

A Cognitive Therapy Intervention for Suicide Attempters: An Overview of the Treatment and Case Examples

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Although suicidal behavior is a serious public health problem, few effective treatments exist to treat this population. This article describes a new cognitive therapy intervention that has been developed for treating recent suicide attempters. The intervention is based on general principles of cognitive therapy and targets the automatic thoughts and core beliefs that were activated just prior to the individual's suicide attempt. Specific cognitive and behavioral techniques are taught to the patient with the goal of decreasing suicidal thoughts and preventing future suicide attempts. The treatment is unique in targeting suicidal behavior as the primary problem, apart from psychiatric diagnosis. Three detailed case examples are provided that illustrate the use of the treatment with different types of patients.

THE TREATMENT of suicidal behavior is one of the most difficult challenges faced by clinicians. In this article, we describe a cognitive therapy intervention developed for treating recent suicide attempters and provide three case examples to illustrate different elements of the treatment. The treatment follows general principles of cognitive therapy and includes a specific set of cognitive and behavioral techniques designed to decrease suicidal thoughts and behavior. The overall goal of the treatment is the prevention of future suicide attempts. One unique aspect of the therapy is that the suicidal behavior itself is the primary target of treatment, rather than it being approached as secondary to an underlying psychiatric disorder. Hence, all issues brought forth by the patient in therapy are discussed and conceptualized in terms of their relation to his or her suicidal behavior. A randomized controlled trial examining the efficacy and effectiveness of the treatment is currently being conducted at the University of Pennsylvania. Although the trial is still in progress, at present, the results are positive and suggest that the intervention reduces subsequent suicide attempts among recent suicide attempters by approximately one-half.

Cognitive Theory and Suicidal Behavior

Prior work on the cognitive model of the emotional disorders and, in particular, depression (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979) provides the framework for the cognitive intervention for suicidal behavior described in this article. According to cognitive theory,

how people think about and interpret life events determines their emotional and behavioral responses to those events (Beck, 1976; Beck et al., 1979; Weishaar & Beck, 1990). Hence, a cognitive model considers maladaptive cognitions to be the central pathway to suicidal behavior (Rudd, Joiner, & Rajab, 2001; Weishaar & Beck, 1990). Based on cognitive theory, as well as our clinical experience with suicidal patients, suicidal behavior is conceptualized in terms of the automatic thoughts and associated core beliefs that were activated just prior to the patient's suicide attempt. Maladaptive cognitions seen in suicidal patients often involve feelings of hopelessness, helplessness, unlovability, and a perceived inability to tolerate distress (Rudd et al., 2001; Weishaar & Beck, 1990). In addition, suicidal patients often display rigid, dichotomous thinking about themselves and others, have poor problem-solving skills, and view suicide as a desirable solution to their problems (Weishaar & Beck, 1990).

Suicidal behavior can also be conceptualized within a cognitive model in terms of the activation of "suicidal modes" (Rudd et al., 2001). In order to provide a comprehensive model of mind and behavior that considers cognition in conjunction with other psychological phenomena, Beck (1996) proposed a theory of "modes." Modes are defined as interconnected networks of cognitive, affective, motivational, physiological, and behavioral schemas that are activated simultaneously by relevant internal and external events, accounting for the multiplicity of symptoms seen in most psychiatric conditions. When the suicidal mode is activated, the patient should experience suicide-related cognitions, negative affect, physiological arousal, and the motivation or intent to engage in suicidal behavior (Rudd et al., 2001).

In particular, for patients who have engaged in prior suicidal behavior, the suicidal mode should become highly accessible in memory and should require minimal

Cognitive and Behavioral Practice 11, 265–277, 2004

1077-7229/04/265-277\$1.00/0

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triggering stimuli to be activated. In support of this notion, it has been shown that negative life events are not correlated with the severity of suicidal crises among multiple suicide attempters (Joiner & Rudd, 2000). Of clinical relevance, these data suggest that suicidal crises may occur rapidly and intensely in these individuals, even when based on seemingly minor precipitating events. Moreover, as the suicidal mode becomes increasingly active, the ability to exert cognitive control over suicidal urges should be decreased along with inhibitions against suicidal behavior. Hence, past suicide attempters should be more likely to engage in future suicidal behavior than nonattempters (see Joiner, 2002). Although further empirical work is needed to further delineate the mode concept, the notion of suicidal modes provides a useful theoretical framework for organizing the multiple elements that result in a suicide attempt. Case examples of how the suicidal mode concept can be applied and utilized as a therapeutic tool are provided later in this article. The major goal of the therapy is to help patients learn how to diminish or deactivate their suicidal mode before they engage in self-destructive behavior.

Cognitive Therapy for Suicide Attempters

The therapy presented here was developed as a brief and flexible intervention that can be used in a variety of settings and as an adjunct to other treatments. The therapist is highly active and directive in using a range of cognitive and behavioral techniques to help the patient develop alternative ways of thinking and behaving during periods of acute emotional distress instead of engaging in suicidal behavior. Treatment also focuses on assisting patients in building a support network by facilitating the use of additional mental health services (e.g., substance abuse counseling) and increasing contact with existing social supports such as family and friends. Therapy sessions are highly structured and follow standard cognitive therapy practices such as agenda setting, the creation of problem and goal lists, capsule summaries, and regular homework assignments. More specific to the present population, each therapy session also includes assessment and monitoring of suicide ideation, intent, and plans, access to lethal means, degree of hopelessness, acute psychiatric symptoms, drug and alcohol use, and the use of psychiatric medication.

The intervention is designed as a 10-session protocol and the typical strategies used in the early, middle, and late phases of therapy are described below. Although we offer this general structure, we also strongly encourage clinicians to tailor the treatment to match the particular needs and capabilities of each patient. Psychiatric symptoms as well as current life stressors and circumstances can vary greatly across individuals even when they share

suicidal behavior in common. The case examples discussed later in the article demonstrate how the basic elements of the treatment can be flexibly and creatively applied to work with different types of patients within this population.

