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Cognitive Behavioral Therapy and Suicidal Ideation: Evaluating Efficacy, Limitations, and the Role of Individual Differences

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Abstract

Cognitive Behavioral Therapy (CBT) is a highly recognized and efficient evidence-based intervention for the treatment of various psychopathological disorders, including suicidal ideations. Interventions for suicidal ideations are multifaceted with modular variables; thus, patient outcomes are increasingly inconsistent, creating a gap in therapy process. In this study, a more reliable CBT guideline for less modularity was formulated with the aid of expert insights in the field of psychopathological and comorbid disorders. This study evaluated the efficacy of CBT through the works of the cognitive triad, maladaptive patterns, and relapse prevention. Exploring cognitive distortions and maladaptive behaviors that contributed to suicidal ideation and neuroplasticity in cognitive restructuring, the study offered insights into a more tailored and relevant process of acknowledging the bifactors of other mental disorders in the treatment of suicidal ideations. The study also evaluated individual differences, including the genetic, environmental, and sociocultural/economic factors that affected outcome results. Despite the validity of CBT and its continuous effectiveness, CBT's applicability varied, and relapse played a significant factor, requiring reinforcement and engagement in post-treatment processes. While CBT fostered adaptive coping strategies, the positive outcome results relied on individualized approaches and the continuous reinforcement of therapeutic mechanisms. Integrating neuroscientific advances and a more tailored intervention for each individual enhanced the efficacy of the treatment, signifying the need for a holistic treatment model to sustain mental health improvement.

Keywords: Cognitive behavioral therapy (CBT), Suicidal ideation, Cognitive triad, Maladaptive patterns, Neuroplasticity, Relapse prevention, Individual differences

1. Introduction

How can a streamlined, expert-informed CBT framework reduce therapeutic modularity and improve clinical outcomes in the treatment of suicidal ideations, particularly in adolescents with co-occurring psychological disorders?

Being the 3rd leading cause of death, suicidal ideations (thoughts of inflicted self-harm) and distortions are critical for the well-being of adolescents between the ages of 10-24 (Teen Suicide, 2024). Even with such statistics, there is not a clear intervention or therapy that can effectively negate the interplay between these two factors of maladaptive patterns (repetitive behaviors that enable short term relief but inhibit a person's ability to adapt) and perception; consequently, The Surgeon General's call to action to prevent suicide, 1999 urges the need for more effective strategies in mitigating suicide (The Surgeon General's Call to Action to Prevent Suicide, 1999). Moreover, the variability of the factors of past suicide attempts, or adolescents with depressive disorders, is at a higher risk of attempted suicide and completed suicide. With these critical factors holistically contributing to the increased mortality rate of adolescents in the presence of suicidal ideations, variations of CBT are created to combat these outcomes. For example, Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), a variation of CBT, is designed to provide a significant boost in the efficacy of Behavioral therapies in the settings of suicidal behaviors. By addressing immediate risks, providing

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emotional tools, and promoting long-term resilience, CBT-SP creates a comprehensive framework to reduce suicidal ideation and prevent recurrence. However, the limitations are not comprehensively conclusive with the benefits of this intervention, including the lack of randomized control trials (RCTs), the basis of the intervention on the therapist's competence, the lack of acknowledgment of sociocultural and environmental factors, and the general difficulty of the intervention (Stanely et al., 2009). Thus, there is a need for a more comprehensive approach and understanding to alter the interplay of variability in a therapeutic setting effectively.

