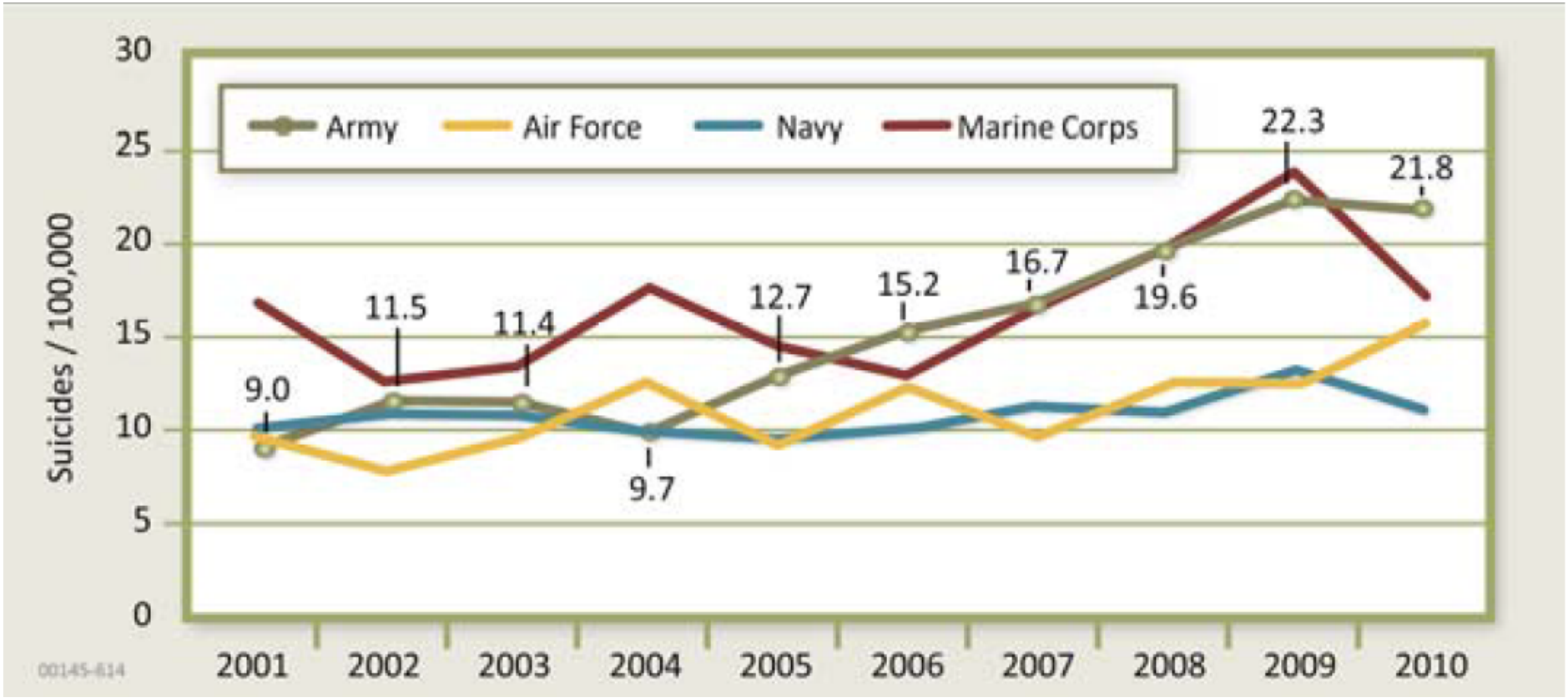
Brief Cognitive Behavioral Therapy for Suicidal Veterans

Craig J. Bryan, PsyD, ABPP
Associate Director
National Center for Veterans Studies
The University of Utah

