CHAPTER 1

Why Brief Cognitive-Behavioral Therapy to Prevent Suicide?

In 2014, more than 41,000 individuals died by suicide in the United States (Centers for Disease Control and Prevention, 2016). From 1970 to 2000, the U.S. general population suicide rate declined approximately 20% from an estimated 13.2 per 100,000 to 10.4 per 100,000. Around the turn of the century, however, this downward trend reversed and the suicide rate steadily increased to 13.4 per 100,000 in 2014. Though suicide rates have increased across most demographic subgroups, the most pronounced increase has occurred among middle-aged (i.e., 45–64 years) white men. Similar trends have been observed globally, although differences by age groups have been noted (Chang, Stuckler, Yip, & Gunnell, 2013). In Europe, for instance, suicides increased most dramatically among young men ages 15 to 24 years. For each death by suicide, there are an estimated 10 to 30 suicide attempts (Centers for Disease Control and Prevention, 2016). In light of these trends, there has been increased interest in identifying and developing interventions and prevention strategies that reduce death by suicide and suicidal behavior more generally.

Within the United States, research focused on the understanding and treatment of suicidal individuals began in earnest during the 1950s, driven in large part by Edwin Schneidman and Norman Farberow, both clinical psychologists, and Robert Litman, a psychiatrist, at the Los Angeles Suicide Prevention Center. Although the number of suicide researchers has since grown rapidly, it was not until the 1990s that clinical researchers, both within the United States and around the world, started to apply rigorous scientific methods to develop and critically evaluate the efficacy of treatments for reducing suicide ideation and preventing suicide attempts. Despite these efforts, the suicide rate of the U.S. general population started to rise in 1999 and in 2014 reached its highest point in nearly 30 years (Centers for Disease Control and Prevention, 2016).

Traditional approaches to treating suicidal patients have largely been influenced by a *risk factor model* of suicide, which seeks to understand suicidal thoughts and behaviors by identifying and describing their correlates. For example, several well-established correlates of suicidal thoughts and behaviors include male gender, white or Caucasian race, age above 45 years, and psychiatric diagnoses (Franklin et al., 2017). Within the general category of psychiatric diagnoses, mood disorders and substance abuse disorders have traditionally been implicated (Kessler, Borges, & Walters, 1999; May & Klonsky, 2016; Nock et al., 2008). The risk factor model does not necessarily propose any specific underlying process or cause for suicidal behavior, but rather assumes that it is the accumulation of multiple risk factors that contributes to suicidal thoughts and behaviors. Treatment informed by this model aims to reduce these risk factors under the assumption that doing so will reduce the incidence and/or severity of suicidal thoughts and behaviors. Countering this assumption are the results of a recent meta-analysis of 50 years of research studies in which the risk factor model was found to have relatively little impact on suicide prevention or the development of effective treatments (Franklin et al., 2017). The utility of the risk factor model of suicide has increasingly been called into question.

The *psychiatric syndromal model,* in which suicidal thoughts and behaviors are conceptualized as symptoms of psychiatric illness, is a specific subcategory of the more general risk factor model. From this perspective, suicidal thoughts and behaviors are described and organized according to observable characteristics and surface features of the behaviors (e.g., method, lethality, and intent), similar to the syndromal classification schemes commonly used in the mental health and medical professions (e.g., the World Health Organization's *International Classification of Diseases,* the American Psychiatric Association's *Diagnostic and Statistical Manual*). In the medical field, a syndrome is reclassified as a disease once the characteristics and surface features of the syndrome are linked to their underlying processes and causes. As applied to suicide, the psychiatric syndromal model implicates the central role of psychiatric illness when treating suicidal patients: that is, treat the psychiatric illness and suicide risk will resolve. By extension, if a suicidal patient is diagnosed with depression, then the clinician should treat the depression to prevent suicide attempts; if a suicidal patient has posttraumatic stress disorder, however, then the clinician should treat the trauma. Although the psychiatric syndromal model has predominated in our clinical understanding of suicide for decades and is the perspective from which most clinicians approach the treatment of suicidal patients, accumulating evidence has failed to support the effectiveness of this conceptual framework (e.g., Tarrier, Taylor, & Gooding, 2008). This may be due in part to the fact that most psychiatric disorders are correlated with suicidal *thoughts* but not suicidal *behaviors* (Kessler et al., 1999; May & Klonsky, 2016; Nock et al., 2008). This suggests that treatments that prioritize psychiatric disorders may not be sufficiently specific to the mechanisms that give rise to suicidal behavior. As a result, they reduce psychiatric symptoms but not the risk for suicide attempts.

A third general framework for understanding suicidal behaviors is the *functional model.* According to this model, suicidal thoughts and behaviors are conceptualized as the outcome of underlying psychopathological processes that specifically precipitate and maintain suicidal thoughts and behaviors over time (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). From this perspective, suicidal thoughts and behaviors are not the result of any

particular psychological process per se (e.g., psychiatric illness); rather, they are the result of how the psychological process is experienced by the individual within the context of his or her personal history, immediate environment, and behavioral responses. Clinically, the functional model suggests that the primary target of treatment with suicidal individuals is not the psychiatric illness itself, but rather it is the context that surrounds the emergence and maintenance of suicide risk over time.