Early Phase of Treatment (Sessions 1–3)

Initial therapy sessions set the stage for the rest of the treatment by focusing on engaging the patient in treatment, orienting the patient to the cognitive model, and developing a list of problems and goals for therapy. A variety of factors can make suicide attempters difficult to engage in treatment and treatment compliance rates are often low (Kreitman, 1979; Morgan, Burns-Cox, Pocock, & Pottle, 1975; O'Brien, Holton, Hurren, & Watt, 1987). These factors include poor economic resources, chaotic lifestyles, negative beliefs about treatment, severe psychiatric symptoms, drug and alcohol abuse, poor coping styles and problem-solving skills, shame about the suicide attempt, and stigma and negative culturally based beliefs about mental health services. Because of this, we recommend that when working with this population, the therapist take a very active role in keeping the patient in therapy. This is in contrast to the more typical approach in which the patient is primarily responsible for his or her treatment. We have found that calling patients to remind them of scheduled appointments, problem-solving impediments to regular attendance, having a list of persons that the patient has agreed we can contact to help locate him or her if he or she does not show up, availability to see patients on a walk-in basis, and practical assistance with transportation (such as providing tokens for public transportation) greatly improves treatment compliance. As part of our research team, we also have bachelor's-level case managers who maintain contact with patients and remind them of appointments. We have found that the case manager as a second supportive contact person in addition to the therapist greatly improves treatment compliance. In an earlier version of this study, in which we did not include case managers, only 33% of the participants attended four or more therapy sessions. In contrast, when case managers were used, 75% of participants attended four or more therapy sessions. Although we realize that many clinicians may not have access to this type of resource, we encourage obtaining assistance from case managers when possible.

Education about the cognitive model is also conducted in the initial sessions. A key element of cognitive therapy is helping patients to implement the skills taught in therapy on their own, outside of the therapist's office. To this end, patients are taught about connection between thoughts, feelings, and behaviors and about the activation of suicidal modes. We also give patients pamphlets on coping with depression and the book *Choosing*

to Live: How to Defeat Suicide Through Cognitive Therapy (Ellis & Newman, 1996). This book is a self-help guide that describes a range of cognitive-behavioral techniques similar to those included in the intervention. Chapters of this book are often assigned as homework.

A focus on improving problem solving is initiated at the very beginning of treatment. In the early therapy sessions, a problem list and a list of goals for treatment are developed. In creating these lists, the therapist works with the patient to understand the problems in his or her life that contributed to the suicide attempt. Later sessions then focus on teaching patients skills to adaptively solve these problems as well as new ones that may arise in the future. Suicidal behavior often occurs as a maladaptive attempt to solve life problems (e.g., Marx, Williams, & Claridge, 1992; Salkovskis et al., 1990). Therefore, establishing the connection between the patient experiencing problems and making a suicide attempt is a crucial point of intervention. The goal is to help the individual see the suicide attempt as an understandable but ultimately dysfunctional way of attempting to cope with severe distress.

Because individuals who have made past suicide attempts are at high risk for future suicide attempts, assessment of suicidal thoughts and behavior is conducted in every therapy session. Indicators of heightened risk include suicidal ideation, intent, plan, and access to lethal means, as well as increased severity of depression and hopelessness, history of suicidal behavior (multiple past suicide attempts versus a single past attempt), unemployment status and other economic factors, immediate life stressors, and active substance abuse/dependence. Monitoring of suicidal ideation, hopelessness, and depression can be conducted both by interview and using standardized self-report measures such as the Beck Depression Inventory–II (BDI-II; Beck, Steer, & Brown, 1996) and the Beck Hopelessness Scale (BHS; Beck & Steer, 1993). Items 2 (Pessimism) and 9 (Suicidal Thoughts and Dying) of the BDI-II are of particular relevance. Of importance, when a patient is in a suicidal crisis, we use a collaborative approach in which crucial clinical decisions, such as whether or not to hospitalize him or her, are made in consultation with the treatment team. In addition to consulting about crisis situations, we also hold a weekly group supervision meeting during which therapists discuss ongoing cases and provide each other with feedback and support.

In addition to establishing the framework that will guide the therapy, two key interventions are introduced in the early phase of treatment: the cognitive conceptualization of the suicide attempt and the development of a crisis plan for suicidal emergencies. Each is described below.

Developing a cognitive case conceptualization. A key component of the treatment is the identification of the specific automatic thoughts and core beliefs that precipitated

the suicide attempt. In order to do this, the therapist asks the patient to tell the story of his or her suicide attempt in detail. The relevant automatic thoughts and core beliefs are then incorporated into an overall cognitive conceptualization of the suicide attempt that also includes related early experiences, conditional beliefs and compensatory behavioral strategies, and the key life events that triggered the suicidal crisis. The conceptualization serves as an important guide for the therapist in planning interventions and can also be shared with the patient as a tool for educating him or her about the typical operation of his or her suicidal mode. Throughout the course of treatment, therapists continue to update the conceptualization as new data are gathered. An example of a cognitive conceptualization is presented in Figure 1.

Developing a crisis plan. It is often difficult for patients to plan and implement adaptive coping strategies in the place of self-harm when they are experiencing overwhelming distress and hopelessness. For this reason, therapist and patient work together from the very beginning of treatment to develop a detailed crisis plan that can be easily accessed for use in future crisis situations. The crisis plan is expanded throughout the therapy as new skills are learned and consists of a list of coping strategies that range from those the patient can perform on his or her own to contacting emergency services. At the top of the list are simple behavioral tasks such as going for a walk, calling a friend, or watching a funny movie. Coping strategies taught in the middle phase of therapy, such as cognitive restructuring, the use of coping cards, relaxation techniques, increased use of social supports, and the use of a “hope kit,” are also incorporated into the crisis plan. The crisis plan always includes the telephone numbers of (a) social supports, (b) the therapist, (c) the psychiatric emergency room, and (d) other crisis hot lines that handle emergency calls. Patients are instructed to contact the therapist or the emergency room when other coping strategies have failed to help.

The Middle Phase of Treatment (Sessions 4–7)

The middle phase of treatment targets suicidal behavior in depth by focusing on both cognitive restructuring as well as behavioral change. Primary interventions utilized in this phase are the creation of coping cards and a hope kit. Patients are also taught specific behavioral skills for managing suicidal thoughts and behavior.

Coping cards. In the middle phase of treatment, therapist and patient work together to identify and modify the core beliefs that became activated when the patient was suicidal. Core beliefs can be identified based on recurring themes in the patient’s automatic thoughts and discussion of early memories and experiences related to the patient’s viewpoints on him- or herself and others. After the key core beliefs have been discovered, standard cog-

nitive therapy techniques such as Socratic questioning, recognizing cognitive distortions, dysfunctional thought records, behavioral experiments, and role-plays are used to create a set of adaptive alternatives to each belief. Each suicide-promoting core belief and set of alternative responses is placed on a coping card. Coping cards are small wallet-sized cards that patients can easily carry around with them. The primary purpose of the coping cards is to provide patients with an easily accessible way of jump-starting adaptive thinking during a suicidal crisis. In a crisis, the patient is often highly distressed and may have difficulty accessing positive thoughts on his or her own. In this case, they can simply pull out and read a coping card. We also recommend to patients that they read the cards regularly when not in crisis to practice the more adaptive ways of thinking they have learned in treatment so that such thoughts do eventually become accessible on their own. Emergency numbers are also placed on the card. Examples of coping cards are presented in Figures 2 through 5.