NATIONAL CENTER FOR VETERANS STUDIES
THE UNIVERSITY OF UTAH

Active duty suicide rates

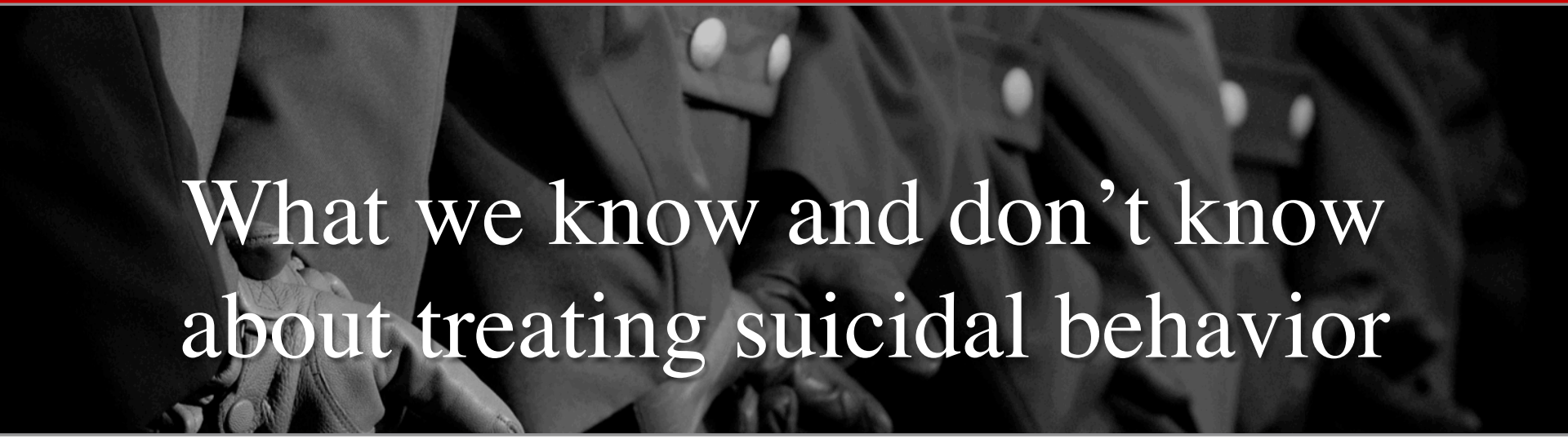


Student veteran suicide risk

Student veterans		General undergrad	
Severe depression	23.7%	Severe depression	28%
Suicidal ideation	46%		
Suicidal plan	20%	Serious suicidal ideation	6%
Suicide attempt	7.7%	Suicide attempt	1.3%
Future attempt likely	3.8%		

(Rudd, Goulding, & Bryan, 2011)

The problem of military suicide…



What we know and don't know about treating suicidal behavior

Why don't we know more about which treatments work for reducing suicidality?

1. Poorly-defined constructs

Suicide attempt?

Nonsuicidal self-injury?

Suicidal ideation?

Morbid ideation?

"Suicidality"?

2. Approximately 45% of treatment efficacy trials exclude high risk patients

3. Limited follow-up periods

4. Variable nature of the construct makes it hard to measure

What do we know about what works for suicide risk?

53 psychosocial clinical trials targeting suicidality

- "Clinical trial" = study including both treatment and control (or comparison) condition
- Randomization not required
- 28 (53%) were cognitive-behavioral
- Only one RCT has utilized military personnel (Rudd et al., 1996)

What works

1. **Theoretical models easily translated to clinical work**
   - Well-defined and theoretical models embedded in empirical research
   - Identify thoughts, emotional processing, and associated behavior responses
   - Patients can easily understand why they have tried or are thinking about suicide

What works

2. Treatment fidelity

- Clinician training to competence with supervision
- Manual-driven
- Clear sequence or hierarchy of treatment targets
- Suicidal behaviors is central treatment focus independent of psychiatric condition

What works

3. Adherence

- Specific interventions and techniques to target poor adherence and motivation
- Clear directions about *what to do* if nonadherence emerges

What works

4. Emphasis on skills-building

- Identification of skills deficits with opportunity for skills building and practice
- Clear understanding of “what is wrong” and “what to do about it”

What works

5. Personal responsibility

- Emphasis on patient self-reliance and self-management
- Patients assume high level of responsibility for their care, including crisis management

What works

6. **Easy access to treatment and crisis services**
   - Clear plan of action for emergencies
   - Dedication of time to practicing skills necessary to identify true crisis, using crisis plan, and using external support services judiciously

What works

1. Theoretical models easily translated to clinical work
2. Treatment fidelity
3. Adherence
4. Emphasis on skills-building
5. Personal responsibility
6. Easy access to treatment and crisis services

Foundations for care

Why adopt a standardized language of suicide?

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

3 important definitional criteria

1. Intent
2. Evidence of self-infliction
3. Outcome

(Maris et al, 1992)

Suicide-Related Terms

Suicide attempt

Intentional, self-enacted, potentially injurious behavior with any (nonzero) amount of intent to die, with or without injury

Suicidal ideation

Thoughts of ending one's life or enacting one's death

Nonsuicidal self-injury

Intentional, self-enacted, potentially injurious behavior with no (zero) intent to die, with or without injury

Nonsuicidal morbid ideation

Thoughts about one's death without suicidal or self-enacted injurious content

Common reactions to suicidal patients

Fear → Helplessness, Hopelessness

Anxiety → Over-protectiveness, Under-protectiveness

Anger → Lack of compassion, Criticism

Emotion reactions lead to mistakes

- **Over-react** and perhaps impose unnecessary external controls or reactions
- **Under-react** and perhaps deny the need for protective measures
- **Reject** or abandon the patient