To highlight the differences between these models, consider two separate women diagnosed with major depression secondary to marital problems. Both individuals have comparable levels of depression severity, but one of these women (Patient A) makes a suicide attempt following an argument with her partner, whereas the second woman (Patient B) experiences suicide ideation following a similar argument but does not make a suicide attempt. According to the risk factor and the psychiatric syndromal models, the suicidal symptoms experienced by both women are explained in part by underlying depression. There is no clear explanation for why only one of these two women made a suicide attempt, but both models would generally presume that, since Patient A made a suicide attempt but Patient B did not, Patient A must have a greater number of risk factors than Patient B. The risk factor model would suggest that the differential risk factor profiles for both women would need to be identified in order to develop a treatment plan for each. These treatment plans would generally seek to reduce or eliminate each woman's risk factors. The psychiatric syndromal model would take a similar, albeit more focused approach: the indicated treatment approach for both women should focus on reducing depression. Because Patient A made a suicide attempt, the psychiatric syndromal model would presume she has a more severe clinical profile overall as compared to Patient B. Patient A might therefore be more likely than Patient B to receive treatment in an inpatient setting because she is more likely to be seen as requiring a higher level of care.

In contrast to these two approaches, the functional model would assume that the suicidal symptoms experienced by both women are explained only in part by their depression; a more complete explanation is provided by considering their depression within the context of each woman's history and the circumstances surrounding the emergence of their suicidal episodes. To understand why Patient A made a suicide attempt but Patient B did not, we would therefore seek to identify differences in how the two women responded to the argument with their spouses across several domains: cognition (e.g., Why does she think the argument happened? What does she believe the argument says about her relationship and/or her as a person?), emotion (e.g., Which emotions did she experience?), behavior (e.g., What actions did she take after the argument? How did she attempt to manage her emotions?), and somatic (e.g., What bodily sensations did she experience during and after the argument?). In short, Patient A made a suicide attempt not because she was depressed, but rather because she experienced the argument in a way that was shaped by previous life experiences and a general deficiency in effective self-regulation and coping. Outpatient treatment for Patient A is therefore likely to be different from treatment for Patient B, and would focus on these deficits in self-regulation and coping instead of focusing exclusively on depression.

The superiority of treatment approaches based on the functional model relative to treatment approaches based on a risk factor or psychiatric syndromal model are now well

established empirically. In a meta-analysis of 24 studies investigating treatment effectiveness for suicide ideation and suicide attempts, for instance, treatments that directly targeted suicidal thoughts and behaviors as the primary outcome (i.e., a functional approach) contributed to statistically significant and larger improvements in suicide risk relative to treatments that primarily targeted psychiatric diagnosis (Tarrier et al., 2008). In light of such studies, the general consensus among suicide researchers is that the treatment of suicidal individuals should focus directly on suicide risk itself as opposed to psychiatric diagnosis. Unfortunately, despite the scientific evidence that supports this perspective, the majority of mental health professionals continue to be influenced heavily by the psychiatric syndromal model of treatment, a situation that is due in large part to insufficient education and training for clinicians in newer and better models of care (Schmitz et al., 2012).

THE EVOLUTION OF COGNITIVE-BEHAVIORAL THERAPY TO PREVENT SUICIDE ATTEMPTS

Although clinical suicide researchers as a whole hail from a remarkably diverse range of disciplines (e.g., psychology, social work, psychiatry, sociology) and clinical traditions (e.g., biomedical, psychodynamic, cognitive-behavioral, interpersonal), the most significant advances in the development of effective treatments for suicidal patients have arguably come from the cognitive-behavioral tradition. This is not to say that important knowledge has not been gained from clinical researchers trained in different theoretical perspectives and traditions, but rather that cognitive-behavioral models may "fit" more readily with the functional approach to conceptualizing suicide. Indeed, the functional model's emphasis on understanding the contextual antecedents and consequences of suicidal thoughts and behaviors (e.g., thoughts, emotions, and behavioral responses) parallels the core conceptual principles of cognitive-behavioral theory.

When considering treatment efficacy for suicidal behaviors in general, it should first be noted that no treatments have been shown to prevent suicide *death*. This is due in large part to the very high cost that would need to be incurred to conduct and implement such a study; death by suicide occurs with such infrequency that it would require a very large sample of participants to examine death as an outcome. To put this in perspective, across two studies of brief cognitive-behavioral therapy (Brown, Ten Have, et al., 2005; Rudd et al., 2015), only 3 out of a total of 272 participants died by suicide during the study period. In other words, only 1% of patients died by suicide. This low base rate is quite notable when one considers that approximately 90% of the participants in these two studies had made at least one suicide attempt during their lives (in most cases, the suicide attempt was within the past month), which means these participants were very high risk. Researchers would therefore need to enroll a very large number of high-risk individuals (over 1,500) into a study to show that a treatment could reduce the risk for death by suicide by half. Tragically, the cost of conducting such a large-scale study, which would necessitate the collaborative participation of multiple research sites, is much higher than what many funding agencies would consider practical.

Because death by suicide is not (yet) a feasible outcome for the purposes of research, treatment efficacy studies typically use proxies for suicide death that occur with greater

frequency, such as suicide attempts and suicide ideation. Studies that evaluate the effects of treatment on suicide attempts as the primary outcome are generally considered to be more rigorous and informative than studies that consider treatment effects on suicide ideation, whereas studies that evaluate the effects of treatment on psychiatric diagnoses and other suicide risk factors are generally considered to be the least informative. This is because suicide attempts are a much closer approximation to suicide death than suicide ideation or psychiatric diagnosis (one must make a suicide attempt in order to die by suicide) and because suicide attempts are a stronger risk factor for later death by suicide than suicide ideation and psychiatric diagnosis. For example, in the classic meta-analysis of 249 studies investigating suicide as an outcome of psychiatric illness, Harris and Barraclough (1997) found that individuals with a history of suicide attempt had a standardized mortality ratio of approximately 40, which means that individuals who have attempted suicide are 40 times more likely to die by suicide than individuals with no such history. By comparison, the standardized mortality ratios for psychiatric disorders commonly associated with suicide were much lower: 20 for major depressive disorder, 19 for substance use disorder, 15 for bipolar disorder, and 8.5 for schizophrenia. Suicide attempt is therefore considered to be the best available proxy for suicide death.