Cognitive behavioral therapy, a commonly used therapeutic intervention that has multiple variations of applications, is a widely used intervention in targeting the general thinking patterns of patients or clients in a therapeutic setting. Other methods of therapy, such as dialectical behavioral therapy (DBT), motivational interviewing (MI), Cognitive Behavioral Therapy for Chronic Pain (CBT-CP), mindfulness-based cognitive therapy (MBCT), and Rational Emotive Behavior Therapy (REBT), all have applications that are variant from the general use of CBT. Aaron Beck's theory of a cognitive model is the epitome of the various applications of different CBT substrates. Effectively targeting different disorders with associations of homogeneous types of distorted thinking, Beck created a cognitive model as a hallmark of future clinical research (Cognitive Behavior Therapy, 2023). However, this model is not a ubiquitous guideline for treating patients with different disorders and situational aspects; thus, the application and the general formation of cognitive therapies have been created for the betterment of clinical experts and patients. More specifically, the prevention of cognitive distortions, especially in the context of suicidal ideations. Distortions related to interpersonal vs. non-interpersonal traumas are integrated with the cognitive triad (e.g. self, world, and future), further complicating the application of a specific intervention due to the dependent factors of the self, world, and future (Whiteman et al., 2019). These homogeneous factors play a role in the effectiveness of specific interventions such as CBT in the context of therapy. The different uses of CBT and the relationship juxtaposing with other approaches in mitigating suicidal ideations are concepts that are amorphous and induced by the variability of each paradigm.

Targeting destructive thought patterns and behaviors to prevent negative emotions, CBT emphasizes the interplay of maladaptive behaviors and modifies these thought patterns to change the emotional responses of clients and patients (Owens and Cherry, 2024). However, this approach has limitations stemming from sociocultural status, socio-economic status, and environmental, situational, and interpersonal dynamics. CBT may not cover the broader influences on a person's mental health beyond their self-perception; thus, the cognitive triad holistically contributes to the effectiveness of CBT applications, leading to a possible misunderstanding of their experiences if not adjunct to their specific circumstances (Hays, n.d). In the context of relapse (a decline in health after improvement) prevention, CBT can be most effective in addiction treatment, providing long-term efficacy against relapse. Reducing relapse rates up to 60 percent when juxtaposed with other conventional interventions, CBT is a powerful tool in preventing recurrent episodes, mainly in the field of addiction (Khoddam, 2023). However, this relation is not universal with all applications of CBT; each applicable situation induced by a patient's specific circumstance has its own scale of success with CBT. For example, relapse prevention in the case of suicidal attempts is reduced by 50 percent with the application of CBT (Baker et al., 2024). However, the reduction of relapse for anxiety is around 14 percent (Levy et al., 2021). This shows the intermittent nature of CBT application in the professional perspective of the general variability of disorders and the patient's specific circumstances or risk factors.

Interventions for suicidal ideations had originally been multifaceted and modular, resulting in therapy inconsistencies and vacillating patient outcomes. Formulating a less modular CBT framework developed with the guidance of expert insights in psychopathology and comorbid mental health disorders, the study responded to the critical gap. By addressing the inconsistent efficacy of various interventions and emphasizing the integration of individualized and contextual factors, this study advanced the clinical applicability of CBT and the prevention/treatment of suicidal ideations.

2. Related Works/Literature Review

2.1 Substance Use Disorders

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CBT tended to yield support for the feasibility, acceptability, and efficacy of the declination of substance use disorder in a multifaceted scale of little significant indications to major changes in the therapeutic setting. Although requiring more extensive participation in therapy sessions, the general efficacy of CBT in substance use disorders yielded promising results from traditional methods of pharmacotherapy. Straying from conventional applications of interventions, CBT exhibited higher rates of abstinence from nonmedical drug use from a baseline. There are limitations; however, the significant indications of an efficient outcome with the interplay of CBT are limited to the correct use and application of the intervention. The effects are not ubiquitous if CBT is not applied in a proper setting regarding sub-populations with a struggle of substance abuse and psychopathology (Barry et al., 2019). Moreover, the heterogeneity between CBT and pharmacotherapy provides differing frameworks for each patient depending on the nature of the situational aspects and the strength of psychoactive substances, leading to the emergence of core principles of CBT in substance use disorders - the holistic interplay of thoughts, feelings, and nature (McHugh, Hearon, and Otto, 2010). The efficacy of the treatment of substance use disorders varies due to the variability of factors in the process of CBT.