Clinician vs. patient goals

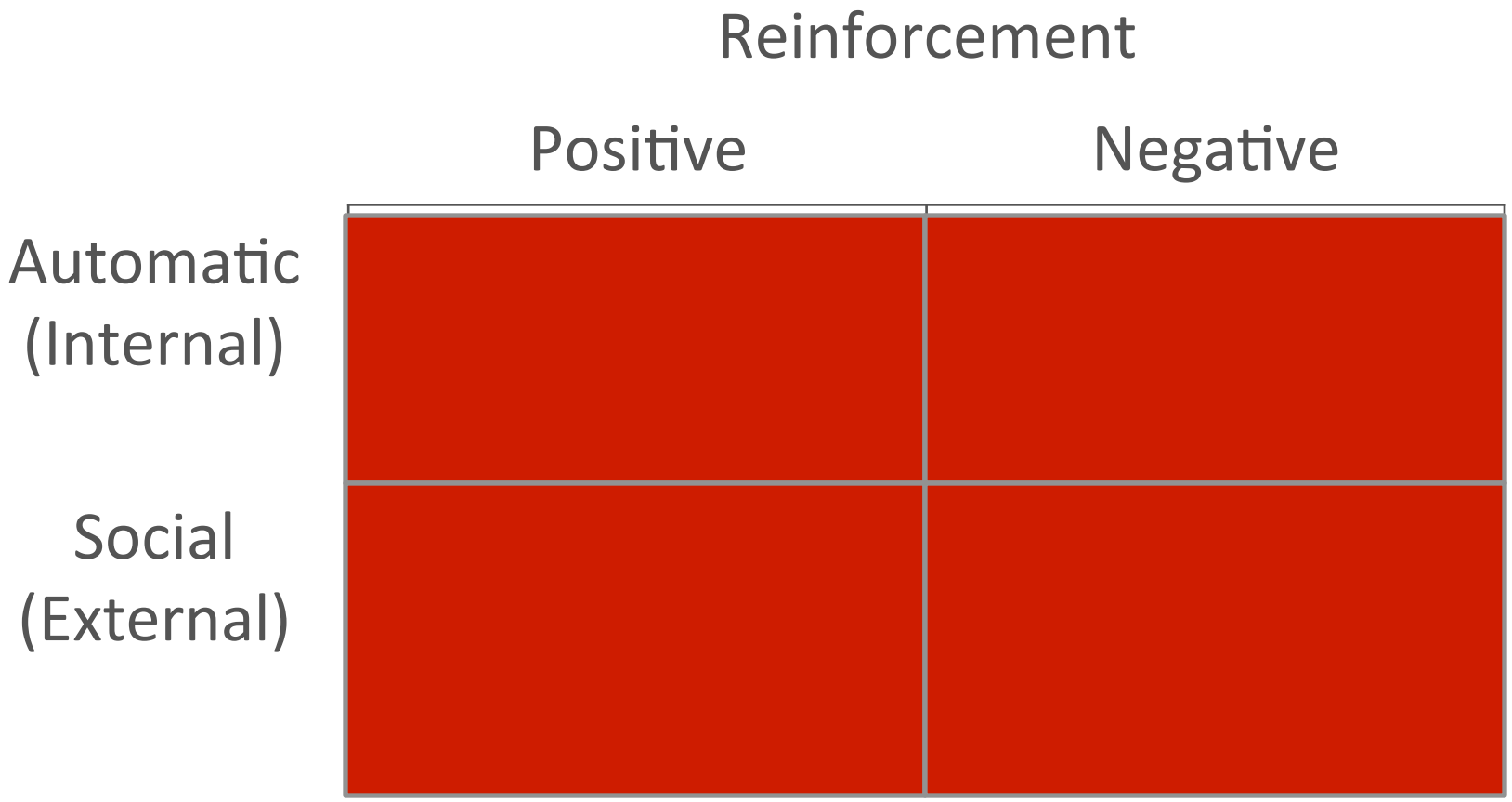
Clinician: prevent death, don't get sued

Patient: alleviate suffering

Resolving the conflict

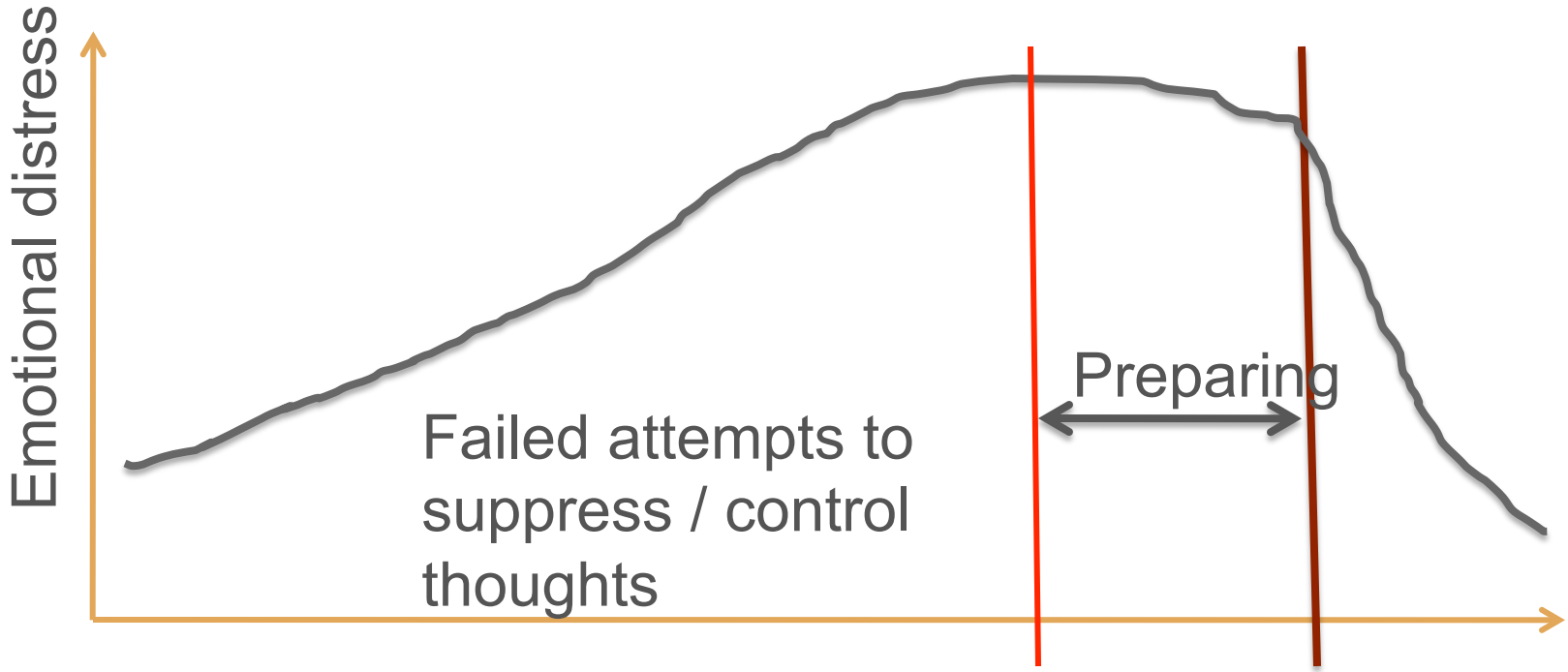
1. Understand that the patient engages in harmful behaviors because they "make sense" and they work
2. Recognize the functional purpose of the behaviors
3. View the patient as individual with unique set of issues and circumstances
4. Listen to the patient's "story"