Another important consideration with respect to treatment efficacy is the nature of the control or comparison treatment condition, without which it is not possible to determine if a treatment is effective. Because it is unethical to *not* treat acutely suicidal individuals, studies of suicidal patients *must* include an active treatment as the control condition. The most common control condition in treatment studies to prevent suicide attempts is *treatment as usual*, also known as *usual care*. Treatment as usual entails standard mental health treatment delivery as it is typically provided by mental health professionals. In most studies, treatment as usual generally entails some combination of individual psychotherapy and psychotropic medications, and may also include group therapy, substance abuse counseling, and case management. In essence, clinicians providing treatment as usual are simply asked to do whatever it is they would normally do with a suicidal patient; they are not asked to change anything about how they conduct treatment. Treatments are only considered to be "effective" for preventing or reducing risk for suicide attempts if they reduce the risk for suicide attempts relative to another active treatment approach that is widely used by mental health clinicians. In other words, an effective treatment is one that has "beaten" another form of treatment in a head-to-head comparison. To date, cognitive-behavioral therapies have garnered the most consistent evidence of efficacy, indicating they have outperformed other forms of therapy in numerous studies.

Brief cognitive-behavioral therapy (BCBT) to prevent suicide is best understood as the "next step forward" in the development and refinement of the cognitive-ehavioral model that been successfully used by clinical researchers over the course of several decades. To date, approximately 30 clinical trials testing the efficacy of cognitive-behavioral therapies to reduce suicide risk have been conducted with varying outcomes (Tarrier et al., 2008). One of the first treatments to demonstrate efficacy for reducing the risk of suicide attempts was dialectical behavior therapy (DBT; Linehan, 1993). Based on the biosocial model of suicide, DBT is a multimodal, structured cognitive-behavioral therapy that entails psychoeducational skills training groups, individual psychotherapy, between-session phone consultation

for patients, and regularly occurring clinician supervision. The efficacy of DBT and modified versions of DBT have been replicated in several clinical trials, making it "the most thoroughly studied and efficacious psychotherapy for suicidal behavior" (National Action Alliance Clinical Care & Intervention Task Force, 2012, p. 17). DBT entails training in emotion regulation, distress tolerance, problem solving, and cognitive reappraisal skills, accomplished with a range of cognitive-behavioral interventions such as cognitive restructuring, exposure, and behavioral rehearsal (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006).

Results of the first randomized clinical trial of DBT (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) indicated that patients receiving DBT were 32% less likely to engage in self-directed violence[1] during the 12-month follow-up period than patients receiving treatment as usual (64% in DBT vs. 96% in treatment as usual). Among those patients in DBT who did engage in self-directed violence, the total number of self-directed violence episodes was significantly fewer than for patients in treatment as usual (1.5 episodes in DBT vs. 9.0 episodes in treatment as usual during the 12-month follow-up), and the medical lethality of their behavior was significantly less severe. In terms of treatment utilization, patients in DBT were significantly more likely to start individual therapy than patients in treatment as usual (100% in DBT vs. 73% in treatment as usual) and were significantly more likely to remain in therapy for an entire year (83% in DBT vs. 42% in treatment as usual). Patients in DBT also had significantly fewer psychiatric hospitalization days during the 12-month follow-up than patients in treatment as usual. In terms of depression, hopelessness, and suicide ideation severity, however, patients in DBT and treatment as usual improved to a comparable degree.

Results of a more recent clinical trial of DBT (Linehan, Comtois, Murray, et al., 2006) were similar to this first study, although in this newer study the control condition was provided by peer-nominated experts from the Seattle Psychoanalytic Society (referred to as *community treatment by experts*) and suicide attempts were assessed separately from nonsuicidal self-injury. Patients in DBT were 50% less likely to make a suicide attempt during the 2-year follow-up period than patients in expert treatment (23% in DBT vs. 46% in expert treatment). Of those who did make suicide attempts, the medical lethality of the attempts was significantly less severe in DBT than in expert treatment. Patients in DBT were significantly more likely to stay in therapy than patients in expert treatment (81% in DBT vs. 43% in expert treatment) and were significantly less likely to be admitted to an inpatient psychiatric hospital. In terms of suicide ideation, depression, and reasons for living, patients in DBT and expert treatment improved to a similar degree. The results of this later study therefore paralleled the pattern of findings from the first DBT trial.

Although DBT has demonstrated considerable promise as a treatment for preventing suicide attempts, wider implementation of DBT has been hindered by the fact that the treatment is very resource intensive, time-consuming, and difficult to learn. Briefer and less

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[1] *Self-directed violence* refers to any form of intentional self-injurious behavior without regard to its intent (i.e., suicidal vs. nonsuicidal). It is therefore a general term that includes both suicide attempts and nonsuicidal self-injury. In Linehan and colleagues' (1991) study, the primary outcome was "parasuicide act," a term that has since been replaced by *self-directed violence* and therefore is no longer in widespread use among suicide researchers. Because a parasuicide act could be either nonsuicidal self-injury or a suicide attempt, the primary outcome from this early DBT study is not specific to suicide attempts.

