Brief Cognitive Behavioral Therapy for Suicide Prevention

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Background & Conceptual Foundation

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Tx</th>
<th># of Sessions</th>
<th>Comparator</th>
<th>Sample</th>
<th>Setting</th>
<th>Follow-Up</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Brown et al. (2005) N=120</td>
<td>RCT</td>
<td>CT-SP</td>
<td>10</td>
<td>TAU</td>
<td>Outpt MH, 40% male, 35 y</td>
<td>18 months</td>
<td>50% rel. reduction</td>
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<tr>
<td>Rudd et al. (2015) N=152</td>
<td>RCT</td>
<td>BCBT</td>
<td>12</td>
<td>TAU</td>
<td>Outpt MH, Minority, 87% male, 27 y</td>
<td>24 months</td>
<td>60% rel. reduction</td>
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BCBT Outcomes: Suicide Attempts

<table>
<thead>
<tr>
<th>Assessment Period</th>
<th>Brief Cognitive-Behavioral Therapy</th>
<th>Treatment as Usual</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Attempt-Free Probability</td>
<td>Attempt-Free Probability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>95% CI</td>
</tr>
<tr>
<td>3 Months</td>
<td>0.96</td>
<td>0.94 - 0.98</td>
</tr>
<tr>
<td>6 Months</td>
<td>0.86</td>
<td>0.84 - 0.88</td>
</tr>
<tr>
<td>12 Months</td>
<td>0.85</td>
<td>0.83 - 0.87</td>
</tr>
<tr>
<td>24 Months</td>
<td>0.86</td>
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BCBT associated with 60% reduction in suicide attempts

BCBT Outcomes: Suicide Ideation & Hopelessness

<table>
<thead>
<tr>
<th>Measure of Suicide Ideation &amp; Hopelessness</th>
<th>Brief Cognitive-Behavioral Therapy</th>
<th>Treatment as Usual</th>
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<tbody>
<tr>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>TSI</td>
<td>44.0</td>
<td>21.7</td>
</tr>
<tr>
<td>RSCL</td>
<td>44.0</td>
<td>21.7</td>
</tr>
<tr>
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<td>11.0</td>
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<td>30.0</td>
<td>11.0</td>
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BCBT and TAU comparable on suicide ideation and hopelessness

BCBT Outcomes: Depression, Anxiety, PTSD

<table>
<thead>
<tr>
<th>Measure of Depression, Anxiety, PTSD</th>
<th>Brief Cognitive-Behavioral Therapy</th>
<th>Treatment as Usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
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BCBT and TAU comparable on depression and anxiety

BCBT slightly better than TAU for PTSD symptoms, but statistically nonsignificant

Rudd et al. (2015)
Mean number of BCBT sessions was 12
BCBT associated with more individual therapy sessions during first 3 months
BCBT associated with fewer hospitalization days over entire study period

Rudd et al. (2015)

Conceptualizing Suicide Risk

Nock & Prinstein (2005)
The Suicidal Mode

Cognitive
- "This is hopeless"
- "I'm trapped"
- "I'm a burden"

Emotional
- Depression
- Guilt
- Anger

Physical
- Agitation
- Insomnia
- Pain

Behavioral
- Substance use
- Social withdrawal

Preparations
- Acute
  - Cognitive: Self-regard, Cognitive flexibility, Problem solving
  - Emotional: Psychiatric disorder, Emotional lability, HPA axis
  - Physical: Genetics, Medical conditions, Demographics
  - Behavioral: Prior attempts, Emotion regulation, Interpersonal skills

Baseline
  - Activating Events: Relationship problem, Financial stress, Perceived loss, Physical sensation, Negative memories

Acute
  - Dynamic Stabilization: Fluid Vulnerability Theory

Bryan & Rudd (2016, 2018)
Core Principles of Treatment with Suicidal Patients

The Language of Suicide

1. Remove pejorative language
2. Improve consistency of documentation
3. Improve communication between clinicians
4. Improve accuracy of risk assessments
5. Improve clinical decision-making
6. Improve treatment outcomes