Functional model of suicide



(Bryan & Rudd, 2012; Nock & Prinstein, 2004)

Negative reinforcement



(Brown, 1998; Najmi, Wegner, & Nock, 2007)

Fluid vulnerability theory

"I got my second Article 15. I'll probably lose a stripe over it, and they're going to send me back home now. I told my girlfriend about it and she got mad at me and hung up the phone. She won't answer my phone calls or emails now. I just don't know what I'm going to do. I was in my room yesterday and I was just thinking to myself "What's the point? I just fuck everything up." So I took out my gun from my holster and loaded it, and held it to my head. I started to pull the trigger, but then my friend came to my door and knocked. She saw me with the gun and asked what I was doing and I told her. She took my gun away and went and told the Shirt, and they took me to mental health. If my friend hadn't come right then I'm pretty certain I'd be dead. It just happened so fast. "

Fluid vulnerability theory

Fundamental Assumptions:

- Baseline risk varies from individual to individual
- Baseline risk is determined by *static* factors
- Baseline risk is higher and endures longer for multiple attempters (2 or more attempts)
- Risk is elevated by aggravating factors
- Severity of risk is dependent on baseline level and severity of aggravating factors

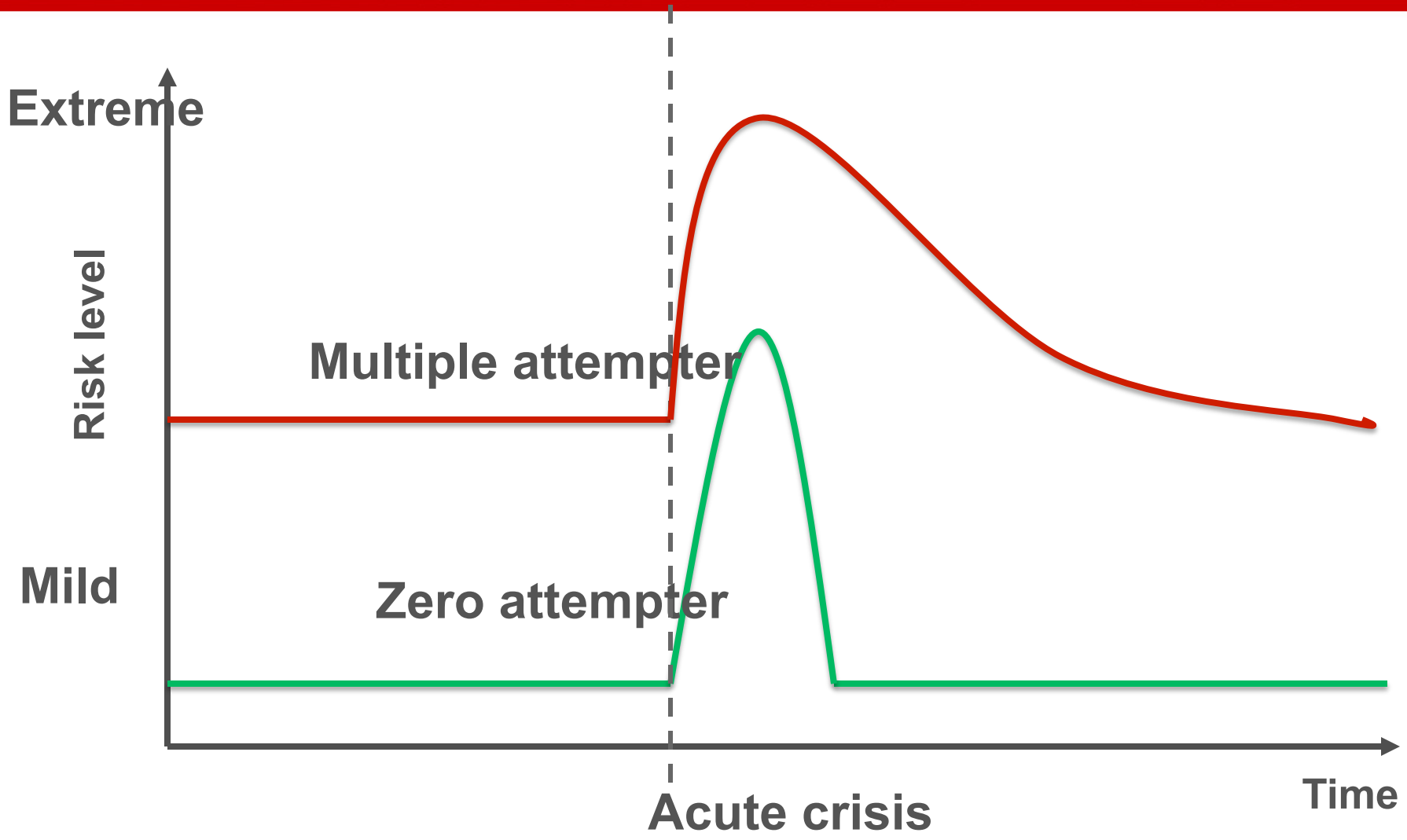
(Rudd, 2006)