Construction of a hope kit. In a suicidal crisis, it is often difficult for patients to identify and remember their reasons to live. To combat this problem, all patients are asked to create a hope kit which consists of a box or other type of container that holds items and mementos that serve as reminders of reasons to live, such as photographs, postcards, and letters. Patients are instructed to be as creative as possible when creating their hope kit, so that the end result is a powerful and personal reminder of their connection to life that can be used when feeling suicidal. We have found that patients report making their hope kits to be a highly rewarding experience that often leads them to discover reasons to live.

Behavioral coping skills. A range of behavioral strategies can be taught to patients in order to safely manage suicidal thoughts and behavior. Distraction techniques can be extremely useful in helping patients to tolerate short-term distress without resorting to self-injury. Almost any activity can serve as a distracter (such as reading, watching television or movies, talking to friends, counting backwards from 100, physical exercise) as long as it is compelling enough to the patient to demand a shift in his or her attention. Creating intense physical sensations (such as holding ice cubes, taking a hot or cold shower, drinking hot tea) can be particularly helpful as a substitute for self-harm (Linehan, 1993). Relaxation techniques can be taught to decrease the physiological arousal associated with painful emotions and to prevent acting impulsively. Emphasizing the short-term nature of most suicidal crises can also be of use as a motivator to tolerate distress rather than escape from it via self-injurious behavior. Finally, self-soothing activities (such as taking a hot bath, having a nice meal, planning a night out with a friend) can also function to decrease negative mood states and

thus offset suicidal behavior. Each behavioral skill that the patient finds useful should be added to his or her crisis plan.

Later Sessions (Sessions 8–10)

The key intervention utilized in the final phase of treatment is the relapse prevention task (RPT). This task is a guided imagery through both the index suicide attempt and a potential future suicidal crisis with a focus on implementing the coping skills learned in treatment. The RPT importantly serves as both a cognitive rehearsal for future coping and as an assessment of treatment progress and whether or not termination is appropriate. When the therapist has confidence that the patient will be able to utilize his or her new skills to prevent future suicide attempts, termination is indicated. If the patient has difficulty imagining successfully coping with a future suicidal crisis, the therapist uses the RPT to identify areas of difficulty and spends more time with the patient working to solidify relevant interventions prior to terminating treatment. The specific procedures used in the RPT are described below.

The task is described to patients as a way of practicing and testing the skills learned in therapy in vivo by applying them to the problems that led to previous suicide attempts in an imagery exercise. After explaining the task in full and answering any questions, the therapist obtains the patient's verbal consent to the procedure. Patients are told that the RPT may elicit negative emotions, but that the therapist will talk these through with them before they leave. Although some patients are initially fearful of performing the RPT, we have found that in most cases patients report it was a highly valuable experience that reassured them of their ability to cope with future crises and reminded them of how far they have come since the index suicide attempt. In cases where the patient refuses to consent to the task, despite a thorough review of his or her concerns with the therapist, we recommend that the therapist and patient simply have a discussion about the coping skills learned and how they might be applied in the future, without engaging in any imagery or emotional provocation.

In the first step of the RPT, the therapist takes the patient through a guided imagery of the index suicide attempt. The patient is asked to imagine the sequence of events (e.g., "as if you are watching a movie of yourself") that led up to the suicide attempt as well as the associated thoughts and feelings. The patient is instructed to close his or her eyes and to use sensory triggers, such as sights, smells, and sounds, from the time of the attempt to enhance the immediacy of the image. The patient is asked to describe each event to the therapist out loud as he or she imagines it happening and to try to reexperience the emotions that occurred at that time.

In the next step, following this same format, the patient again imagines the sequence of events leading up to the index attempt, but this time also imagines him- or herself using the skills learned in therapy to cope with each event. This serves as a test of whether or not the patient can successfully implement adaptive coping strategies.

The final step of the RPT involves imagining a future suicidal crisis. Based on the cognitive conceptualization, the therapist assists the patient in imagining a sequence of events that might occur in the future that would result in him or her becoming suicidal. Once again, the patient is assisted in imagining this scenario in as real and immediate a way as possible and to talk through how he or she would cope with such a situation. At the end of the RPT, the patient is debriefed and his or her reactions to the task are reviewed. If any current suicidal ideation was activated by the task, the therapist explores this in detail with the patient, assesses suicidal risk, and conducts the appropriate interventions from those described in this article. As noted earlier, if the patient cannot imagine successfully coping with a future suicidal crisis, the therapy continues and appropriate coping skills are reviewed. When the therapist feels the patient has made the necessary gains, the RPT is conducted again. Therapy is typically not terminated until the patient performs the RPT successfully.

Termination. The therapist helps the patient prepare for termination from the very first session by emphasizing the brief nature of the treatment and encouraging the use of additional mental health services and social supports. Because patients are aware that the treatment will be short-term from the very beginning, we have found that termination typically progresses smoothly. However, the therapist should take the time to discuss and validate all feelings about termination expressed by the patient. Due to the high-risk nature of suicidal patients, we typically offer patients the option of booster sessions and inform patients that they can contact their therapist in the future for a review of coping skills or in an emergency for crisis intervention. Suicide attempters can often be vulnerable to relapse due to chronic life stressors and poor economic and social resources. It is helpful to prepare patients for the possibility of relapse in advance by talking about how they will cope with setbacks, and in particular, how to avoid engaging in hopeless, all-or-none thinking patterns about setbacks if they occur.

Case Examples

Under optimal circumstances, therapy proceeds as outlined above. However, the therapy must often be modified to suit the needs and capacities of the individual patient. For example, patients who are less psychiatrically stable may require a great deal of symptom management

and mobilization of outside resources prior to addressing the cognitive aspects of the suicide attempt. Depending on a range of factors, such as the patient's degree of psychopathology, level of education, intellectual capacity, and personal style, he or she may respond better to certain types of interventions, such as those that are cognitively versus behaviorally based. We recommend that therapists emphasize what works with a given patient and not feel pressured to utilize elements of the treatment that the patient is not responsive to.