2.2 Anxiety

Cognitive Behavioral Therapy in the treatment of youth anxiety tended to be efficacious in the core principles of the intervention - comprehensive assessment, development of a good therapeutic relationship and working alliance, cognitive restructuring, repeated exposure with reduction of avoidance behavior, and skills training (Seligman and Ollendick, 2011). Differing strategies did not alter the progress of the intended bifactor targeted. Compared to other treatments, CBT can be considered a cost-effective intervention as post-treatment effects can last, depending on the variability of patients and circumstances. As children with anxiety disorders experience a time-dependent benefit from treatment, the effects can indicate CBT as a time-limited and skill-based treatment (Peris et al., 2015). Following the Unified Protocol for Emotional Disorders, addressing transdiagnostic mechanisms such as neuroticism, CBT can be applied to different circumstantial cases following the modules of mindfulness of emotions, cognitive flexibility, preventing emotion-driven behaviors, tolerating physical sensations, and emotion-focused exposure exercises. A conceptualization of cognitive behavioral therapy in the context of anxiety disorders emphasizes the identification of dysfunctional thinking patterns, distressing feelings or physiological experiences, and unproductive behaviors. The holistic nature of these three factors, especially when each reinforces the other, can lead to significant distress and impairment of levels of anxiety, a common basis for CBT philosophy (Curtiss et al., 2021).

2.3 Depression

Mindfulness-based cognitive therapy (MBCT) is an effective intervention derived from CBT in the context of relapse prevention for patients with major depressive disorders (MDD). Cognitive therapy is a positive reinforcement intervention in the premise of MDD, as the risk ratio is .66 compared to other treatments or placebo controls. Moreover, a corresponding risk reduction of 34% (single) with a 43% risk reduction in subgroups with three or more previous episodes. MBCT works by decreasing ruminations, improving mindfulness and self-perception, and balancing limbic regions and their activations regarding neural pathways (Piet and Hougaard, 2011). Additionally, training in CBT and improved therapist competence can lead to promising outcomes in reducing depressive symptoms. Competence in CBT, as measured by the Cognitive Therapy Scale, has been shown to enhance the effectiveness of CBT processes and contribute to a significant reduction in harmful ideations (Simons et al., 2010).

2.4 Theory

To analyze the efficacy and the intersection of CBT in a therapeutic approach for the prevention of suicidal ideations/behaviors, direct primary sources were utilized to conclude the effects of CBT in a clinical setting and a theoretical sense. Theorizing the improved efficacy of CBT with the holistic interplay of neurobiological, cognitive, and environmental factors, CBT can be more effective by tailoring the treatment to the uniqueness of each individual. This qualitative analysis uses insights from experts specializing in the field of psychopathology and, more specifically,

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CBT. Utilizing the efficacy of CBT in the treatment of various mental disorders, the analysis uses insights into the long-term effects, individual differences, and treatment limitations to emphasize the significance of variability. By gathering information from different premises of mental disorders, a more conclusive treatment plan can be formulated with the consideration of a broader scope.

3. Methodology

3.1 Participant Recruitment and Selection

Participants were recruited using a volunteer sampling method in which cold emails served as the primary recruitment strategy. Over 500 individualized emails were sent to clinicians, psychiatrists, and professors specializing in CBT. Participants were also identified through Boolean search operators and academic databases such as Google Scholar, PubMed, and Research Gate, focusing on keywords like "CBT," "suicidal ideations," and "suicide prevention. This process created a selective pool with individuals who have not only theoretical knowledge but also substantial clinical or research-based experience in the application of CBT. Participants held advanced degrees - PhD, PsyD, or MD - that were affiliated with academic or clinical institutions.

The final sample included 11 experts - 9 females and 2 males, with a total of 10 participants affiliated with institutions such as MIT, Arizona State University (ASU), Virginia Tech, The College of New Jersey (TCNJ), TRAILS, Yale University, Ohio State University/Brown University, the University of Alabama at Birmingham (UAB), the University of Michigan, Penn State, and Brown University. This ensured that participants possessed the qualifications and insights to contribute to the study's core aim of refining CBT interventions for suicidal ideations.