complex cognitive-behavioral treatment models that could be delivered more practically and flexibly were therefore desired. Rudd, Joiner, and Rajab (2001) were among the first clinical researchers to articulate a brief, time-limited cognitive-behavioral therapy for suicidal patients. Based on the *fluid vulnerability theory* of suicide and the concept of the *suicidal mode* (described in detail in Chapter 2), this structured outpatient individual therapy entailed skills training in cognitive reappraisal, problem solving, and emotion regulation. A central component of Rudd and colleagues' treatment approach was the *crisis response plan,* an intervention that provides explicit guidelines outlining the steps that a patient should take during times of crisis to more adaptively cope with and respond to crises (the crisis response plan is described in detail in Chapter 10). Versions of the crisis response plan have since been retained in subsequent refinements of cognitive-behavioral therapies to prevent suicide attempts (e.g., Wenzel, Brown, & Beck, 2009). In addition, the crisis response plan has subsequently been refined and adapted for use as a stand-alone crisis intervention for use across multiple settings including emergency departments, inpatient psychiatric units, outpatient clinics, primary care clinics, and crisis hotlines (Bryan, Mintz, et al., 2017; Stanley & Brown, 2012). The crisis response plan's focus on effective skills use in response to behavioral emergencies has become a central feature of subsequent treatment refinements for preventing suicide attempts.

Empirical evidence supporting the efficacy of a brief, time-limited cognitive-behavioral therapy for preventing suicide attempts was first published by Brown, Ten Have, and colleagues (2005), who used a 10-session outpatient individual cognitive therapy that was similarly based on the concept of the suicidal mode and focused on skills training in cognitive reappraisal, problem solving, and emotion regulation. Similar to the approach described by Rudd and colleagues (2001), the crisis response plan played a central role in this cognitive therapy protocol, although it was subsequently renamed the *safety planning intervention* (Stanley & Brown, 2012). Several new interventions were developed for this treatment, the most notable of which are the survival kit (described in Chapter 15) and the relapse prevention task (described in Chapter 20). In a randomized clinical trial comparing cognitive therapy for suicide prevention to usual care, Brown and colleagues reported results that were very similar to those obtained from the earlier DBT trials. In terms of suicide attempts, patients receiving cognitive therapy were 50% less likely to make a suicide attempt during the 18-month follow-up period than patients receiving usual care (24% in cognitive therapy vs. 42% in usual care), but there were minimal differences between patients in cognitive therapy and usual care in terms of depression, hopelessness, and suicide ideation. Also similar to DBT, patients in cognitive therapy were significantly more likely to remain in treatment (88% in cognitive therapy vs. 60% of usual care during the first 6 months) but were no more likely to be hospitalized during the 18-month follow-up (13% in cognitive therapy vs. 8% in usual care). Many of the refinements and improvements to the cognitive-behavioral model made by Brown and colleagues have been retained in BCBT.

The findings of Brown, Ten Have, and colleagues (2005) marked an important advance in the development of brief cognitive-behavioral therapy, and demonstrated that time-limited treatments had the potential to be just as effective as longer and more complex cognitive-behavioral therapies. Although one might assume that time-limited treatments would be especially ill suited for high-risk patients who tend to have challenging clinical issues such as

complex comorbidities and a tendency to refuse or negate help from others (Rudd, Joiner, & Rajab, 1995), meta-analytic results suggest that longer-duration cognitive-behavioral therapies are no more (or less) effective than briefer cognitive-behavioral therapies (Tarrier et al., 2008). Even within DBT, the total number of sessions attended by patients is not associated with clinical outcomes (Linehan et al., 1991; Linehan, Comtois, Murray, et al., 2006). If the duration of treatment has little to do with cognitive-behavioral therapy's ability to prevent suicide attempts, then what aspects of treatment contribute to its efficacy?

Common Elements of Effective Therapies

In light of mounting evidence that some forms of cognitive-behavioral therapy were better than other forms of treatment for reducing the risk for suicide attempts, researchers became interested in identifying the elements or "ingredients" that accounted for these differences. What was it that made some therapies more effective than others? Answering this question would be critical for developing more focused and potent treatments. In recent years, clinical researchers have converged on several common factors that differentiate effective therapies from less effective treatments (Rudd, 2009, 2012). These findings laid the foundation for the specific changes made during the development of the BCBT protocol described in this treatment manual. As will become apparent throughout this manual, BCBT was based on all of these core ingredients.

Simple, Clinically Useful Theoretical Models

All of the most effective treatments are based on simple and practical models that are easily translated to clinical work. For example, DBT is based on a biosocial model of suicide (Linehan, 1993), whereas cognitive therapy for suicide prevention is based on the concept of the suicidal mode (Wenzel et al., 2009). A common feature of these theoretical models is their emphasis on recognizing how the connections among thoughts, emotional processing, and associated behavioral responses contribute to suicidal thoughts and behaviors. By extension, in order to change the suicidal process, the clinician and patient must directly target and alter the connections among these domains. The effectiveness of a treatment is enhanced when it is based on a useful model because the clinician can more easily explain to the patient why he or she desires suicide and why the specific interventions will help. In short, effective therapies provide a conceptual model to help the patient understand "what is wrong" and "what to do about it." Consistent with this principle, BCBT is based on the fluid vulnerability theory of suicide and the concept of the suicidal mode, both of which will be discussed in detail in Chapter 2.