In the following section of the article, we provide three case illustrations showing how the treatment can be used successfully with suicidal patients with differing clinical presentations. Case 1 provides an in-depth account of how all of the major treatment components were implemented with a patient who is most typical of our population—an individual with depression, substance abuse, and poor economic and social resources. Case 2 illustrates how the treatment can be used with a patient who is psychiatrically unstable. This patient had a long history of severe bipolar disorder and was manic for much of the therapy. Case 2 also includes excerpts of a session transcript, in order to provide a detailed demonstration of how the therapist conducts the treatment. Finally, Case 3 describes the treatment of an educated young woman with a history of chronic, severe depression and suicidal ideation. Coping cards and cognitive restructuring were heavily emphasized in this case. Each patient gave written consent to present aspects of their treatment in this article and identifying details have been altered to protect each person's confidentiality.

Clinical Case 1

Description of the Attempt

M., a 49-year-old female, overdosed on antidepressant medication with a moderate degree of suicidal intent and low level of lethality following a drug and alcohol relapse and subsequent conflict with her significant other. After feeling depressed for several weeks, she first relapsed on alcohol and then binged on cocaine for a 2-day period. She then called her significant other and confessed her relapse, whereupon he berated her, called her a failure, and said she was “no good for anything.” Angry with him, but also believing he was correct, she reached into her bag and impulsively swallowed “two handfuls” of her Zoloft pills, thinking that she “deserved to die because she was a crack addict.” After approximately 10 minutes, she became fearful that the pills would cause her further health problems, but not kill her, so she called 911. After being medically cleared in the emergency room, she was evaluated by a psychiatrist and eventually admitted to an inpatient dual-diagnosis program where she stayed for 15 days.

Diagnosis

Diagnosed with major depressive disorder, recurrent, severe, M. was also cocaine dependent with a history of alcohol and marijuana abuse. She was not given a personality disorder diagnosis, although she had borderline and dependent personality features in that she demonstrated marked affective instability, had serious problems in many of her relationships, was preoccupied with feelings of guilt and shame, and believed she was completely helpless. Medically, she had a prior diagnosis of congestive heart failure, substantial back and hip problems, and fibroid tumors.

Relevant History

At intake, M. was despondent and hopeless (BDI-II = 30; BHS = 19). She reported a long history of moderate to severe depressive episodes that began at age 13 and coincided with sexual abuse from her stepfather. M. described how the boredom in her previous marriage led to exploration with various drugs and finally a cocaine addiction, divorce, and poverty. The years prior to her suicide attempt were characterized by brief periods of stability, followed by drug relapse, and then drug rehabilitation. Approximately 1 year prior to the index attempt, she met a man and “fell in love.” Unfortunately, as the relationship progressed he began to dominate and control her, at times becoming verbally and physically abusive. At one point he seriously beat her, at another he made her sit naked in a chair for over 12 hours. She reported that her dream relationship had transformed into a nightmare. M. felt alone, scared, confused, and depressed. Although she experienced a long history of depression and significant suicidal ideation, this was her first suicide attempt. In addition to her problems with her significant other and her health, M. was also experiencing serious financial and housing difficulties. She lived by herself in an old house with no heat or hot water and her only source of income was a social security check of \$50 per week.

Early Sessions (Sessions 1–4)

The first three sessions took place over a 5-day period while M. was still in the hospital. Session 4 occurred 10 days after M. was discharged and several phone conversations were had in the interim. The initial goals for the therapy included the following: (a) identify the sequence of events that led up to the suicide attempt; (b) identify goals for therapy and living in general; (c) combat suicidal thoughts and behavior, feelings of depression, and beliefs about the hopelessness of her situation by adopting an active, problem-solving orientation, educating M. about the cognitive model, and providing bibliotherapy in the form of *Choosing to Live*; and (d) refer M. to a social worker to develop a plan for separating from her significant other, including obtaining a restraining order; and (e) develop a safety plan.

The first session was spent orienting M. to the cognitive model, hearing her story, and obtaining the relevant history described above. The second session focused more specifically on her current relationship. Because her boyfriend had become significantly abusive and was integrally related to her suicide attempt, it was deemed that this problem required immediate attention. As she recounted her boyfriend's actions, M. at one point stated, “I wonder why I stay in this relationship.” This self-posed question served as a catalyst to identify and explore core beliefs that pertained to her sense that she “deserved to be abused because [she was] unlovable” and that she “needed a man in order to be happy.” The former belief was connected to her history of being molested and “used” by her stepfather. The latter belief was explored in a more empirical manner by charting out some periods in her life on a time line. After creating the time line, it was clear to M. that she had many periods in which she was relatively happy without a man and many periods in which she was miserable when she was with a man. It also became clear to her that she did not deserve to be abused by anybody.

By the third session, M. was committed to ending her relationship with her boyfriend. Because of concern for her safety, it was agreed that M. should obtain a restraining order as soon as she was discharged from the hospital, and the therapist worked with her to develop a safety plan in case he violated the restraining order. Strategies were developed to cope with feelings of loneliness, isolation, and longing. These included talking with her sister, a friend, or one of her children, going for a walk, volunteering at a local community center to feel productive, and completing projects around the house (i.e., painting a room).

By the fourth session, M. had effectively ended the relationship with her boyfriend, obtained a restraining order against him, dealt with some feelings of loneliness and despair, and established a new relationship with a friend she met at the hospital. Her depression (BDI-II = 20) and hopelessness (BHS = 5) were reduced. Her boyfriend had accepted her decision to end the relationship with only minimal protestations and never violated the restraining order. The fourth session focused primarily on dealing with ongoing periods of suicidal ideation. She constructed a hope kit and developed a list of reasons for living. She was also given the assignment to read the first two chapters of *Choosing to Live*.

The Middle Sessions (Sessions 5–9)

The middle sessions took place over a 2-month period. The focus became increasingly cognitive and the relationship between her automatic thoughts, core beliefs, mood, and behavior was explored. Session 5 took place over a month after Session 4. M. had decided to stay with

one of her daughters. She reported that she initially enjoyed the visit, but she became increasingly depressed and hopeless during the several weeks prior to the session (BDI-II = 35; BHS = 16). She had also experienced some suicidal ideation and had effectively used the coping strategies and hope box. M. had run out of her antidepressant medication 3 weeks prior and had not gotten the prescription filled. Much of the session was spent educating M. about the cycle of depression and how a negative series of events can lead to a negative mindset and beliefs such as, "It's no use to keep trying," which in turn lead to ineffective decision making based on overly pessimistic and hopeless interpretations. The therapist also discussed with M. possible employment, friendships, and activities that she could engage in that might yield productive results. For homework, she was to call a friend and the unemployment office about possible vocations. She was also assigned to complete the reasons for living/reasons for dying exercise in *Choosing to Live*.