The Language of Suicide

**Suicide attempt**
A nonfatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

**Nonsuicidal self-injury**
Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent.

Crosby et al. (2011)
Clinician vs. Patient Goals

**Clinician**
- prevent death
- don’t get sued

**Patient**
- alleviate suffering
- solve the problem

Suicide Risk Assessment

<table>
<thead>
<tr>
<th>Domain</th>
<th>Examples</th>
</tr>
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<tbody>
<tr>
<td>Baseline Risk Factors</td>
<td>Prior Suicide Attempts, History of Psychiatry Disorders</td>
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<tr>
<td>Activating Events</td>
<td>Relationship Problems, Financial Strain</td>
</tr>
<tr>
<td>Symptoms (Emotional &amp; Physical)</td>
<td>Depression, Guilt</td>
</tr>
<tr>
<td>Suicide-Specific Beliefs (Cognitive)</td>
<td>Hopelessness, Perceived Burdensomeness</td>
</tr>
<tr>
<td>Impulse Control &amp; Dysregulation (Behavioral)</td>
<td>Non-suicidal Self-Injury, Alcohol use</td>
</tr>
<tr>
<td>Protective Factors</td>
<td>Reasons for Living, Hope</td>
</tr>
</tbody>
</table>

Bryan & Rudd (2006)

Dimensions of Suicidal Thinking

**Resolved Planning**
- Sense of courage
- Availability of suicide means
- Opportunity to attempt suicide
- Specificity of suicide plan
- High duration & High intensity ideation

**Suicidal Desire**
- No reasons for living
- Wish to die
- High frequency ideation
- Desire and expectancy to die
- Lack of deterrents

Joiner, Rudd, & Hasan (1997)
Overview of Treatment

Structure of BCBT

Phase I
- Emotion Regulation
  - Session 1
    - Intake
      - Narrative Risk Assessment
      - Crisis Response Plan
      - Means Safety Counseling
  - Sessions 2-5
    - Treatment Plan
    - Sleep Disturbance
    - Relaxation / Mindfulness
    - Reasons for Living
    - Survival Kit

Phase II
- Cognitive Flexibility
  - Sessions 6-10
    - ABC Worksheets
    - Challenging Questions
    - Patterns of Problem Thinking
    - Activity Planning
    - Coping Cards

Phase III
- Relapse Prevention
  - Sessions 11-12
    - Relapse Prevention Task

General Structure of BCBT Session

1. Review assignments and bridge from previous session
   - Crisis response plan
   - Homework assignments
2. Introduce new skill or intervention
   - Verbally describe the skill
   - Explicitly connect the skill to the suicidal mode
3. Demonstrate and practice the skill
   - Discuss patient’s experience
   - Develop plan for practice and address potential barriers
4. Enter lesson learned into treatment log
Defining Treatment Completion

Treatment is terminated when patient demonstrates acquisition of emotion regulation and cognitive flexibility skills, typically indicated via use of crisis response plan and other BCBT skills.

Relapse prevention task serves as final competency check.

If patient is unable to effectively complete relapse prevention task, continue therapy until mastery is achieved.

The First Session

Setting the Stage

1. Describe cognitive behavioral session structure
2. Describe the phased structure of BCBT
3. Discuss confidentiality and limits to confidentiality
4. Discuss potential role of family members
5. Assess patient comprehension and invite questions
Narrative Assessment vs. Traditional Interview Assessment

**Narrative Assessment**
- Higher empathy ratings
- Higher affective synchrony
- Emotional co-regulation
- Lower speech complexity

**Traditional Interview Assessment**
- Lower empathy ratings
- Lower affective synchrony
- Emotional co-dysregulation
- Greater speech complexity

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**Narrative Assessment**
1. Invite the patient to tell his or her story of the index suicidal episode
   - “Let’s talk about your suicide attempt/what’s been going on lately.”
   - “Can you tell me the story of what happened?”
2. Assist the patient in identifying and describing sequence of events
   - “What happened next?”
   - “And then what happened?”
   - “What were you saying to yourself at that point?”
   - “Did you notice any sensations in your body at that point?”
3. Provide emotional validation

