Cognitive Therapy for Suicide Prevention

Program Snapshot

Evidence Ratings*

Effective	Depression and Depressive Symptoms
Promising	Suicidal Thoughts and Behaviors
Promising	Self-Concept
Promising	Social Competence

*Ratings definitions can be found in the appendix.

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Program Type
Mental health treatment

Gender
Male
Female

Age
18-25 (Young adult)
26-55 (Adult)
55+ (Older adult)

Geographic Locations
Urban

Settings
Hospital / Medical Center
Outpatient Facility
Mental Health Treatment Center

Race/Ethnicity
American Indian or Alaska Native
Black or African American
Hispanic or Latino
White
Other

Implementation/Dissemination
Implementation materials available

Program Description

Cognitive Therapy for Suicide Prevention is a cognitive–behavioral psychotherapy program designed for patients who have previously attempted or thought of suicide. The intervention teaches patients skills to use alternative ways of thinking and behaving during episodes of suicidal crises and assists them in building a network of mental health services and social supports to prevent future suicide attempts. It is designed to be provided by individual therapists on a one-to-one basis. Therapists must have a master's degree and must either be a licensed mental health provider or work under the supervision of a licensed mental health provider.

The brief therapy typically includes 10 to 16 structured sessions (the number of sessions is flexible depending on the needs of the patient) and consists of three phases: early, middle, and late. The early phase of treatment introduces patients to the intervention and the cognitive model. During this phase, the therapist conducts a narrative interview of a recent suicidal crisis. Based on the narrative interview, the therapist and patient work together to develop a list of problems and goals for therapy. Early interventions in this phase also include the collaborative development of a Safety Plan and Hope Kit.

The middle phase of treatment focuses on teaching the patient cognitive and behavioral skills to manage suicidal thoughts, prevent suicidal behavior, and to address other treatment goals. Typical strategies include cognitive restructuring, coping cards, problem-solving, behavioral activation, and distress tolerance skills. The later phase of treatment focuses on skill consolidation, relapse prevention, and preparing patients for the end of treatment. Booster sessions are offered to patients for a review of skills learning and in case of emergency.

The average time needed to implement Cognitive Therapy for Suicide Prevention as designed is between 6 months to 1 year.

Evaluation Findings by Outcome

OUTCOME: DEPRESSION AND DEPRESSIVE SYMPTOMS

PROGRAM EFFECTS ACROSS ALL STUDIES	This program is effective for reducing depression and depressive symptoms. The review of the program yielded strong evidence of a favorable effect; Based on one study and two measures, the average effect size for depression and depressive symptoms is .42 (95% CI: .17, .55). Click here to find out what other programs have found about the average effect sizes for this outcome.
KEY STUDY FINDINGS	The intervention group reported significantly fewer depressive symptoms than the usual care group, at a 6-month posttest; there were no significant differences between the intervention and comparison groups in the severity of depression (Brown et al., 2005).
MEASURES	Brown et al. (2005): Beck Depression Inventory, and Hamilton Rating Scale for Depression
ADDITIONAL DETAILS	This outcome was also assessed at 12-month and 18-month follow-up periods (Brown et al., 2005). Follow-up findings are not rated and therefore do not contribute to the final outcome rating.

OUTCOME: SUICIDAL THOUGHTS AND BEHAVIORS

PROGRAM EFFECTS ACROSS ALL STUDIES	This program is promising for reducing suicidal thoughts and behaviors. The review of the program yielded sufficient evidence of a favorable effect. Based on one study and two measures, the average effect size for suicidal thoughts and behaviors is .38 (95% CI: .03, .56). Click here to find out what other programs have found about the average effect sizes for this outcome.
KEY STUDY FINDINGS	Brown et al. (2005) found that participants in the intervention group demonstrated a statistically significant lower reattempt rate over a period of 18 months than participants in the usual care control group; they were 50% less likely to reattempt suicide. There were no between-group differences on the rate of suicide ideation at any of the assessment periods.
MEASURES	Brown et al. (2005): Participant-reported suicide attempts and Scale for Suicidal Ideation.
ADDITIONAL DETAILS	This outcome was also assessed at 12-month and 18-month follow-up periods (Brown et al., 2005). Follow-up findings are

	not rated and therefore do not contribute to the final outcome rating.