3.2 Inclusion and Exclusion Criteria

Participants were filtered to meet specific inclusion criteria. They had to have a substantial time (4-5 years) of professional experience with the application of CBT, possess demonstrated expertise in either treating or researching suicidal ideations or psychopathological disorders, be fluent in English, and express willingness to participate in a 30-60 minute recorded interview. Participants were excluded if they lacked verified professional or clinical experience with CBT, failed to provide credentials, or did not respond to follow-up communications (emails). These criteria ensured validity in the study and the distribution of relevant and high-quality insights in the respective research.

3.3 Interview Guide and Data Collection

Data was gathered from semi-structured interviews constructed from ten key questions. The questions addressed three core themes for the research study: four on the cognitive triad (perception of self, world, and future), four on maladaptive patterns, and two on relapse prevention. The overall framework didn't vary from interview to interview, but questions were unique to the participant's own specific expertise, so the discussion remained on point and reinforced expert knowledge. This flexibility enabled further exploration on the practical use of CBT.

These questions on the cognitive triad aimed to target the participants' understanding of self-perception, worldview, and future orientation, and the link between these and CBT in the treatment of suicidal behavior. The questions involved discussion on the applicability of the concepts to the treatment of disorders other than depression and anxiety—like schizophrenia and drug dependence—information processing in brain components, and the theory of intervention with CBT. In the maladaptive patterns questions, the participant ventured into the therapy effect on small-scale brain components like the prefrontal cortex and amygdala, and large-scale psychological entities like cognitive dissonance and synaptic plasticity, and neuroplasticity (the brain's ability to reorganize and form neural connections). The questions also touched on the role of individual variables—socioeconomic status, environment, and culture—and the outcome of CBT in the form of its success. The questions on relapse-prevention tended towards the theoretical and opinion path and asked the participant about the possibility of CBT preventing the re-emergence of suicidal behavior, long-term occurrences, and the difference between a complete relapse and lapse.

All the interviews took place over Zoom or phone and lasted approximately 30 to 60 minutes. By permission,

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recordings and transcripts of the meetings were also prepared. Identifying information and names were stripped shortly after each session, and original recordings ceased for the maintenance of privacy and confidentiality.

3.4 Data Analysis

Qualitative data entailed the use of a manual thematic system of analysis. Since the transcripts were not coded using third-party software, they were manually coded and investigated to preserve their qualitative richness and analytical relevance. The process began from the original open coding from which the thematic units and core ideas from the transcripts were extracted and constructed. The thus unveiled codes combined and situated further into axial themes depicting the theoretical difference or matching between participant responses, the transferability of CBT between the diverse clinical environments, and the individual or environmental variables conferring CBT outcomes on patients.

Four themes directed the analysis: Cognitive Triad and Distortions, Clinical Frameworks and Interventions in the Presence of Maladaptive Patterns, Relapse Prevention, and Individual Differences. In the themes, information from all interview responses was examined to identify patterns, points of agreement, and common and perennial opinions. An act of constant comparison to maintain the research consistently and rigorously, as well as the taking and use of discussions with third parties outside the research, aided in tracing decisions. This panel of analysis and co-work allowed coexistence between the depth and the comprehensiveness of the interpretation and ensured the insights remained based on the experts' responses and highly scrutinized information.

3.5 Ethical Considerations

Participants gave verbal consent before interviews and were told that participation was completely voluntary and could be withdrawn at any time. To maintain participant anonymity, all identifying information was removed during transcription, and only anonymized data were transferred for the final analysis. Audio recordings were deleted after transcription to keep data secure. No ethical issues were encountered during the study, and participants weren't exposed to any psychological, emotional, or other harm. This approach protected participant privacy while ensuring the research was ethical and maintaining integrity throughout the study.

