PsycCRITIQUES
September 9, 2009, Vol. 54, No. 36, Article 1



Effective Treatment for Suicidal Patients

A Review of

Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications
by Amy Wenzel, Gregory K. Brown, and Aaron T. Beck
Washington, DC: American Psychological Association, 2009. 377 pp. ISBN 978-1-4338-0407-6. $69.95

doi: 10.1037/a0016829

Reviewed by

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Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications is a major contribution to the literature on empirically based treatment of suicidal people. The book is a treatment manual for one of the few treatments that have been shown to reduce suicidal behavior. The authors, Amy Wenzel, Greg Brown, and Aaron Beck, describe in detail their treatment, which has been shown in a randomized control trial to reduce suicidal behavior. There are only a very few treatments, such as dialectical behavior therapy for chronically suicidal persons with borderline personality disorder, that have similarly been shown in randomized control trials to reduce suicide attempts (Linehan, 1993).

This is a book of great value for all clinicians, even for those who do not regard themselves as cognitive therapists. The authors bring to this effort a wealth of clinical knowledge and experience that will be of value to all clinicians. Their treatment is not a narrow or rigid application of cognitive therapy principles but rather a rich integration of interventions that focus on the thoughts, emotions, and behavioral patterns that frequently characterize suicidal persons.

The book contains an excellent review of assessment issues and of risk factors for suicide. The literature on suicidology has been hampered by the identification of an overabundance of risk factors based on correlational studies that have had limited impact in advancing clinical practice because of the failure to specify those risk factors that are of real clinical utility. The authors make a significant contribution by identifying as risk factors only those that have been found prospectively to predict those who will die by suicide, such as the presence of a previous suicide attempt (particularly in the first year following discharge from a hospital for that attempt), the increasing severity of attempts among multiple attempters, and stable levels of hopelessness that persist over time.

The authors also deepen our understanding of previously well-documented clinical characteristics of suicidal persons such as perturbation and tunnel vision (Shneidman, 1985) by integrating them into the phenomenon of *attentional fixation*. What is of particular value is that the concept of attentional fixation provides a coherent, detailed description of both the thinking and emotions associated with an acute suicidal state consistent with empirical findings. The term describes a state of agitation and restlessness, with racing thoughts and a preoccupation with suicide as a solution to problems and an escape from torment. While intense emotional pain is clearly the driving force for this attentional fixation, it is the perception of this state as unbearable that may be the cognitive linchpin.

One extremely important component of the treatment is the emphasis on patient engagement and case management. In fact, for the research to proceed, it was necessary for the researchers to initiate contact through inpatient units and in emergency departments, stay in contact with patients, and then help problem-solve barriers to care. Both the experimental and control groups received this active engagement and case management, so these treatment features were not responsible for the almost 50-percent reduction in suicide attempts found in the research. However, this kind of engagement and case management following a suicide attempt may be a necessary, if not a sufficient, component of successful treatment of those who attempt suicide.

Another important component of the treatment, and one that extends its potential use beyond those who consider themselves cognitive therapists, is the central focus on issues directly related to the suicidal crisis and most likely to be helpful in preventing future suicidal crises. Both the work in therapy sessions and the homework assignments focus on issues involved in the suicidal crisis and assist the patient in gaining skills and strategies that can be used during a suicidal crisis. The therapy sessions and homework also help link a patient's more subtle cognitive characteristics with his or her more obvious mood and emotional distress.

The treatment is divided into early, intermediate, and later phases of therapy. In each of these, the authors make important contributions. An important early task of treatment is to obtain informed consent and to make transparent the clinical decision making that will take place during a suicidal crisis. Making clear that talking openly about suicidal thoughts is an expected part of the treatment process and not an indication that hospitalization is mandatory is critical for honest communication to take place. Rather, evidence that there is real suicidal intent with imminent risk, and that the patient is unwilling to collaborate to reduce that risk, is what would trigger hospitalization.

Another significant contribution for the early phase of treatment is the use of safety plans. Safety plans are not to be confused with no-suicide contracts, which are widely used but highly problematic. Rather than a promise from the patient about what he or she will not do, a safety plan is a multicomponent intervention focused on what the patient will do when in a suicidal crisis. Safety plans focus on recognizing warning signs, using coping strategies, contacting family members or friends, and finally contacting professionals and agencies. The importance of a focus on restricting access to lethal means, including the importance of gun management, is especially well described.

In the intermediate phase of treatment, the focus is on improving social connections, as well as on improving affective coping strategies. The authors describe useful clinical tools such as the development of what is called a "hope kit," as well as the use of "coping cards," with the content informed by the assessment of risk and protective factors obtained at the start of treatment.

The later phase of treatment focuses on relapse prevention. The clinician is walked through how to use guided-imagery exercises with a relapse retention protocol checklist that is based on a review of the recent suicidal crisis and the use of alternative coping skills. The book also has excellent sections on dealing with challenges in clinical treatment and on working with special populations, such as adolescents, older adults, and those with substance abuse problems.

Since all clinicians must be prepared to work with suicidal patients, this book is an indispensable guide for all therapists.

References

Linehan, M. M. (1993). *Cognitive behavioral treatment of borderline personality disorder.* New York: Guilford

Press.
Shneidman, E. (1985). *Definitions of suicide.* New York: Wiley.

Footnotes

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