OUTCOME: SELF-CONCEPT

PROGRAM EFFECTS ACROSS ALL STUDIES	This program is promising for improving personal resilience/ self-concept. The review of the program yielded sufficient evidence of a favorable effect. Based on one study and one measure, the effect size for personal resilience/self-concept is .39 (95% CI: .03, .75) Click here to find out what other programs have found about the average effect sizes for this outcome.
KEY STUDY FINDINGS	The intervention group reported significantly less hopelessness than the usual care group, at a 6-month posttest (Brown et al., 2005).
MEASURES	Brown et al. (2005): Beck Hopelessness Scale
ADDITIONAL DETAILS	This outcome was also assessed at 12-month and 18-month follow-up periods (Brown et al., 2005). Follow-up findings are not rated and therefore do not contribute to the final outcome rating.

OUTCOME: SOCIAL COMPETENCE

PROGRAM EFFECTS ACROSS ALL STUDIES	This program is promising for improving social functioning/competence. The review of the program yielded sufficient evidence of a favorable effect. Based on one study and two measures, the average effect size for social functioning/competence is .34 (95% CI: .09, .47). Click here to find out what other programs have found about the average effect sizes for this outcome.
KEY STUDY FINDINGS	Participants assigned to the intervention group were significantly less likely than those assigned to the usual care group to report a negative view toward life problems and an impulsive/careless problem-solving style (Ghahramanlou-Holloway et al., 2012).
MEASURES	Ghahramanlou-Holloway et al (2012): Impulsivity/Carelessness style (ICS) sub-scale of the Social Problem-Solving Inventory Revised, Short Form; Negative Problem Orientation (NPO) sub-scale of the Social Problem-Solving Inventory Revised, Short Form.
ADDITIONAL DETAILS	

Study Evaluation Methodology

BROWN ET AL. (2005); GHAHRAMANLOU-HOLLOWAY ET AL. (2012)

STUDY DESIGN NARRATIVE	This study randomly assigned 120 adults who had attempted suicide and been admitted to a hospital to either Cognitive Therapy for Suicide Prevention or to a usual care control group for outpatient treatment following hospital discharge. Participants in

	the treatment as usual group received care from clinicians in the community as well as tracking and referral services from the study case managers. Case managers contacted participants throughout the follow-up period on a weekly to monthly basis by mail and by telephone using a community voice mail account. Additionally, case managers offered referrals to community mental health treatment, addiction treatment, and social services (as needed during the follow-up period) and obtained feedback from participants regarding their contact with these services.
SAMPLE DESCRIPTION	The study included 120 participants who had attempted suicide within 48 hours. There were 60 in the intervention group and 60 in the usual care group. Study participants ranged in age from between 18 and 66 years, with a mean age of 35. The racial composition of the sample was approximately 60% African American, 35% white, 2% Native American, 2% other, and 1% Hispanic. The majority of participants were female (61%), never married (57%), and without a college education (71%). Approximately half (47%) were unemployed. The average number of previous suicide attempts was 5 per participant.

References

STUDIES REVIEWED

Brown, G. K., Ten Have, T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. JAMA, 294(5), 563–570.

Ghahramanlou-Holloway, M., Bhar, S. S., Brown, G. K., Olsen, C., & Beck, A. T. (2012). Changes in problem-solving appraisal after cognitive therapy for the prevention of suicide. Psychological Medicine, 42(06), 1185–1193.

SUPPLEMENTAL AND CITED DOCUMENTS

None provided.

OTHER STUDIES

None provided.

Resources for Dissemination and Implementation *

** Dissemination and implementation information was provided by the program developer or program contact at the time of review. Profile information may not reflect the current costs or availability of materials (including newly developed or discontinued items). The dissemination/implementation contact for this program can provide current information on the availability of additional, updated, or new materials.*

Implementation/Training and Technical Assistance Information

Cognitive Therapy for Suicide Prevention has been implemented in multiple mental health agencies across the United States since 2002. The program is designed to be provided by individual therapists on a one-to-one basis. Therapists must have a master's degree and must either be a licensed mental health provider or work under the supervision of a licensed mental health provider. The average time needed to implement the program as designed is between 6 months to 1 year.