Treatment Protocols and Clinician Fidelity

All of the most effective treatments are protocol driven, which means they specify in advance how to optimally prioritize problems or issues and how to sequence specific interventions most rapidly and effectively. In effective treatments, suicide risk is the highest-priority clinical issue and each intervention is selected to directly target this priority. Treatments that

only indirectly target suicide risk (e.g., by targeting the psychiatric diagnosis instead) are not as effective (Tarrier et al., 2008). To ensure the treatment protocol is implemented as intended, effective treatments often employ a manual for clinicians to follow. The notion of a manualized treatment carries a good deal of negative connotation for many clinicians, often because the term "manualized" is taken to mean "fixed" or "rigid," when in reality clinicians have considerable flexibility in determining how to best administer the protocol for each individual patient. Clinicians also receive intensive training and supervision to minimize the tendency to "drift" from the prescribed protocol. The degree to which a clinician follows the protocol is referred to as *clinician fidelity*. Treatments in which clinicians have high fidelity (i.e., they "follow the directions") yield better results than treatments in which clinicians show low fidelity. This is because fidelity reflects reliability: when following the protocol, the clinician delivers the treatment in a consistent manner both for a given patient as well as across multiple patients. Similar to other effective treatments, BCBT is manualized and clinician fidelity is emphasized. This treatment manual therefore outlines the interventions and procedures that have been found to be effective for preventing suicide attempts. Because clinician fidelity is so crucial to effective care, BCBT fidelity checklists are available in Appendix B.1. These fidelity checklists can be used by clinicians to assess their adherence to the BCBT protocol. They are also used by approved BCBT consultants to provide individualized feedback to clinicians learning the treatment.

Patient Adherence

In addition to clearly articulating what is expected of clinicians, effective treatments also articulate what is expected of patients. Of particular importance is the patient's level of engagement in the treatment process. Effective treatments therefore provide a clear plan for what the clinician should do if the patient does not complete assignments, does not participate during therapy sessions, drops out of treatment unexpectedly, or engages in other therapy-interfering behaviors (cf. Linehan, 1993). The emphasis on patient adherence is reflected by findings showing that effective treatments retain patients much better than comparison treatments (Brown, Ten Have, et al., 2005; Linehan et al., 1991; Linehan, Comtois, Murray, et al., 2006). In BCBT, patient adherence is emphasized throughout the treatment, and is crystallized in the commitment to treatment statement (described in Chapter 11), a new intervention added to the BCBT protocol in order to directly target patient adherence.

Skills-Training Focus

Although cognitive-behavioral therapies are, broadly speaking, a form of "talk therapy," the content of effective treatments is not limited to merely talking about problems and solutions. Effective treatments translate these discussions into behavior change through the demonstration of behavioral skills that target identified skill deficits that contribute to and sustain suicidal crises. In addition to telling patients what to do, clinicians therefore also *show* patients what to do and allow ample time in session to practice these skills and receive feedback to problem-solve or troubleshoot difficulties. Patients then practice these new skills in between sessions and report their progress back to their clinicians. The clinician in turn

reinforces skill acquisition and mastery and helps the patient to generalize skills across multiple situations. In BCBT, the clinician teaches a new skill or concept in each session, shows the patient how to do the skill, practices the skill with the patient in session, and then sets up a plan for the patient to practice the skill in between sessions.

Patient Responsibility and Autonomy

In traditional approaches to treating suicidal patients, primary responsibility for treatment progress is often assumed to be held by the clinician, whereas in effective treatments the primary responsibility for treatment progress is *shared* between the patient and clinician. Effective treatments therefore emphasize the patient's autonomy and invite the patient to fully participate in treatment planning and crisis management. Clinicians, by comparison, are primarily responsible for administering the protocol reliably (i.e., clinician fidelity) and addressing patient nonadherence when it arises. In BCBT, patient responsibility for treatment progress is exemplified by the crisis response plan (described in Chapter 10), which is aimed at teaching patients how to effectively manage crises on their own. Patient autonomy is also highlighted in interventions like means safety counseling (described in Chapter 13), which invites patients to create and then implement a plan to maximize their safety.

Clear Guidance for Crisis Resolution

Effective treatments teach patients how to identify emerging crises and provide them with clear steps to follow in order to resolve them. Consistent with the principle of personal responsibility and autonomy, these plans prioritize strategies that patients can use themselves. Should these personal steps fail or prove to be inadequate, effective treatments also make sure that patients know how to access professional and/or emergency services as a backup. Critically, effective treatments always dedicate sufficient time to practicing crisis management skills. As previously noted, the crisis response plan serves as the foundation for teaching patients how to identify and effectively manage crises in BCBT. Likewise, all of the interventions and procedures used in BCBT are designed to augment the patient's crises management skill set.

Individual Therapy Format

According to the results of Tarrier and colleagues' (2008) meta-analysis of 28 trials of cognitive-behavioral therapies, treatments that are provided in an individual format alone or in an individual format combined with group sessions (e.g., DBT) are associated with significant reductions in suicide attempts and suicide ideation, but treatments that are provided in a group format only are not associated with better outcomes. Although the exact reasons for this are not yet fully understood, a leading hypothesis is that group therapies that employ a more traditional interpersonal process format do not focus sufficiently on skills training. In light of these findings, BCBT was developed as an individual therapy.

Summary

Overall, several trends have emerged in treatments that effectively prevent suicide attempts. First, effective cognitive-behavioral therapies have several notable similarities that appear to be essential for preventing suicide: a useful theoretical model; manualization and clinician fidelity; emphasis on patient adherence; skills training; respect for patient autonomy; crisis management skills; and a format that includes individual therapy. Second, cognitive-behavioral therapies consistently reduce patients' risk for making a suicide attempt by up to 50% for up to 18 months posttreatment. Third, when a patient in an effective CBT *does* make a suicide attempt, the attempt tends to be less medically severe, which means the patient is more likely to survive. Fourth, risk for suicide attempts is reduced in effective cognitive-behavioral therapies despite the fact that these treatments are not necessarily better than other treatments at reducing psychiatric symptoms or suicide ideation. This lends support to the perspective that a psychiatric syndromal model for understanding suicide risk is inadequate, and suggests that psychiatric symptoms and even suicide ideation may be less useful as indicators of clinical outcome, treatment progress, and overall risk for suicide. Fifth, patients are more likely to stay in effective cognitive-behavioral therapies. When considered in light of evidence that treatment duration and total number of sessions attended do not correlate with outcome, this finding may suggest that some cognitive-behavioral therapies do a better job of undermining patients' hopelessness about treatment and their capacity to change. Finally, effective cognitive-behavioral therapies prevent suicide attempts even though patients are less likely to be hospitalized, suggesting that outpatient therapy is safe and effective as compared to more intensive treatment modalities.