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**The Suicidal Mode**

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Treatment Log & Case Conceptualization

1. Introduce the treatment log
2. Enhance motivation to keep the treatment log
3. Collaboratively review the suicidal mode

Crisis Response Plan

1. Explain rationale for CRP
2. Provide card for patient to record CRP
3. Identify personal warning signs
4. Identify self-management strategies
5. Identify reasons for living
6. Identify social supports
7. Provide crisis / emergency steps
8. Verbally review and rate likelihood of use

Sample Crisis Response Plans
Phase I: Emotion Regulation

Treatment Planning

1. Explain the rationale for a treatment plan
2. Prioritize suicide risk
3. Identify and collaboratively establish additional treatment goals

Commitment to Treatment Statement

I. ___________________ agree to make a commitment to the treatment process. I understand that this means I have agreed to be actively involved in all aspects of treatment, including:

1. Attending appointments (or letting my provider know when I can’t make it)
2. Setting goals
3. Voicing my opinions, thoughts, and feelings honestly and openly with my provider (whether they are negative or positive, but most importantly my negative feelings)
4. Being actively involved during appointments
5. Completing homework assignments
6. Taking my medications as prescribed
7. Experimenting with new behaviors and new ways of doing things
8. Implementing my crisis response plan when needed
9. Any additional terms that my provider and I agree to
Means Safety Counseling

<table>
<thead>
<tr>
<th>Phase</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Engaging</td>
<td>Raise the issue of suicide means (e.g., firearms) and invite the patient to share his or her initial thoughts.</td>
</tr>
<tr>
<td>2. Focusing</td>
<td>Introduce the topic of safety and invite the patient to share his or her existing safety procedures.</td>
</tr>
<tr>
<td>3. Evoking</td>
<td>Ask open-ended questions to encourage further discussion about commitment to safety.</td>
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<tr>
<td>4. Planning</td>
<td>Assist the patient in developing a concrete plan of action for temporarily limiting his or her access to potentially lethal means.</td>
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Britton, Bryan, & Valentien (2015)

Targeting Sleep Disturbance

Improving Your Sleep Handout

1. Go to bed only when you’re sleepy. There is no reason to go to bed if you are not sleepy. When you go to bed too early, it only gives you more time to become frustrated. Individuals often consider the events of the day, plan the next day’s schedule, or worry about their inability to fall asleep. These thoughts can keep you awake longer. You should therefore sleep your bedtime until you are sleepy. This may mean that you go to bed later than your scheduled bedtime. However, stick to your scheduled bedtime regardless of the time you go to bed.

2. Get out of bed when you can’t fall asleep or cannot go back to sleep in 15 minutes. When you recognize that you’ve become a clock watcher, get out of bed. If you wake up during your sleep and you’re hard falling back asleep for 15 minutes and can’t, get out of bed. Remember, the goal is to fall asleep quickly. Return to bed only when you are sleepy (i.e., yawning, hard falling asleep, and shallow breathing). This goal is for you to retrain your body with the help of sleep. Avoid taking naps if possible.

3. Use your bed for sleep and sex only. The purpose of this guideline is to associate your bedroom with sleep rather than with activities such as reading, watching TV, and eating. The goal is to retrain your body with the help of sleep. Avoid doing these activities in your bedroom.

4. Avoid caffeine, nicotine, and alcohol after 3 PM. These substances can interfere with your ability to fall asleep. Avoid caffeine, nicotine, and alcohol after 3 PM to help you relax and improve your sleep quality.

5. Establish a relaxing bedtime routine. A relaxing bedtime routine can help you fall asleep more quickly. This may include activities such as reading a book, taking a warm bath, or listening to soft music.

6. Use your bed only for sleep and sex. Establishing a regular bedtime routine can help you fall asleep more quickly. This may include activities such as reading a book, taking a warm bath, or listening to soft music.

7. Avoid using electronic devices before bedtime. The blue light emitted by electronic devices can interfere with your ability to fall asleep. Avoid using electronic devices at least 1 hour before bedtime.

