Cognitive behavioral therapy (CBT) is one of the most researched treatments in psychotherapy (Butler, Chapman, Forman, & Beck, 2006). The goal of CBT is to aid patients in identifying and tracking thoughts and behaviors that are associated with inaccurate and unhealthy emotions, and to assist patients in challenging these beliefs through cognitive restructuring.

When treating patients with suicidal ideation, clinicians focus specifically on challenging the negative thoughts and cognitive distortions that contribute to the patient’s belief that death is the only option. In clinical practice, the specific CBT components (i.e., behavioral activation; challenging negative automatic thoughts, cognitive errors, and misattributions; problem solving; interpersonal interventions) used should be based on the problems experienced by the individual patient (Persons, Davidson, & Tompkins, 2000).

What is cognitive behavioral therapy?

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What is the theoretical model underlying CBT for suicidality?

CBT is based on Beck’s theory of depression which states that in a negative mood state information processing is highly biased and inaccurate. This faulty thinking results in selective attention to negative experiences (Beck, 1967; Beck, 2008). Wenzel and Beck (2008) proposed a cognitive model of suicidal behavior based on empirical data on cognitive and behavioral correlates and risk factors for suicidality. This model outlines three principal constructs as the basis for suicidal behavior: 1) dispositional vulnerability factors, 2) cognitive processes associated with psychiatric disturbance, and 3) cognitive processes associated with suicidal acts. Dispositional vulnerability factors are “long-standing and trait-like variables” that place a person at-risk for the development of non-specific psychiatric problems and suicidal behavior. Cognitive processes associated with psychiatric disturbance refers to maladaptive thought processes and information processing biases associated with psychiatric disorders. The frequency and intensity of such processes are theorized to trigger cognitive processes associated with suicidal acts, which operate when a person is in suicidal crisis.

Is CBT recommended as a front-line treatment for suicidality in the Military Health System (MHS)?

The 2013 VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide considers CBT an umbrella term that comprises different therapies sharing a conceptual foundation. The CPG gives a “B” strength of recommendation to cognitive therapy (CT) for suicide prevention and to problem-solving therapy (PST) that directly addresses the risk for suicide-related behaviors for non-psychotic patients with more than one previous suicide attempt. The CPG also recommends CBT as a treatment to target underlying mental health conditions. Notably, however, the CPG states that “there is a lack of strong evidence for any interventions in preventing suicide and suicide attempts.”

The MHS relies on the Department of Veterans Affairs (VA)/Department of Defense (DoD) clinical practice guidelines (CPGs) to inform best clinical practices. The CPGs are developed under the purview of clinical experts and are derived through a transparent and systematic approach that includes, but is not limited to, systematic reviews of the literature on a given topic and development of recommendations using a graded system that takes into account the overall quality of the evidence and the magnitude of the net benefit of the recommendation. A further description of this process and CPGs on specific topics can be found on the VA clinical practice guidelines website.

Do other authoritative reviews recommend CBT as a front-line treatment for suicidality?

No. Other authoritative reviews have not substantiated the use of CBT for suicidality.

Several other recognized organizations conduct systematic reviews and evidence syntheses on psychological health topics using similar grading systems as the VA/DoD CPGs. These include the Agency for Healthcare Research and Quality (AHRQ) and Cochrane.
The VA/DoD CPG recommends that clinicians use CT and PST to address the risk for suicide-related behaviors for non-psychotic patients with more than one previous suicide attempt. CBT to treat the underlying disorder is recommended as an evidence-based treatment to reduce repetition of suicide behaviors. Notably, quality research on treatments for suicidality/suicide prevention is still lacking. The low base rate of suicide makes this outcome difficult to study in both retrospective and prospective study designs and it is unclear whether suicidal self-report measures are valid proxies for suicidal behaviors. Further, the causes of suicide are complex and idiosyncratic, and identified risk factors can vary in their degree of effect and can change over time.

What conclusions can be drawn about the use of CBT as a treatment for suicidality in the MHS?

The VA/DoD CPG recommends that clinicians use CT and PST to address the risk for suicide-related behaviors for non-psychotic patients with more than one previous suicide attempt. CBT to treat the underlying disorder is recommended as an evidence-based treatment to reduce repetition of suicide behaviors. Notably, quality research on treatments for suicidality/suicide prevention is still lacking. The low base rate of suicide makes this outcome difficult to study in both retrospective and prospective study designs and it is unclear whether suicidal self-report measures are valid proxies for suicidal behaviors. Further, the causes of suicide are complex and idiosyncratic, and identified risk factors can vary in their degree of effect and can change over time.

References