The sixth session was held 2 days later and she was feeling better (BDI-II = 23; BHS = 3). She had called several friends and the unemployment office and had several leads on finding possible employment. Much of the therapy session was spent examining her reasons for living and her reasons for dying. A primary reason for living was her children and grandchildren. At the same time, a primary reason for dying was that she believed no one cared about her and that she was a complete burden to other people. The validity of this belief became the central focus of the therapy session. The evidence for and against this belief was examined and it became clear that there was much evidence against the notion that other people would not care if she killed herself. Because the therapist was extremely confident that M.'s children did in fact care about her based on data obtained throughout therapy, a behavioral experiment was proposed in which M. was to call her children and tactfully inquire about how they would feel if she were to die. The therapist role-played with M. how she might bring this up and how the conversation might proceed. The therapist role-played both enthusiastic and less than enthusiastic responses and processed how M. felt after the exercise.

M. returned for the seventh session feeling better (BDI-II = 18; BHS = 2). She had called all of her children and her sister and spoken with them about their feelings for her and how they would feel if she died. She believed 100% that they would care if she killed herself and this dramatically influenced both her sense of wanting to live and her belief that she was a burden to others (which was reduced to 15%).

The eighth and ninth sessions were conducted with a continued focus on M.'s core beliefs. A cognitive conceptualization was developed and shared with her (see Figure 1). A relapse prevention task was also performed and

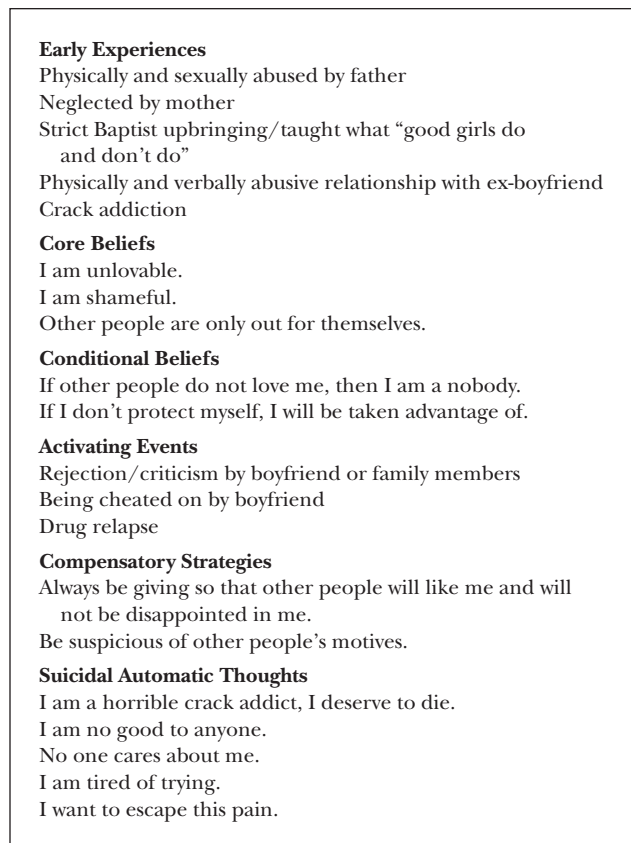


Figure 1. Cognitive conceptualization diagram for M.

M. did extremely well in generating adaptive responses to her suicidal beliefs and listing coping strategies that she might perform if she became suicidal. An interesting belief emerged, however, which was that she believed that if she relapsed on crack cocaine she deserved to die and should kill herself. The therapist explored the pros and cons of this belief and why M. believed it, although she remained committed to this belief at the end of the session.

Coping With a Lapse (Sessions 10–11)

Two weeks after the ninth session, M. relapsed on crack after a friend brought crack over to her house. After M. failed to show for her tenth session, the therapist used contact information and finally located M., who was in the midst of a crack binge. The therapist drove out to M.'s house and brought her to the emergency room, staying with her until she was admitted to a drug rehab program. M. was severely distressed (BDI-II = 53; BHS = 14) and suicidal during this episode. She believed that everything she was working toward was ruined. This belief was examined and reframed: She had experienced a setback, but not a complete loss. The therapist helped M. explore various ways of coping with this lapse. Eventually M. called two of her children and informed them of the lapse

and they both were relatively supportive. Within a week, M. was feeling much improved and was very glad that she did not kill herself. It is useful to note that, according to M., a primary function of her initial belief—that if she were to relapse she should kill herself—was that the rule would keep her from lapsing on cocaine. However, her degree of conviction in this belief lessened significantly after this episode. As of this writing, 15 months have passed and she has reported no further lapses.

Termination (Sessions 12–13)

M. was able to resume adequate functioning within a month of her relapse. She had significantly increased her communication with her oldest son and he invited her to live with him, which she accepted. Before she moved, the course of therapy was reviewed and the most important points were evaluated. She reported that the treatment was very helpful and that she no longer experienced suicidal impulses or feelings. When asked to list the most helpful strategies, she listed:

- to think things through—not act before I think
- to speak out and ask instead of assuming
- to get help from other organizations
- to analyze the situation at hand
- to use the Hope box

She also reported that the single most effective intervention was calling her family and finding out that they did care about what happened to her. She also said that it was very unlikely she would make another suicide attempt.

Clinical Case 2

Description of Suicide Attempt

L., a single, 48-year-old female, overdosed in a serious attempt to end her life. Her attempt was made with a high degree of intent and a high degree of lethality. She reported she was stressed by problems in her personal life. She was experiencing problems with her family members, she and her significant other had recently broken up, and she was having both medical and psychiatric problems. She believed she was unloved, unwanted, and misunderstood. She contemplated suicide for approximately 1 week, though she had been depressed for over 6 months. Several hours after L. made the suicide attempt, her daughter came home. L. told her daughter she needed to go to the hospital, but she did not reveal having made the suicide attempt. Her daughter said that she would take her to the hospital, but not right away. L. felt increasingly rejected by her daughter not taking her to the hospital immediately, so she ingested more pills. L. continued to conceal having made the suicide attempt until she arrived at the hospital, where she was treated for her attempt. She was admitted to an inpatient unit.

Diagnoses

Bipolar I disorder, most recent episode mixed, severe with psychotic features; borderline personality disorder; history of cocaine and sedative dependence.

Relevant History

L. was diagnosed with bipolar disorder at age 25 and had a history of numerous psychiatric hospitalizations. The index suicide attempt was L.'s fifth; her first attempt was at age 22. L. had one daughter and one son, both of whom she had when she was a teenager. At the time of treatment, L. lived with her daughter and her three grandchildren. She had never been married, though she reported several meaningful relationships in her history. Her most recent relationship ended just prior to the index suicide attempt.