4. Results

4.1 The Cognitive Triad in Suicidal Ideation

Experts highlighted Beck's structure of the cognitive triad, consisting of negative beliefs about self, world, and future, as the core construct that ultimately develops suicidal ideations. Distortions in the dimension of self-perception were identified as the most critical domain expressed through thoughts like "I'm a burden," "I don't matter," or "I'm not good enough". These beliefs reflect the interwoven early relational trauma, invalidation from third-party individuals, or chronic emotional neglect and discrimination. One clinician shared, "It always comes back to 'I'm a burden,' or 'I'm not good enough.' These are core beliefs that CBT has to unravel." Another clinician stated that for many suicidal individuals they experience interpersonal struggles: "they're not trying to escape life—they're trying to escape themselves."

In the world or the environmental domain, beliefs were evaluated as equally destabilizing. Experts described patients' perceptions of others as hostile, untrustworthy, or indifferent, especially after interpersonal conflict or trauma with others. "Patients say the world's unsafe, people don't care, or they always get rejected. That narrative gets internalized deeply," one therapist explained. These perspectives in the cognitive triad, more specifically, the world, tended to reinforce the relative feeling of isolation and defensive mechanisms, further entrenching and monotonously narrowing the client's sense of support through third-party sources.

The last dimension of the triad - future - was almost ubiquitous in discussions of suicidal ideations. "The inability to see a future—not just a good one, but *any* future—is what makes suicidal ideation escalate," said one practitioner. Prevalent in individuals with comorbid psychopathological disorders like depression or those experiencing

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environmental stagnation, CBT's goal was to reinforce or alter the possibility of different futures by breaking the perceived permanence of suffering.

4.2 Maladaptive Cognitive and Behavioral Patterns

All experts evaluated the self-reinforcing loop between the distortions in cognition and avoidance behaviors as the most significant mechanism in suicidal ideations. Negative thoughts were seen to galvanize harmful societal behaviors, such as substance use, emotional withdrawal, or isolation, which then reinforced the original maladaptive beliefs. One expert put it, "It's like a mental echo chamber. You think you're worthless, then every interaction confirms it. CBT helps break that." This echo chamber was often worsened by environmental stressors, including familial rejection, poverty, or even systematic discrimination, all out of the patients' reach.

A significant subcategory that emerged was the mechanism of cognitive dissonance in galvanizing behavioral change. When patients expressed contradicting desires - such as wanting to survive while engaging in self-destructive behavior- clinicians utilized these thoughts as therapeutic targets. "MI [motivational interviewing] works well when there's ambivalence—like someone says they want to get better but keeps using. That contradiction is key to change," noted one clinician.

Experts also emphasized the neurocognitive mechanisms underlying CBT, especially the regulation of emotional responses through top-down control. One clinician explained, "You have to close the prefrontal cortex around the amygdala—CBT helps do that over time." This metaphor illustrates the neurological basis for CBT's capacity to reframe emotionally loaded experiences, particularly in trauma-exposed individuals with compromised regulation networks.

Experts also emphasized the neurocognitive warriors in the process of CBT, especially the regulation of emotional feedback through top-down control. One clinician explained, "You have to close the prefrontal cortex around the amygdala—CBT helps do that over time." Illustrating the neurological factors for CBT's capacity to alter and reintroduce emotionally heavy experiences, this metaphor, particularly in the context of trauma-exposed individuals, states the compromise in regulation networks.

Distortions such as catastrophizing, black and white thinking, and personalization were repeated and evaluated as barriers to healthy cognition in emotional processing, said experts. One therapist remarked, "Many of our suicidal clients have a cognitive style that's overly global. One bad event confirms their entire worldview." These distortions often resulted in behavioral shutdowns or impulsivity that maintained the individuals' sense of hopelessness and helplessness.

