity of Ideation Scale: Worst Point Since Last Assessment



$b = -0.05; p = .02; 95\% \text{ CI: } -0.10 \text{ to } -0.01$

Columbia Suicide Severity Rating Scale Intensity of Ideation Scale: Worst Point Since Last Assessment



$b = -0.24; p = .01; 95\% \text{ CI: } -0.43 \text{ to } -0.05$

Acknowledgements

◆ Co-Investigators

Kelly L. Green, PhD

Aaron T. Beck, MD

David W. Oslin, MD

Michael Thase, MD

Warren Bilker, PhD

◆ Study Therapists

Shari Jager-Hyman, PhD

Kristin Pontoski Taylor, PhD

Laura Mowery, PsyD

Abby Adler Mandel, PhD

Keith Bredemeier, PhD

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Gabriela Khzanov, PhD

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Guy Weissinger, PhD, RN

Bridget Moran, MPH

Ariel Domlyn, MA

Peter Awad, MA

Jennifer Greene, MS

Michelle Gordon, MPH

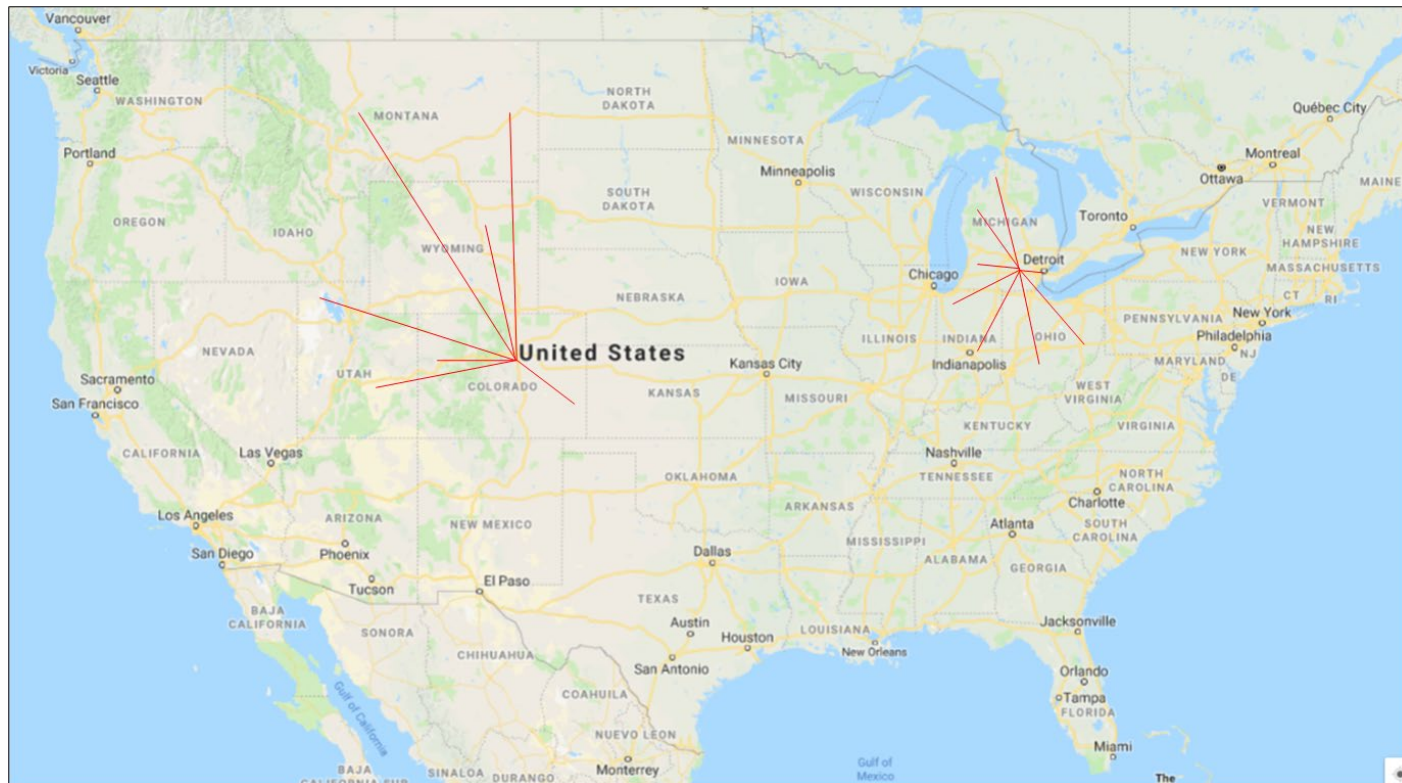
Karoline Myhre, MEd

Special thanks to the VISN 4 MIRECC, CPL Michael J Crescenz VA Medical Center

VA CBT-SP Telehealth Pilot Program

Well Vets: CBT-SP for Veterans with Substance Use Disorders (N=300): RCT comparing CBT-SP vs supportive psychotherapy on suicide outcomes over 2-year follow-up.