Early Sessions (Sessions 1–4)

L. was discharged from the hospital in a manic state. She was not actively suicidal at the time of her discharge, but she reported suicide ideation. Her medications at the time were a mood stabilizer and an antidepressant. L. had difficulty remaining focused on therapy topics due to her level of manic symptoms and she demonstrated poor skills at cognitive restructuring. She demonstrated grandiosity and paranoia and limited ability to provide alternative explanations for situations. When she discussed family issues, she became irritable and expansive. She responded well to the structure of sessions. She demonstrated an awareness of her inability to focus, reporting she had "racing thoughts" and that her thoughts were "confused." Sessions focused on providing structure, summarizing important points L. made, and redirecting L. when she jumped from topic to topic. Therapy also focused on increasing L.'s focus outside of session. The therapist encouraged her to set homework assignments for herself. She assigned herself bibliotherapy, reading *Choosing to Live*. She reported she enjoyed doing the reading because it helped her focus, helped her learn more about her situation, and helped her prioritize improving her mental health.

Despite L.'s high level of manic symptoms, her ability to use cognitive restructuring improved. It was determined that certain situations, especially those related to conflict with family members, activated her suicidal mode. She was able to generate alternative explanations for situations and to provide evidence against her beliefs that she was unloved and unwanted. She reported the coping card accurately summarized her dysfunctional thoughts at the time of her suicide attempt; in addition, she reported those same beliefs became activated when her suicide ideation returned. She became receptive to engaging in nondangerous activities when she was in situations that activated her suicidal mode. She was encouraged to

“leave the house instead of leaving this world” if she became upset in response to hurtful interactions at home. L. began to engage in pleasant activities outside the home and to decrease her impulsivity. She reported that becoming engaged in church-related activities and going for walks helped her feel more balanced in her life and increased the amount of pleasure she experienced.

L., after Session 4, had an argument with her family members. She personalized the situation and felt manic and irritable. She recognized that her suicidal mode had been activated. She reported she read her coping card, went to church, and tried to call some people she trusted. She reported she was unable to calm herself down and was concerned she would act impulsively and make a suicide attempt, so she requested help at a crisis center. She was hospitalized manic and psychotic. Her medication was adjusted while she was at the hospital to also include an antipsychotic medication and she demonstrated less manic symptoms following this hospitalization. She continued to have trouble staying focused, yet her paranoia decreased. After she was discharged, she reported feeling proud of herself that she sought help rather than having made a suicide attempt.

Middle Sessions (Sessions 5–8)

L. demonstrated an increased ability to utilize her skills in cognitive restructuring and in writing. L. demonstrated a high level of creativity, speaking often in metaphors, which the therapist encouraged her to utilize through writing and journaling. L. reported this was helpful, as it both tapped into her strengths in writing, which increased her self-esteem, and also that it helped her focus when she was upset, decreasing the likelihood she would react impulsively.

L. engaged in discussions with the therapist related to the removal of lethal means from her home, notably flushing medications she did not need. However, despite these conversations, L. did not flush these medications. In order to address this issue, the therapist asked L. to complete an advantages/disadvantages analysis in session. Excerpts of the session transcript of this intervention are provided below.

THERAPIST: How are you doing in terms of flushing your meds?

L: When I was in the hospital, I was thinking, I know I have all these medications. I know I should just go home and flush them. I’ve been wondering if there might be a reason why I haven’t done that yet.

T: You’re wondering if there’s a reason you have not flushed your meds? That perhaps on some level you don’t want to flush the meds?

L: Right. It’s almost like just as good as I can prepare for life I can prepare for death.

T: So you’re wondering if on some level you’re avoiding flushing the meds, because in the event you become suicidal, you’d like to know that they’re there.

L: *Right!* I knew I was coming to see you and I didn’t want to have to tell you that I hadn’t done it, but I hadn’t done it. I still want to do it, though.

T: It sounds to me like you’re conflicted. It sounds like part of you wants to flush the meds, and part of you wants to hold onto them. Sometimes when there’s a decision to be made and it feels uncertain, it can be helpful to fill out a list of advantages and disadvantages to each decision. Maybe this will help organize the decision process of flushing the meds.

L: Okay.

L.’s list of advantages/disadvantages is shown in Table 1. After completing the advantages/disadvantages analysis, L. reported surprise at how it turned out. The list was reviewed with the therapist as depicted below.

T: It seems that one of the advantages to flushing the meds is also a disadvantage of flushing the meds—not having the means for suicide.

L: Yeah. That’s amazing.

T: Are there any other disadvantages of flushing the meds?

L: Well, no. That’s it.

T: So there are several advantages of flushing your meds—not being able to kill yourself, keeping your family safe, not getting mixed up with the medications you are currently taking, and taking a step toward the goal of life. The disadvantage of flushing the meds is the concern that you are going to want to die and you won’t have them.

L: Yeah.

T: You’ve made suicide attempts before, even when you thought you might not. So, it makes sense that even though you’re feeling better, you wonder if you might want to kill yourself later, at some other time. So you wonder if it might help you to keep the means available.

Table 1
Advantages/Disadvantages Analysis for L.

Advantages to Flushing Meds	Disadvantages to Flushing Meds
<ul style="list-style-type: none"> • Won’t have the means for suicide • Safety of household (my grandchildren won’t find them and take them) • Won’t get them mixed up with meds I’m currently taking • Accomplishing goal for taking a step toward living 	<ul style="list-style-type: none"> • Won’t have the means for suicide

L: Yeah. Putting it down on paper and seeing it before me and working it out like a puzzle like that—it just makes things more clear.

T: Putting it on paper made it more understandable. When you're looking at the advantages and disadvantages now, what goes through your mind about flushing the meds?

L: I know that I have to go and flush them.

Based on the discussion of the advantages/disadvantages list, the therapist was also able to help L. identify and modify an important belief related to her suicidal behavior.

T: One thing that strikes me is that you seem to have a belief that if you become suicidal, the only answer you will have is to overdose and kill yourself.

L: Hmm.

T: Do you have evidence from the past week, that you can have suicidal thoughts without acting on them?

L: Yes! I felt suicidal last week and went to a crisis center. I did not make a suicide attempt.

T: So, is it necessary to have a means for suicide in order to deal with suicidal thoughts?

L: No, it isn't.