8. Use your bedroom for sleep and sex only. Establishing a regular bedtime routine can help you fall asleep more quickly. This may include activities such as reading a book, taking a warm bath, or listening to soft music.

9. Avoid using electronic devices before bedtime. The blue light emitted by electronic devices can interfere with your ability to fall asleep. Avoid using electronic devices at least 1 hour before bedtime.

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25. Avoid using electronic devices before bedtime. The blue light emitted by electronic devices can interfere with your ability to fall asleep. Avoid using electronic devices at least 1 hour before bedtime.
Relaxation and Mindfulness Skills Training

<table>
<thead>
<tr>
<th>Relaxation</th>
<th>Mindfulness</th>
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<tbody>
<tr>
<td>Focuses on reducing physiological indicators (e.g., muscle tension) of heightened autonomic arousal</td>
<td>Focuses on reducing rumination and cognitive-affective reactivity while increasing perspective-taking</td>
</tr>
</tbody>
</table>

Reasons for Living List

1. Introduce the concept of reasons for living
2. Identify the patient’s reasons for living
3. Increase the emotional salience of these reasons for living
   - Tell me more about that.
   - What do you find so enjoyable about that?
   - Why is that person so important to you?
4. Write the reasons for living on an index card

Survival Kit

1. Introduce the concept of the survival kit
2. Review the content of the survival kit at the next session
   - Tell me more about this item.
   - Why did you decide to include this item?
   - When you think of this item, what happens to your emotions?
3. Identify a location for keeping the survival kit
Phase II: Cognitive Flexibility

Exotic Worksheet:

- What label does it have? Why? Why does the label not work?
- What is something that can tell people it is a white elephant?

Adapted from Cognitive Processing Therapy for PTSD: A Comprehensive Manual by PA Resick, CM Monson, and KM Chard

Exotic Worksheet:

- What is the evidence for supporting this idea?
- Is your belief based on facts or evidence?
- Evidence also had the belief in this scenario, would you consider it accurate?
- Are you thinking all or most?

Adapted from Cognitive Processing Therapy for PTSD: A Comprehensive Manual by PA Resick, CM Monson, and KM Chard
Activity Planning

1. Introduce the concept of activity planning

2. Identify pleasurable activities

3. Develop a specific plan for engaging in the activity
   - How often do you currently do this activity?
   - How often would you like to do this activity?
   - When would you be able to start this activity?
   - How long do you think you would be able to do this activity?
   - Where will you do this activity?
   - When will you do this activity?
   - Is there anything you need to do to prepare for this activity?

Coping Cards
Phase III: Relapse Prevention

Relapse Prevention Task

1. Ability to select a self-regulation skill that is relevant or appropriate to the situation
2. Ability to select a self-regulation skill that is practical within the constraints of the situation
3. Ability to adapt in response to situational demands and/or unexpected contingencies
4. Ability to rapidly select and implement skills

Relapse Prevention Task

1. Review the patient’s treatment log and crisis response plan
2. Educate the patient about how the relapse prevention task will occur and the potential for emotional distress
3. Guide the patient through a relapse prevention task focused on the original suicidal crisis or episode that prompted treatment
4. After completion, discuss the patient’s experience
   - How was that for you?
   - What did you notice while doing this?
   - What was easy and what was difficult?
The Final Session

1. Review the patient’s treatment log and identify a final lesson learned
2. Educate the patient about follow-up procedures and provide recommendations for continuing care
3. Discuss the patient’s preferences regarding posttreatment caring contacts

Additional Resources

Treatment Manual

Provides step-by-step instructions for administering BCBT.
Provides an overview of how the central concepts of BCBT have been adapted for use in different settings and populations.

Additional Reading

Provides an overview of the Collaborative Assessment and Management of Suicidality (CAMS), an assessment-based framework that complements BCBT.

Download copies of published articles focused on BCBT and the crisis response plan at www.veterans.utah.edu.
Training Videos
Watch training videos and demonstrations on our YouTube page. Search for “National Center for Veterans Studies”

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