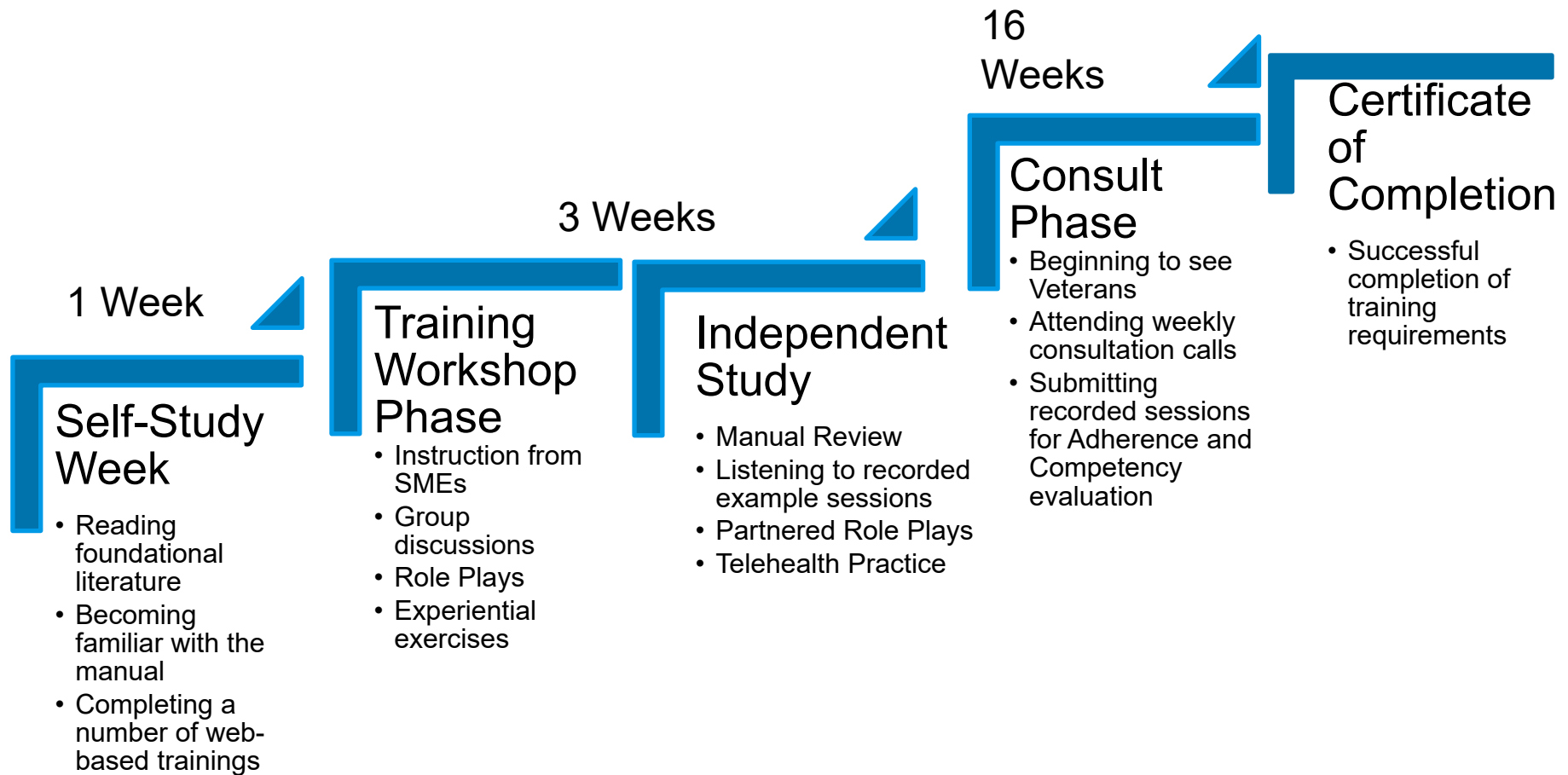
VA OMHSP: Pilot of CBT-SP using a telehealth “hub and spoke model” at VISN 10 and VISN 19.