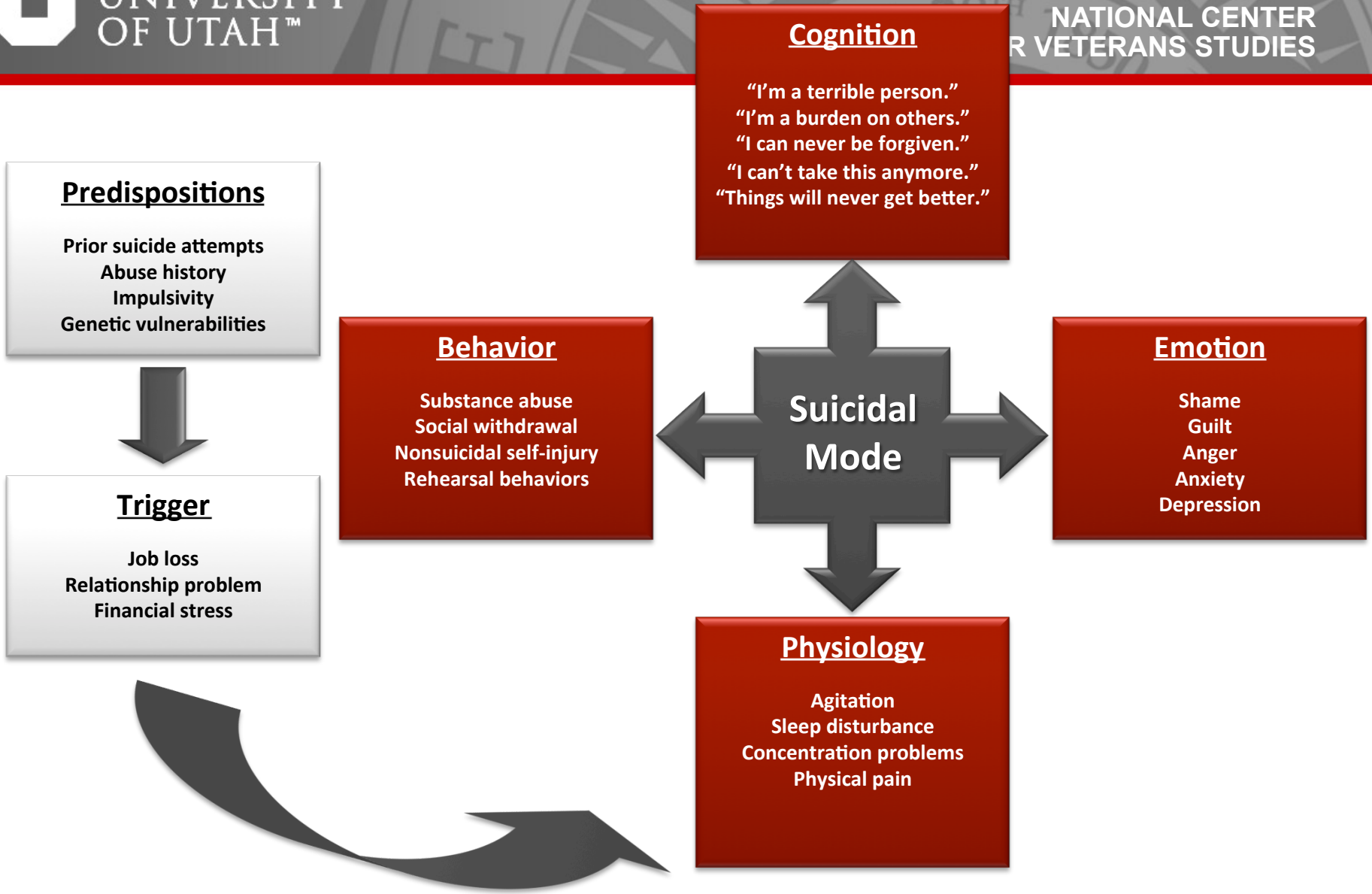
Fluid vulnerability theory

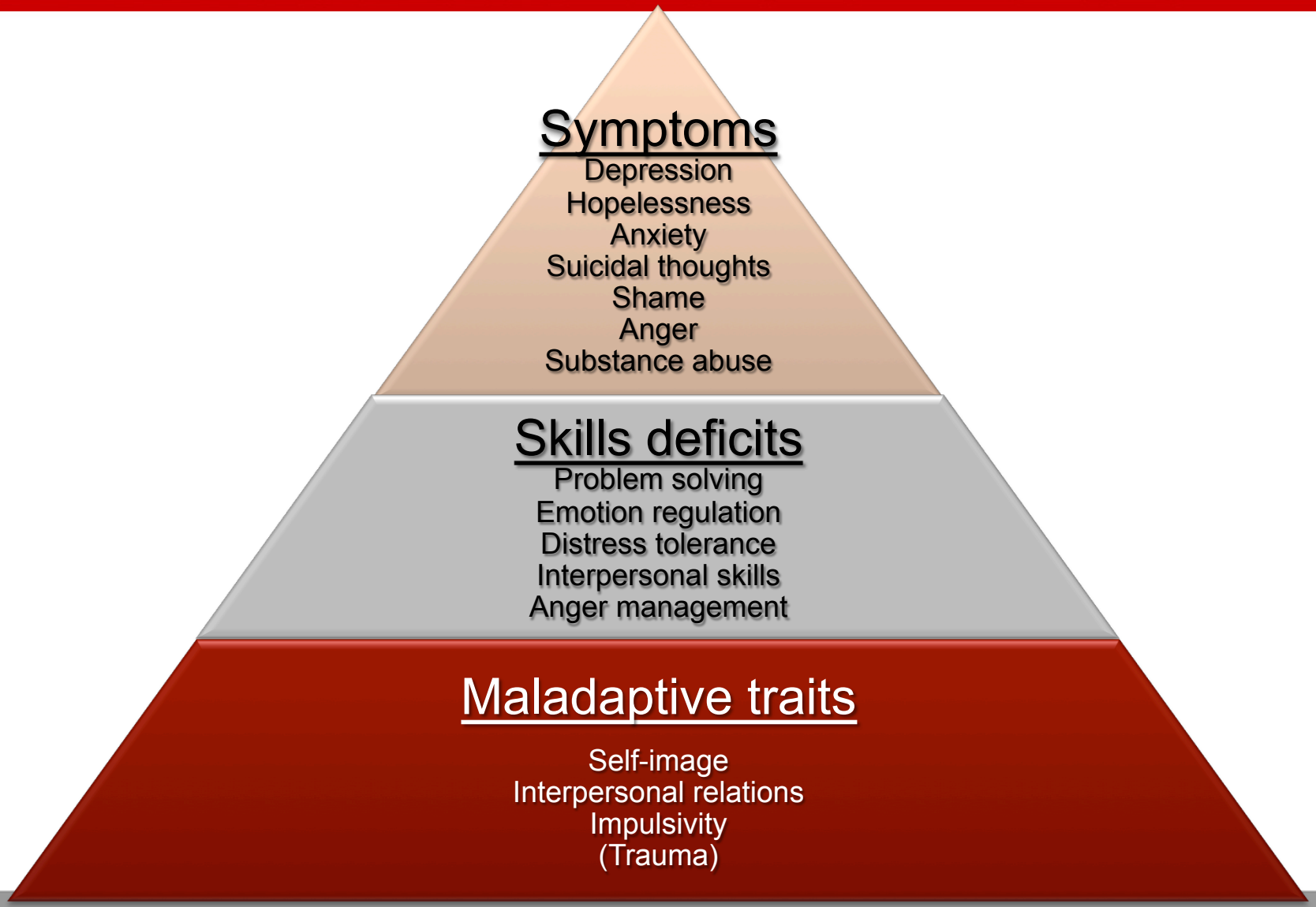
Fundamental Assumptions (cont'd):

- Risk is elevated by aggravating factors for limited periods of time (hours, days, weeks), and resolves when risk factors are effectively targeted
- Risk returns to baseline level only
- Risk is reduced by protective factors
- Multiple attempters have fewer available protective factors (support, interpersonal resources, coping/ problem-solving skills, etc.)