4.3 Relapse and the Long-Term Efficacy of CBT

Relapse was a dominant theme, evaluated and explained by ten of eleven experts as a predictable and often cyclical component of recovery from suicidality. In addition, there was a distinction between passive suicidal thoughts, active ideations, and behaviors, noting that the recurrence of ideation does not necessarily always equate to treatment failure. "Most clients don't go all the way back—they just lose the grip on skills. There's a difference between thinking it and doing it," one expert clarified.

The long-term effectiveness of CBT was consistently linked to the sustained practice of skills developed during treatment. Without reinforcement, cognitive and behavioral tools were observed to decay over time. One therapist offered the following analogy: "Skills decay if you don't keep using them. We need to think of CBT like physical therapy—follow-up is essential." Experts advocated for booster sessions, low-intensity digital interventions, or group-based maintenance models as viable strategies for relapse prevention.

The long-term efficacy of CBT was consistently linked to the patients' sustained practice and behavior developed during treatment. Without consistent reinforcement, cognitive and behavioral tools were observed to diminish over time as patient recovery becomes harsher. One therapist offered the following analogy: "Skills decay if you don't keep using them. We need to think of CBT like physical therapy—follow-up is essential." Experts suggested and advocated for booster sessions consisting of low-intensity interventions through digital meetings or group-based maintenance

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models as performative strategies for the prevention of relapse.

Numerous clinicians discussed the biological sensitivity to relapse, especially among patients with dysregulated stress systems or histories of conditions or trauma. “Some people relapse more easily because their baseline stress response is higher. CBT isn’t a cure—it’s a toolkit. And some brains just default faster to stress responses,” noted one therapist. These gaps and vulnerabilities underscore the significance of a tailored therapy approach in accordance with CBT to account for both psychological and physiological risk factors, specifically in high-acuity populations.

While CBT was broadly regarded as durable and empowering, its long-term success was seen to depend on contextual factors, including life stability, social support, and systemic accessibility to ongoing care.

4.4 Systematic Analysis of Individual Differences

All participants identified individual variability as a key determinant in CBT’s effectiveness. This variability was described across four intersecting domains: cultural orientation, neurobiological function, cognitive flexibility, and socioeconomic constraint.

Cultural Alignment and Communication Style

Eight experts emphasized that CBT’s structure is best aligned with individualistic cultures that bolster emotional expression and transparency. In contrast, clients from collectivist or emotionally restrained cultures may find CBT’s direct targets and goals uncomfortable or even inappropriate. “Some patients don’t respond because it’s not culturally appropriate to express distress that way,” explained one clinician. As a result, practitioners must adapt CBT’s pacing, intentions, and nuances - incorporating metaphors, family systems perspectives, or indirect disclosure - to ensure a cultural consensus with patients.

Neurobiological and Temperamental Factors

Seven experts explained the biological and temperamental differences that shape a patient's application and readiness for CBT. Individuals with executive function deficits, past trauma, or more reactive limbic activation were noted to have difficulty applying CBNT’s cognitive restructuring strategies early in therapy processes. “You can’t just talk someone out of panic or shame—they need to feel safe in their body first,” one practitioner explained. Insights support the need for a more trauma-informed or neurodivergence-sensitive CBT adaptation.

Cognitive Flexibility and Learning Profile

Cognitive rigidity—manifesting as inflexible beliefs, difficulty with abstraction, or low tolerance for ambiguity—was reported by five clinicians as a substantial barrier to progress. “Rigid thinkers really struggle—they can’t unlearn as easily,” one therapist noted. Patients with differing cognition in specific terms of learning profiles require more repetitive exposure to reinforcement exercise, increased scaffolding, and slower progression, often coming in conflict with socioeconomic barriers.

Structural and Socioeconomic Barriers

Six experts described how financial instability, inadequate insurance, or even systemic inequality disrupts CBT therapy outcomes regardless of clinical responsiveness in client-therapist relations, cognition, and substantial progress. “A lot of my clients can’t afford therapy long enough for CBT to stick. That’s not a treatment issue—it’s a system issue,” stated one clinician. Experts suggested policy-level solutions such as more funded treatment initiatives, telehealth expansions, and the integration of CBT principles into schools and primary care institutions.