To implement the program, providers must participate in a program-training workshop, use a specified program manual, and receive consultation training services. The 2–3 day Cognitive Therapy for Suicide Prevention Workshop can be delivered in person or via Webinar. Workshop costs vary, depending on the delivery method, length of training, and number of trainers needed. The required manual, Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications, is available for purchase online for $50. The required consultation services are provided by phone with the program developer on a weekly basis, for 4–6 months, and cost is based on specific consultation needs. The consultation includes a review of audio-recorded sessions and other training needs.

The program developer offers optional consultation services to assist with implementation and technical assistance needs. These services can be provided by phone or in person and cost is based on specific consultation needs. Additionally, two optional resources, an article and a book, are available for purchase. The article, “A Cognitive Therapy Intervention for Suicide Attempters: An Overview of the Treatment and Case Examples,” is available online for $36, or upon request of the program developer at no cost. The book, Choosing to Live: How to Defeat Suicide Through Cognitive Therapy, is available online for $22.

For quality assurance, the program requires completing session ratings using the Cognitive Therapy Rating Scale and audio recordings. The assessment is available upon request of the program developer and cost is based on specific site needs. Optional session-by-session, self-assessment checklists are available upon request of the program developer.

Dissemination Information

No dissemination information is available for Cognitive Therapy for Suicide Prevention.

Summary Table of RFDI Materials

Description of item	Required or optional	Cost	Where obtained
Implementation Information			
Cognitive Therapy for Suicide Prevention Workshop For mental health professionals Available in person or via Webinar 2–3 days, depending on need	Required	Varies	Contact program supplier: gregbrow@mail.med.upenn.edu
Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications Book by Amy Wenzel, Gregory K. Brown, and Aaron T. Beck Available for purchase online for mental health professionals	Required	$40 (for APA members) $50 (for others)	http://www.apa.org/pubs/books/4317169.aspx
Weekly Consultation Services For mental health professionals Available by phone Between 4–6 months	Required	Varies	Contact program supplier
Cognitive Therapy Scale and Cognitive Therapy Scale Rating Manual For mental health professionals Available upon request of program supplier	Required	Varies	Contact program supplier

Hourly Consultation Services For mental health professionals Available by phone or in person Duration varies on need	Optional	Varies	Contact program supplier
Session Adherence Checklists For mental health professionals Paper checklist available upon request of program supplier	Optional	Free	Contact program supplier
“A Cognitive Therapy Intervention for Suicide Attempters: An Overview of the Treatment and Case Examples” Article by Michele S. Berk, Gregg R. Henriques, Debbie M. Warman, Gregory K. Brown, and Aaron T. Beck Available for purchase online or upon request of program supplier For mental health professionals	Optional	$36 (online access) Free reprints upon request of developer	http://www.sciencedirect.com/science/article/pii/S1077722904800415 Contact program supplier
Choosing to Live: How to Defeat Suicide Through Cognitive Therapy Book by Thomas E. Ellis and Cory F. Newman. Available for purchase online For mental health professionals	Optional	$22	http://www.amazon.com/Choosing-Live-Suicide-Through-Cognitive/dp/1572240563 *Note: this is an Amazon link.

Appendix

Evidence Rating Definitions

Effective — The evaluation evidence has strong methodological rigor, and the short-term effect on this outcome is favorable. More specifically, the short-term effect favors the intervention group and the size of the effect is substantial.

Promising — The evaluation evidence has strong methodological rigor, and the short-term effect on this outcome is favorable. More specifically, the short-term effect favors the intervention group and the size of the effect is substantial.

Ineffective — The evaluation evidence has sufficient methodological rigor, but there is little to no short-term effect. More specifically, the short-term effect does not favor the intervention group and the size of the effect is negligible. Occasionally, the evidence indicates that there is a negative short-term effect. In these cases, the short-term effect harms the intervention group and the size of the effect is substantial.