EFFECTIVENESS OF
BRIEF COGNITIVE-BEHAVIORAL THERAPY

As noted above, the BCBT protocol described in this treatment manual is the next incremental step in the advancement of treatments to prevent suicide attempts. During the past 25 years, the cognitive-behavioral approach to preventing suicide attempts has steadily improved from 32% reduced risk (Linehan et al., 1991) to 50% reduced risk (Brown, Ten Have, et al., 2005; Linehan, Comtois, Brown, Heard, & Wagner, 2006). Because it has retained many of the elements found to be effective in these cognitive-behavioral treatments, BCBT has many similarities to DBT and cognitive therapy for suicide prevention. BCBT also contains some refinements and new components intended to improve the overall effectiveness of the treatment based on recent advances in suicide research; these refinements and additions are described in subsequent chapters along with the rationale behind them.

A randomized clinical trial testing the efficacy of this BCBT protocol was recently completed and published (Rudd et al., 2015). Participants in this trial included 152 active-duty military personnel (85% male) with suicide ideation during the past week and/or a suicide attempt within the past month. Participants were referred to the study upon discharge from inpatient hospitalization for suicide risk; half were randomized to receive BCBT and half were randomized to receive treatment as usual. Treatment as usual was determined by

the participant's primary mental health clinician (i.e., a licensed psychologist or psychiatrist) and included individual and group psychotherapy, psychiatric medication, substance abuse treatment, and/or support groups. In addition to treatment as usual, participants randomized to BCBT were scheduled to receive 12 outpatient individual BCBT sessions scheduled on a weekly or biweekly basis, with the first session lasting 90 minutes and subsequent sessions lasting 60 minutes. BCBT was administered by two clinical social workers with different levels of professional experience: one who had just recently completed her master's degree and one who had been a licensed practitioner for over 20 years.

With respect to outcomes, results of this study were also consistent with previous clinical trials. As can be seen in Figure 1.1, differences between treatments in suicide attempt rates emerged within 6 months and persisted for up to 2 years after the start of treatment. Over the course of the 2-year study, participants in BCBT were 60% less likely to make a suicide attempt as compared to participants in treatment as usual (14% in BCBT vs. 40% in treatment as usual). In terms of psychiatric symptom severity, participants in BCBT tended to report slightly less severe symptoms over time as compared to those in treatment as usual, but these differences were not statistically significant (see Figure 1.2). This pattern of results therefore aligns with previous studies of DBT and cognitive therapy for suicide prevention. In contrast to previous studies, however, the BCBT trial followed participants for up to 2 years—the longest follow-up conducted to date. The BCBT trial also marked the first study to enroll a predominantly male sample, thereby confirming the model's efficacy for men.
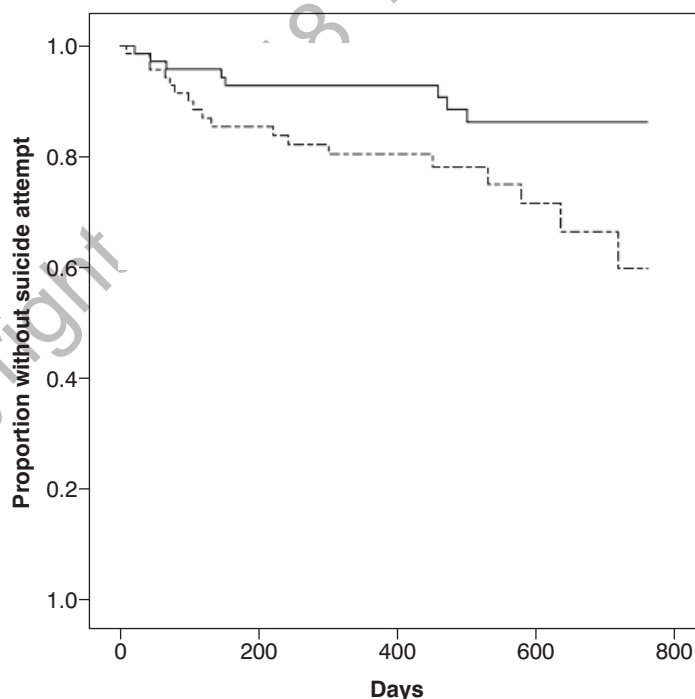