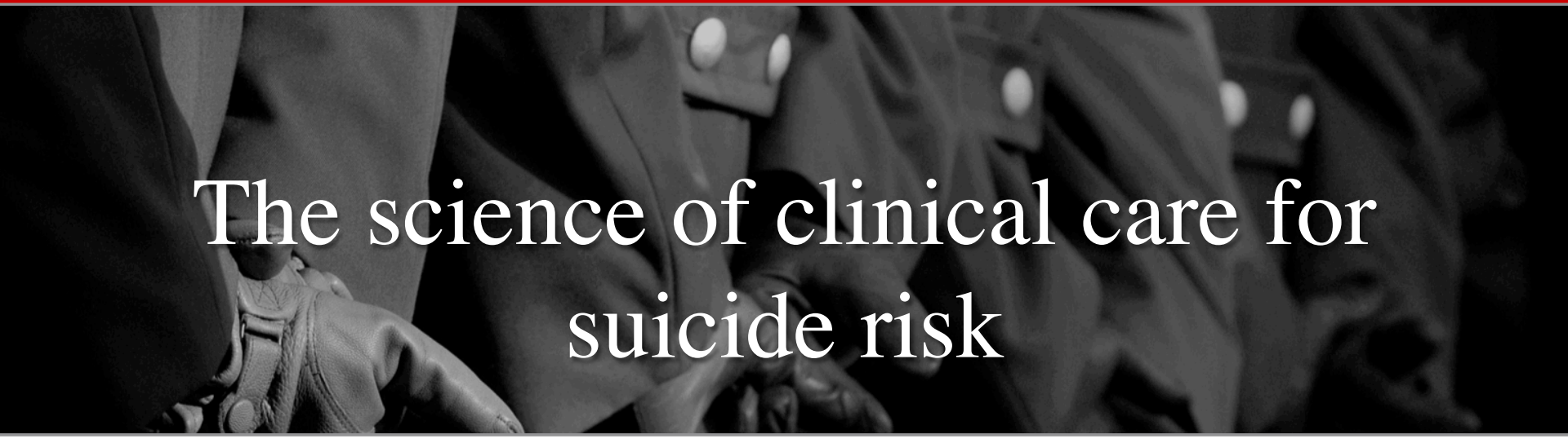
(Rudd, 2006)


Extreme
Risk level
Mild
Multiple attempter
Zero attempter
Acute crisis
Time


Cognition
"I'm a terrible person."
"I'm a burden on others."
"I can never be forgiven."
"I can't take this anymore."
"Things will never get better."
Predispositions
Prior suicide attempts
Abuse history
Impulsivity
Genetic vulnerabilities
Behavior
Substance abuse
Social withdrawal
Nonsuicidal self-injury
Rehearsal behaviors
Suicidal Mode
Emotion
Shame
Guilt
Anger
Anxiety
Depression
Trigger
Job loss
Relationship problem
Financial stress
Physiology
Agitation
Sleep disturbance
Concentration problems
Physical pain


Symptoms
Depression
Hopelessness
Anxiety
Suicidal thoughts
Shame
Anger
Substance abuse
Skills deficits
Problem solving
Emotion regulation
Distress tolerance
Interpersonal skills
Anger management
Maladaptive traits
Self-image
Interpersonal relations
Impulsivity
(Trauma)

(Rudd, 2001)



The science of clinical care for suicide risk

Dialectical behavior therapy

Number of Parasuicidal Acts, by Condition and Time*

Assessment Period	Descriptive Statistic	Condition: DBT	Condition: Control	z
Pre–4 mo	Median (IQR)	0.00 (4.50)	3.50 (22.00)	2.36†
	Median ± SD	3.50 ± 7.88	15.91 ± 25.02	. . .
	n	22	22	. . .
4-8 mo	Median (IQR)	0.00 (2.00)	2.50 (4.25)	1.62‡
	Mean ± SD	2.82 ± 8.13	8.73 ± 25.48	. . .
	n	22	22	. . .
8-12 mo	Median (IQR)	0.00 (1.00)	1.00 (4.00)	1.98‡
	Mean ± SD	0.55 ± 0.94	9.33 ± 26.95	. . .
	n	20	21	. . .
Year total	Median (IQR)	1.50 (9.25)	9.00 (43.50)	2.69†
	Mean ± SD	6.82 ± 12.35	33.54 ± 69.97	. . .
	n§	22	22	. . .

*DBT indicates dialectical behavior therapy; IQR, inner quartile range.
†$P<.01$, one-tailed test.
‡$P<.05$, one-tailed test.
§For year total, data to end point were used for subjects who were not in study at the 8- to 12-month period.

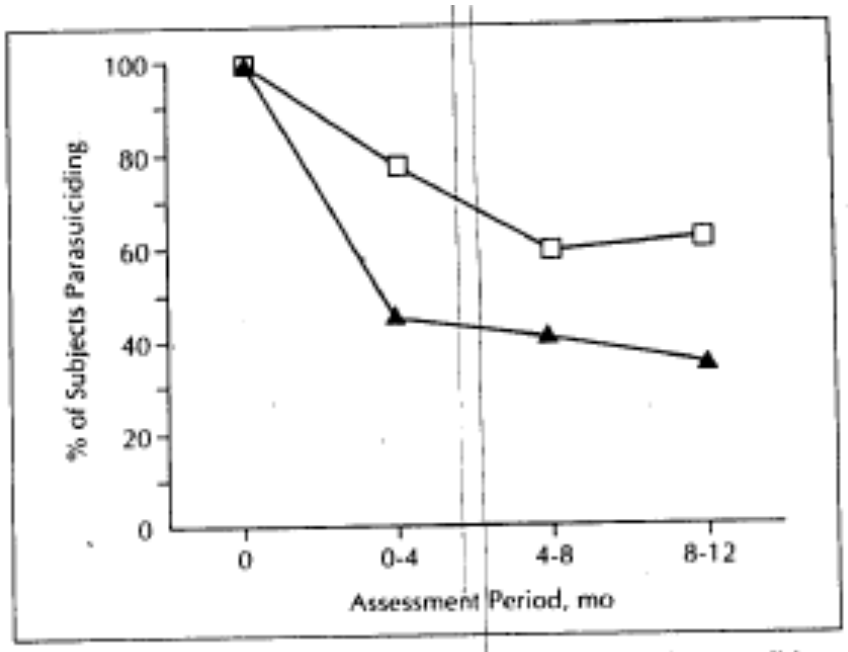


Fig 1.—*Percentage of subjects with parasuicide, by condition. Months 0 to 4 indicated significant difference between subjects (triangles) who received dialectical behavior therapy and control subjects (squares) (z = 2.7, P<.05); months 8 to 12, significant difference between subjects who received dialectical behavior therapy and control subjects (z = 1.74, P<.05).*