5. Discussion

This study adds empirical nuance to our understanding of how Cognitive Behavioral Therapy (CBT) operates in the treatment of suicidal ideations, more specifically through the perspective of individual differences. Inconjunction with Beck’s cognitive model, experts emphasized the holistic nature of the cognitive triad - self, world, and future - as the foundational underlying cause of suicidality. Insights obtained from clinical experience advance this literature by incorporating unique adaptations, which are often absent in therapeutic settings. Experts described suicidal

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ideations not as a symptom, but as a holistic model of cognition - a complex construct shaped by trauma, invalidation, and maladaptivity. The target of CBT lies in its ability to disrupt existing cognitive loops through reinforcement methods like self-monitoring, emotional regulation, and behavioral experimentation. These intersections of distortions and feedback-driven behaviors are consistent with established models for the treatment of depression and suicidality, but are further refined through expert reflection.

Most importantly, the differences in individual circumstances emerged as not only moderating and changing variables but as the main determinants of treatment cooperation and treatment outcome. Cultural incompatibility, neurodivergence, dysfunction, and financial strain were consistent as primary barriers inhibiting the benefits of therapy outcomes. For instance, one expert discussed how cultural and societal norms around conservation and emotional suppression may significantly lackluster the efficacy of the therapy and its application methods. Another expert evaluated that among neurodivergent individuals, pacing and cognitive scaffolding were significant to tailor to differences in the therapy process, including initiative, given unique circumstances. These insights support the need for a more holistic model of mental health treatment, where homogeneity restructures and accommodates biological, cognitive, and contextual circumstances.

In the context of relapse, rather than being conceptualized as a therapy failure, it was understood by experts as a predictable feature of chronic suicidality. Long-term improvement was not associated with therapy treatment and intensity, but with reflective reinforcement. The qualitative analysis extended its breadth by comparing CBT's effectiveness in treating suicidal ideations to its multifaceted applications in psychopathological disorders such as anxiety, depression, schizophrenia, and OCD. The findings suggested that CBT remains generally effective, but its success in the dependence of suicidality is mediated by the holistic nature of the cognitive triad and diverse patient circumstances. However, several methodological limitations must be acknowledged. The small sample size and qualitative design limit the generalizability of findings. Moreover, variability in response depth, occasional inconsistencies in thematic coding, and brief interview durations constrained interpretive scope. Crucially, this study operated within a relatively underdeveloped research area—namely, the modular analysis of how socioeconomic, sociocultural, environmental, and situational factors interplay to shape therapy outcomes.

The study also evaluates the limitations of CBT and its nuances. For example, factors like cognitive dissonance, negativity, and the variability in neuroplastic change all dilute CBT's efficacy. Even though cognitive restructuring and emotional regulation methodology form the core foundation of CBT, their usage is limited due to the insurmountable variability in neurobiological and psychological capacity. Ongoing research into the limbic prefrontal circuitry, dysfunction, and maladaptivity may offer a more pragmatic and promising result for the intervention in fields of cognition and restructuring. Despite its empirical support, CBT is limited by its lack of ubiquitous efficacy. Differences in genetic predisposition, levels of emotional regulation, and real-world stressors—such as economic hardship or community violence—can attenuate its effectiveness.

Ultimately, CBT's efficacy relies on its ability to adapt. Its structured yet malleable framework enables it to serve a wide range of psychopathological disorders with tailored approaches. Future research should aim to develop the modularity of CBT applications that allow for both cultural adaptation and neurodivergence-informed pacing. Additionally, the integration of adjunctive methods—such as trauma-informed mindfulness, motivational interviewing, and digital health interventions—may broaden CBT's reach and resilience. To ensure equitable mental health outcomes, systemic barriers such as limited access to care, high costs, and restrictive insurance policies must be addressed. Without the restructuring of societal constructs, even the most refined therapeutic frameworks will remain ineffective for those most in need.

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