FIGURE 1.1. Survival curves for time to first suicide attempt among participants receiving BCBT (solid line) and participants receiving treatment as usual (dashed line).
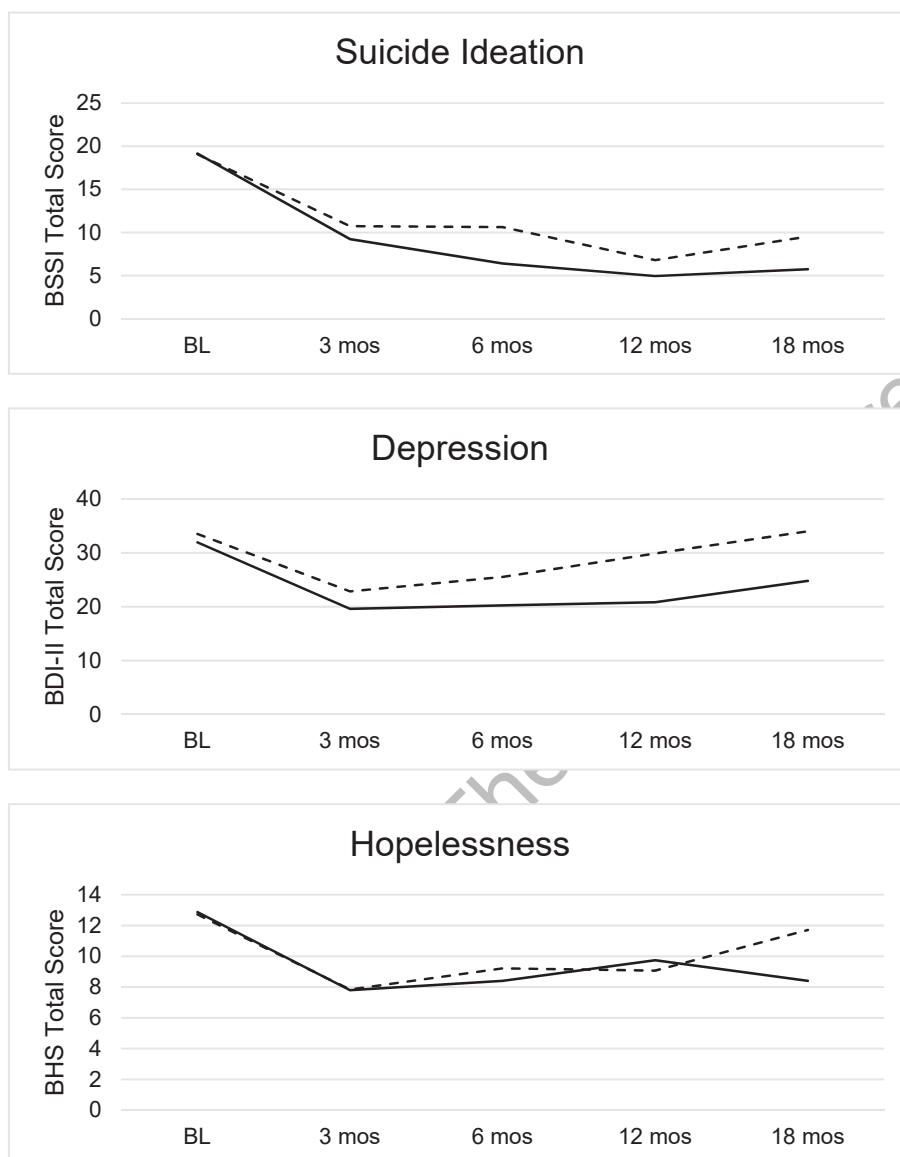
Suicide Ideation

Depression

Hopelessness

FIGURE 1.2. Differences in severity of suicide ideation, depression, and hopelessness among participants receiving BCBT (solid line) and participants receiving treatment as usual (dashed line). BSSI, Beck Scale for Suicide Ideation; BDI-II, Beck Depression Inventory—2nd Edition; BHS, Beck Hopelessness Scale.

Because this study was conducted in a military setting, the effect of treatment on career outcomes was also examined. Results showed that participants in BCBT were less likely to be medically retired from the military than participants in treatment as usual (27% in BCBT vs. 42% in treatment as usual), suggesting that BCBT may have a positive impact on social–occupational functioning in addition to its clinical benefits. Overall, participants in BCBT attended a mean of 12 BCBT sessions and participants in treatment as usual attended a mean of 12 individual therapy sessions during the first 3 months of the study, suggesting participants in both treatments received a comparable "dose" of individual therapy. There

were no differences between the two groups in terms of overall treatment utilization (i.e., group therapy, self-help therapy, substance abuse treatment, medication) during the entire study, although participants in BCBT had significantly fewer days of inpatient psychiatric hospitalization (3 days in BCBT vs. 8 days in treatment as usual), similar to previous findings from DBT. Secondary analyses have since been conducted to examine the potential role of dose effects in BCBT (Bryan & Rudd, 2015). Among participants who received fewer than 12 individual therapy sessions, suicide attempt rates during follow-up were 0% in BCBT as compared to 26.3% in treatment as usual. Among those who received 12 or more individual therapy sessions, the suicide attempt rates during follow-up were 19.7% in BCBT as compared to 43.8% in treatment as usual. Of note, suicide attempts were dramatically reduced in BCBT even among those participants who received a much smaller number of individual therapy sessions overall (see Table 1.1), which suggests that even a few sessions of BCBT are better than a large number of sessions of treatment as usual.

Several additional data analyses have since been conducted to determine if BCBT may be more or less effective for different patient subgroups. The results of these analyses are summarized in Table 1.2. As can be seen, BCBT is associated with reduced risk for suicide attempts regardless of gender, history of suicide attempt, and psychiatric diagnosis, which supports the treatment's efficacy across a diverse range of patient characteristics.

In summary, the results of Rudd and colleagues (2015) partially replicated those of Brown, Ten Have, and colleagues (2005) and confirmed the effectiveness of BCBT as a

TABLE 1.1. Estimated Suicide Attempt Probabilities in BCBT and Treatment as Usual by Total Number of Individual Therapy Sessions Attended during Follow-Up

No. of individual therapy sessions	BCBT	Treatment as usual
0–12	0.0%	25.5%
13–24	11.5%	38.5%
25–48	20.9%	21.0%
49+	18.6%	51.0%

TABLE 1.2. Estimated Suicide Attempt Probabilities in BCBT and Treatment as Usual According to Various Patient Characteristics

Subgroup	BCBT	Treatment as usual
Gender		
Women	9%	58%
Men	14%	34%
Diagnosis		
Posttraumatic stress	14%	34%
Substance use	21%	47%
Borderline personality	0%	51%
Prior suicide attempts		
No	0%	54%
Yes	15%	32%

viable alternative to longer and more time-intensive treatments like DBT. Perhaps more importantly, the 60% reduction in risk for suicide attempts among individuals receiving BCBT was the largest magnitude reduction in suicide attempt risk to date, which hints at the possibility of further incremental improvement in the effectiveness of cognitive-behavioral therapies over time. Although efforts to further refine BCBT continue, the protocol described in this book currently represents the latest and most effective treatment for preventing suicide attempts developed to date.