At the following session, L. reported she flushed her medication. She reported she did a burial for them—she buried the choice to die. She used her creative strengths to enact a symbolic, meaningful burial for the medication and she wrote a eulogy for her choice to die, which she read aloud before she “put the medications to rest.” (She also read the eulogy aloud in session.) L. brought her hope kit to the therapy session, which, among pictures of her family members, scriptures, and gifts from people she cherished, contained an empty pill bottle, symbolizing her choice to live.

L. continued to make significant progress utilizing cognitive techniques. She reported that she was learning how to take a step back when she was feeling overwhelmingly emotional and to find logical, alternative interpretations for situations. She stated this helped to calm her down on numerous occasions, including situations that had, historically, been particularly painful for her and that had previously activated her suicidal mode quite quickly, such as interactions with her daughter that made her feel rejected and unloved. She continued to assign herself homework tasks, including reading, scheduling a routine, and looking for alternative interpretations for situations when upset.

Later Sessions (Sessions 9–10)

In the final sessions, L. was receptive to reviewing her suicide attempt and alternative methods of coping. She stated that at the time of her suicide attempt, she had

given up hope that things would improve; she believed very strongly that she was unloved and that she never would be loved. She provided evidence against these beliefs. She reviewed her crisis plan and described numerous steps she could take in the event suicide ideation returned. She reported that the image of her flushing her medications served as a repeated reminder of her having made the choice to live. At the closing session, she denied suicide ideation and reported a high level of commitment to life.

Clinical Case 3

Description of Suicide Attempt

R., a single female in her late 20s, cut her wrists in a moderately serious attempt to end her life. The attempt was impulsive and was made with a high degree of intent and a moderate degree of lethality. The attempt occurred at home after a seemingly minor argument with a relative with whom she had a history of conflict. After the argument, she experienced intense angry and depressive affect and had the following automatic thoughts: “I can't stand getting upset so easily” and “I can't take being depressed anymore.” R. told the therapist that she wanted to die in order to escape from her strong negative emotions. R. had a history of chronic suicidal ideation and reported that on that day, prior to the argument, it was no greater than usual. She cut her wrists for an hour with a knife but was unable to find a vein. When she realized she was not going to die, she informed a family member of the attempt and asked to be taken to the hospital. She was admitted to an inpatient unit.

Diagnosis

Major depressive disorder, recurrent, severe, without psychotic features. She did not meet criteria for a diagnosis of a personality disorder and had no medical problems.

Relevant History

R. had a history of major depression starting in adolescence, for which she had been hospitalized twice. She was also hospitalized following the index suicide attempt. During this most recent hospitalization, she received ECT due to several prior failed medication trials. She reported two prior suicide attempts, but these were not medically serious enough to require hospitalization and she did not tell anyone about them. She experienced chronic depressive affect and suicidal ideation. In addition to the present treatment, she had an outpatient psychotherapist whom she had been seeing once a week for the past year. She also had an outpatient psychiatrist.

R. graduated from college and had been employed in the past. She was unemployed at the time of the suicide attempt and had recently moved into her parents' home

following a hospitalization for depression. She was single and had had relationships with men in the past. She used alcohol socially. She denied a history of physical or sexual abuse.

Early Sessions (Sessions 1–4)

Early sessions focused on reviewing the suicide attempt in detail and identifying the automatic thoughts, core beliefs, and triggers associated with the suicide attempt. The impulsive nature of the attempt and the speed with which R.'s suicidal mode was activated was highlighted as an important area of intervention. R. indicated that learning to avert suicidal crises was a goal that she wanted to achieve. During these beginning sessions, R. was frequently depressed and hopeless and had episodes of suicidal ideation. In particular, her hopelessness was due to her long history of chronic depression and she questioned the point of life if she could never enjoy it. In one session, R. reported ideation about going home and looking for a gun her father, who worked in law enforcement, kept in the house. This crisis was averted by having R. call her father during the session and asking him to remove the gun from the home to an undisclosed location. R.'s willingness to make this telephone call and to decrease her access to lethal means was a strong indicator of her commitment to giving up suicide as an option. An initial crisis plan was developed. The therapist also worked with R. on daily activity scheduling to decrease depressive symptoms. For example, R. scheduled lunch dates, spent time volunteering at a friend's office, and went to the gym.

Due to R.'s insightful nature and long history of suicidal ideation, several cognitions about suicide were readily identified. She reported several automatic thoughts that occurred when she was feeling suicidal, including: "I don't see any reason to be alive"; "I can't stand getting upset so easily"; "I'm sick of getting upset over nothing"; "I can't take being depressed anymore"; and "I want to be dead." These automatic thoughts were linked to four central core beliefs: "Life is pointless"; "I can't tolerate the pain"; "I shouldn't be depressed"; "I'm a burden." Finally, typical triggers for suicidal crises were identified as intense depressive or angry affect and interpersonal conflict.

Middle Sessions (Sessions 5–9)

Sessions in the middle phase of treatment focused on developing alternative adaptive responses to each core belief and understanding the origins of each belief. R. was able to create several alternative responses to each core belief, which were then made into coping cards. R.'s homework was to read her coping cards every night with the goal of replacing suicide-promoting thoughts (which were highly salient due to frequent suicidal ideation) with more adaptive responses and decreasing the accessibility of her suicidal mode. R. also carried her coping

Negative Belief

I shouldn't be depressed.

Feeling

Depression, hopelessness

Positive Beliefs

1. I've been through a lot. I have every right to feel however I want.
2. I have a chemical imbalance which lots of people have. I'm sad because of that.
3. There's usually a reason why people feel certain ways. Reasons can be from the past or current issues.
4. It's okay to be depressed.
5. One advantage to being depressed is that I've met some real good friends because of it.
6. Being depressed has made me be able to be a very feeling person and I can be very understanding of others due to all that I've been through.

If you cannot control the impulse to harm yourself call the Emergency Room at XXX-XXXX or the Suicide and Crisis Center at XXX-XXXX or 911.

Figure 2. Coping card for the core belief "I shouldn't be depressed."

cards in her purse and read them whenever she felt depressed or suicidal. She used the coping cards to offset suicidal ideation on several occasions and found them very helpful. R.'s coping cards are displayed in Figures 2 through 5.

As a means of examining the evidence for and against each core belief and constructing adaptive responses, the therapist encouraged R. to look at the origins of each core belief. For example, R. reported that the first time she remembered believing "life is pointless" was after experiencing her first major depressive episode at age

Negative Belief

Life is pointless so why not do it [suicide]?