VA CBT-SP Telehealth Pilot Program

- ◆ **VA OMHSP “SP 2.0” Initiative:** National telehealth expansion of Evidenced-Based Psychotherapies (EBPs) for suicide prevention
- ◆ Adapted CBT-SP for telehealth delivery with Drs. Gregory Brown and Craig Bryan: Developed VA CBT-SP Therapist Manual and CBT-SP Workbook for Veterans
- ◆ Delivered via VA Video Connect with Veterans participating primarily from home
- ◆ Pilot clinics received over 375 referrals from VISNs 10 and 19; Over 190 Veterans were enrolled and completed at least 1 CBT-SP session

Overview of VA CBT-SP Training Program



VA CBT-SP Team and Acknowledgements

- ◆ **Leads:** Mark Ilgen, PhD & Jennifer Olson-Madden, PhD
- ◆ **Master Trainer:** Erin Goldman, LMSW
- ◆ **Pilot/Training Coordinator:** Samantha Lhermitte, MSW
- ◆ **Special thanks to:**
 - **VISN 19:** Ann Weatherby, LICSW, Lisa M. Betthausen, PHD, MBA, Matthew Podlogar, PhD, Herbert Nagamoto, MD
 - **VISN 10:** Susan Shadley, LMSW, Sarah Emeritz, LMSW, Ann Jones, LMSW, Jessica Curtis, LMSW, Christina Boozer, LMSW, Jesse Burgard, PhD, Reiko Buckles, LMSW, Lisa Valentine, PhD, Nicole Stromberg, MD
 - **OMHSP:** Jessica Walker, PhD, Andrew Moon, PhD, Catherine Rotolo, MSSA, LISW-S

Questions?: Samantha.Lhermitte@va.gov

Advanced Training in the Safety Planning Intervention (ASPI)

- ◆ For VA providers who regularly encounter Veterans at elevated risk for suicide and routinely complete safety plans
- ◆ Sponsored by the VA Office of Mental Health and Suicide Prevention (OMHSP)

Training Program Staff	Role
Dr. Wendy Batdorf	ASPI Program Coordinator
Dr. Greg Brown	ASPI Master Trainer and Subject Matter Expert
Sheena Sharma	ASPI Program Administrator
Drs. Chris Crowe, Mandy Kumpula, Eric Dedert, Kristine Day, Wendy Batdorf, Greg Brown, Barbara Stanley, Jeff Hoerle	ASPI Program Development, Leadership, and Evaluation Team

ASPI Program Summary

Training Component	Training Participant Activities
Component 1: Didactic Training	Interactive training with video skill demonstrations: <ul style="list-style-type: none"> • Program Orientation • Review VA Safety Planning Manual, SPI competency measures & Safety Plan Note Template User Guide • ASPI Web-based Training course
Component 2: Experiential Training	Experiential role-play exercises with individualized feedback from Training Consultants
Component 3: Participant Evaluation	Individual evaluation of SPI using standardized patient role plays and standardized rating measures of fidelity
Component 4: Follow-Up Evaluation	Follow-up individual evaluation of SPI using standardized patient role plays and standardized rating measures of fidelity Discussion of implementation challenges

Advanced Training in the Safety Planning Intervention: Resources and Contact

◆ ASPI Program SharePoint

- VA Safety Planning Intervention Manual
- Brief SPI Checklist for VA Providers
- Safety Planning and suicide prevention articles
- Links to additional VA Suicide Prevention resources and trainings

◆ **ASPI Web-based Training Course (TMS #43804)**

- Available to all VA providers

◆ **ASPI Training Program Overview** - Rocky Mountain MIRECC CPG Series presentation by Dr. Wendy Batdorf

- August 24th at 12pm ET

◆ **Contact Dr. Wendy Batdorf, ASPI Training Program Coordinator:** wendy.batdorf@va.gov

THANK YOU!



Supporting Providers Who Serve Veterans

Free consultation and resources for any provider in the community or VA who serves Veterans at risk for suicide.

Request a consult: srmconsult@va.gov

#NeverWorryAlone



Risk assessment



Lethal means safety counseling



Conceptualization of suicide risk



Best practices for documentation



Strategies for how to engage
Veterans at high risk



Provider support after a suicide loss
(Postvention)



CPG
for **SUICIDE PREVENTION**
Webinar Series

Join us next month for the

May 2021 CPG Webinar

Virtual Webinar on

**WHO BIC as a Strategy
to Prevent Suicide
After Hospitalization**

5/25/21 @ 12:00 ET

**presented by
Dr. Natalie Riblet**

For virtual webinar registration details go to:

<https://www.mirecc.va.gov/visn19/cpg/>