OVERVIEW OF
THE BRIEF COGNITIVE-BEHAVIORAL THERAPY MANUAL

This manual describes all of the procedures and interventions that comprise the BCBT protocol tested by Rudd and colleagues (2015).

The first part of this manual provides a discussion of the theoretical and conceptual principles that underlie BCBT and its implementation. The fluid vulnerability theory of suicide and its embedded notion of the suicidal mode are first described in detail. Core principles and strategies for establishing an effective therapeutic alliance with high-risk patients are next reviewed, followed by procedures for approaching the informed consent process. The following chapter describes strategies and tips for assessing a patient's risk for suicide and subsequently documenting a suicide risk assessment. Next comes a description of various methods for monitoring progress during BCBT, including recommended methods for addressing suicide attempts and psychiatric hospitalizations that occur during the course of treatment. Part I concludes with an overview of BCBT, including a discussion of two issues that are commonly raised by clinicians as concerns when working with suicidal patients: substance use and psychotropic medication use.

The second part of this manual focuses on the first session of BCBT, the most structured session of the entire treatment. The chapters in this section describe the specific sequence of procedures comprising the first session: describing BCBT, conducting a narrative assessment of the suicidal crisis, explaining the treatment log, completing the case conceptualization in collaboration with the patient, and creating a crisis response plan.

Part III describes the procedures and interventions that comprise the first phase of BCBT, which generally spans Sessions 2 to 5. This phase begins with the development of a treatment plan and the use of the commitment to treatment statement, the latter of which directly targets patient adherence. Strategies for addressing the patient's safety and risk for repeat suicide attempts are next described via means safety counseling. Subsequent chapters describe a variety of procedures and interventions used during the first phase of BCBT: stimulus control and sleep hygiene, relaxation, mindfulness, reasons for living, and the survival kit. This aligns with BCBT's overarching approach, which prioritizes emotion regulation and crisis management skills training in order to rapidly reduce symptomatic distress and short-term risk of suicide attempts. In contrast to other manualized therapies that prescribe a particular sequence of procedures, BCBT allows for the flexible selection of procedures and interventions that optimally fit with the patient's needs and treatment goals. In this way, the clinician can customize the delivery of specific procedures to the unique needs of their patient while maintaining fidelity to the model. Despite this flexibility, we

have found that some sequences often work better than others. As a result, we ordered the chapters in this section to reflect the sequence of procedures that seems to work best for both patients and clinicians.

The fourth part of this manual describes the procedures and interventions that comprise the second phase of BCBT, which generally spans Sessions 6 to 10. In this phase of the treatment, the focus shifts to the patient's suicidal belief system, which is comprised of automatic thoughts, assumptions, and core beliefs that contribute to and sustain suicidal thoughts and behaviors. As is discussed in Chapter 2, the suicidal belief system is hypothesized to be a chief mechanisms of vulnerability that underlies the patient's risk for future suicidal behavior. The procedures described in this section are based on the worksheets developed by Resick, Monson, and Chard (2017) for cognitive processing therapy for posttraumatic stress disorder (PTSD) and are designed to teach the patient how to identify the relationships among life circumstances, beliefs, and negative emotions, and how to adopt more helpful thoughts: ABC worksheets, challenging questions, and patterns of problematic thinking. Also described here are activity planning and coping cards, two behavioral strategies that complement and support cognitive change. As with the first phase, we ordered the chapters in the sequence that seems to work best for patients and clinicians, although clinicians have the flexibility to use an alternative sequencing pattern.

The fifth part of this manual describes the sole procedure that constitutes the third and final phase of BCBT: the relapse prevention task, which entails a guided imagery exercise that typically spans Sessions 11 and 12. In this final procedure, the patient demonstrates his or her ability to implement the skills learned during BCBT to successfully resolve emotional crises and reduce the likelihood that suicidal behavior will be used as a coping strategy in the future. Also covered in this part is determining when a patient should be considered ready to end BCBT, with suggestions for wrapping up the treatment.

The manual concludes with two appendices that provide specific tools and resources for successfully implementing BCBT. Appendix A includes copies of all patient forms and handouts required for BCBT, and Appendix B includes copies of clinician tools such as fidelity checklists, suicide risk assessment documentation templates, and relaxation and mindfulness scripts. (The materials in Appendices A and B are also available for downloading; see the box at the end of the table of contents.)

To facilitate ease of learning by clinicians, the concepts and procedures described in this manual are supplemented by sample scripts that can be used as a guide for clinicians learning BCBT. These scripts are not necessarily intended to be followed exactly; rather, they provide examples of language and structure that a clinician might use when implementing BCBT. In addition, several case studies are introduced and followed throughout the manual to provide examples of how BCBT can be implemented with patients reflecting a range of risk levels and clinical complexity. These case studies are based on actual patients who completed the BCBT protocol, although details have been changed to preserve privacy and confidentiality. Finally, this manual includes "tips and advice" sections throughout to highlight important lessons learned during the course of our clinical research, collaborations with other suicide researchers, supervision of clinicians learning to use BCBT, and our own personal experience treating suicidal patients with BCBT.