Feeling

Depression, hopelessness

Positive Beliefs

1. Because my family would be devastated.
2. Because I am able to feel better now.
3. I wouldn't want one of my family members to kill themselves.
4. I have a job that's meaningful.
5. There may be things to come in my future that will be meaningful to me.

If you cannot control the impulse to harm yourself call the Emergency Room at XXX-XXXX or the Suicide and Crisis Center at XXX-XXXX or 911.

Figure 3. Coping card for the core belief "Life is pointless so why not do it [suicide]?"

<p>Negative Belief I can't tolerate the pain.</p> <p>Feeling Depression, hopelessness</p> <p>Positive Beliefs</p> <ol style="list-style-type: none"> 1. I can handle it. I have always handled it in the past. 2. I am capable of feeling good. 3. There are things to look forward to. 4. I've gotten through it before. <p>If you cannot control the impulse to harm yourself call the Emergency Room at XXX-XXXX or the Suicide and Crisis Center at XXX-XXXX or 911.</p>

Figure 4. Coping card for the core belief "I can't tolerate the pain."

15. Continued, frequent episodes of severe depression strengthened this belief. In addition, at this same point in time, she contemplated her religious beliefs and decided that she did not believe in the idea of heaven or an after-life. She then questioned, "What is the point if life is full of pain and there is nothing better afterward?" In creating alternative responses to this belief, the therapist worked with R. to examine the evidence that her life is pointless and, in particular, highlighted for R. how she tended to disqualify the positive experiences in her life, such as completing college. The possibility that, due to R.'s young age, she had not yet discovered what would ultimately be most meaningful to her in life was also discussed and helped modify her belief. Finally, around this time, presumably at least in part due to ECT, R. experienced relief from her depressive symptoms for the first time in many years, which had a great influence on lessening her belief that life is pointless and full of pain.

A second, central core belief for R. was "I shouldn't be depressed." This belief occurred during times of intense emotional crisis and increased her suicidal ideation and

<p>Negative Belief I'm a burden.</p> <p>Feeling Depression, hopelessness</p> <p>Positive Beliefs</p> <ol style="list-style-type: none"> 1. These are my family. They will do anything for me. They don't think I'm a burden. 2. If someone I loved was suffering, I wouldn't think they were a burden. <p>If you cannot control the impulse to harm yourself call the Emergency Room at XXX-XXXX or the Suicide and Crisis Center at XXX-XXXX or 911.</p>
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Figure 5. Coping card for the core belief "I'm a burden."

impulses because it led to strong self-criticism and feelings of worthlessness. R. traced the origin of this belief to childhood memories of a family member being emotionally unpredictable and prone to angry outbursts. She remembered thinking that this individual should be able to control her emotions and then applied this belief to herself and to her depression. R. often felt she had to have a "reason" to be depressed and frequently compared her problems to others' and wondered if she had a right to feel depressed. Discussion of depression as a biological illness similar to diabetes or other medical disorders helped lessen R.'s self-blame and made it easier for her to focus on ways to manage depressive symptoms productively. R. also reviewed the pros and cons of depression in a homework assignment and was able to identify ways depression had added to her life, such as by making her a more feeling, compassionate person.

Other interventions used during this period included having R. create a hope kit (her kit included photographs of friends and family and a bracelet given to her by a close friend) and elaborating on her suicidal crisis plan (e.g., calling people on the telephone, using various methods of distraction, reading coping cards, looking at her hope box, calling her therapists or the ER). A key component of R.'s suicidal thoughts and behavior was feeling that she could not tolerate her intense depressive affect and needed to escape from it, as exemplified by her core belief, "I can't tolerate the pain." The coping skills included in her crisis plan were heavily focused on distress tolerance, which R. found very useful as a way to safely endure periods of strong depressive affect.

In Session 9, R. did a relapse prevention task in which she imagined how she would manage a future suicidal crisis using what she had learned in therapy. R. was not confident during this task that she could avoid making a suicide attempt when most severely depressed (although she was confident she could avoid suicide attempts at lesser levels of depression). Because of this, treatment was extended to 13 sessions.

Later Sessions (Sessions 10–13)

The last sessions with R. focused on how to prevent suicide attempts when experiencing severe depressive affect. In this instance, she still anticipated believing "the only way out is to kill myself." Additional alternative responses to this belief (which seemed to be a variant of "I can't tolerate the pain") were created. They were: "I've felt bad many times but not hurt myself"; "Just wait and it will stop"; "I can distract myself by writing in my journal or finding someone to talk to"; "The pain lasts under an hour." R.'s reasons to live (her family, her job, going back to school) were reviewed in detail. She also augmented her crisis plan with additional distraction techniques (reading, playing the piano, walking up and down the stairs,

drinking hot tea, taking a hot or cold shower, holding ice cubes, writing) as well as calling her family members, therapists, or the ER, reading her coping cards, and looking at her hope kit.

During this time, R. serendipitously got a phone call from a friend she had met in the hospital who was experiencing depression and suicidal thoughts. R. found she was able to provide her friend with several suggestions on how to decrease suicidal thoughts and behavior and realized that she could no longer imagine herself in a suicidal crisis. She remarked to the therapist, "I hadn't realized how much my own thinking on suicide had changed." The relapse prevention task was redone successfully. Around the 11th session, R. went back to work, which boosted her self-esteem and helped her see her life as meaningful. In the final therapy session R. stated, "I feel I have control over depression and suicide."

Conclusions

This article described a cognitive intervention for treating recent suicide attempters and provided three case examples detailing the use of the treatment with different types of patients. The treatment is novel in its approach in that it directly targets suicidal behavior as the primary focus of the therapy rather than the underlying disorder, which has been the standard. We have developed a specific set of cognitive-behavioral interventions for suicidal behavior, derived from general principles of cognitive theory and therapy for the emotional disorders (e.g., Beck, 1976; Beck et al., 1979). These interventions include the development of a multi-step crisis plan, a detailed cognitive conceptualization of the suicide attempt focusing on the key automatic thoughts and core beliefs that were activated at the time of the attempt, coping cards that list the patient's alternative responses to his or her key suicide-promoting negative cognitions, a hope kit that includes tangible reminders of the patient's reasons to live, and a guided-imagery relapse prevention task that serves as a vivid cognitive rehearsal of coping skills as well as an assessment of treatment progress. We hope that clinicians will find this article useful as a guide for working with patients who have recently attempted suicide, a highly difficult-to-treat population for which at present there are few empirically validated therapies.

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This research was supported by grants from the National Institute of Mental Health (R01 MH60915) and the Centers for Disease Control and Prevention (R37 CCR316866).

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Received: February 15, 2003

Accepted: November 2, 2003