Linehan et al. (1991). Arch Gen Psychiatry, 48, 1060-1064

Dialectical behavior therapy

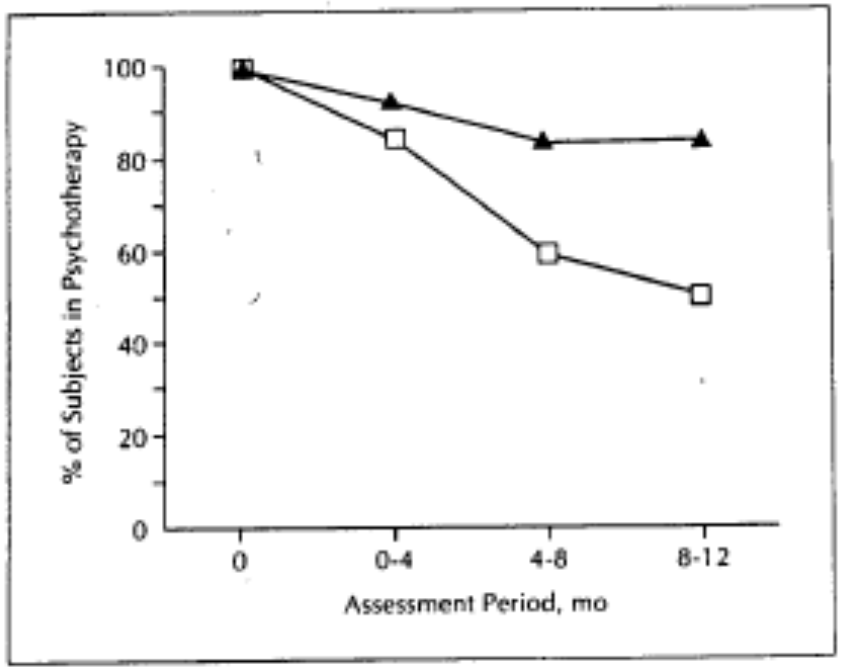


Fig 2.—*Percentage of subjects in individual psychotherapy, for those subjects beginning with a new therapist at pretreatment, by condition. Months 4 to 8 indicate significant difference between subjects who received dialectical behavior therapy (triangles) and control subjects (squares) (z = 1.63, P<.05); months 8 to 12, significant difference between subjects who received dialectical behavior therapy and control subjects (z = 2.11, P<.01). Note that two subjects who were assigned to dialectical behavior therapy and who were out of therapy also stopped assessments. It is possible that they entered some other individual therapy. To be conservative, they are counted as not in individual therapy.*

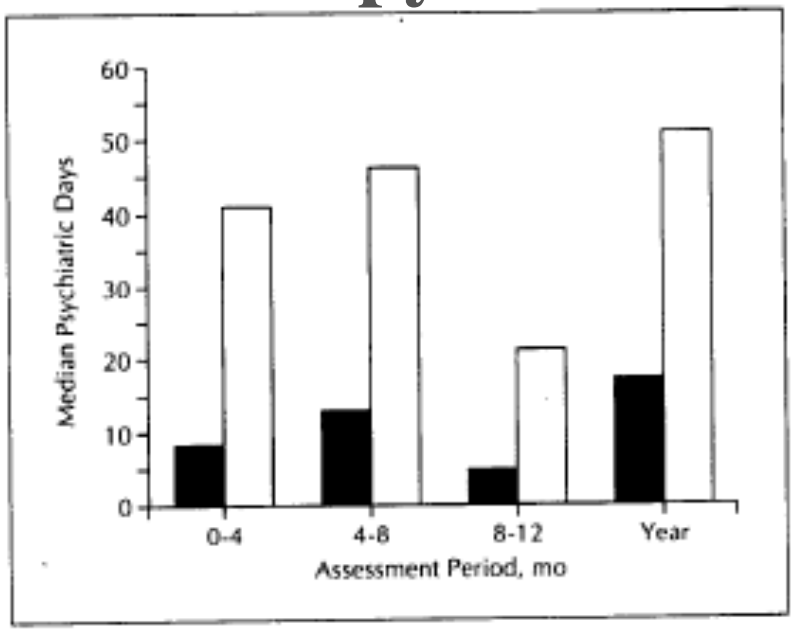


Fig 3.—*Median psychiatric days for hospitalized subjects, by condition. Months 0 to 4 indicate significant difference between subjects who received dialectical behavior therapy (shaded bars) and control subjects (open bars) (z = 2.54, P<.005); months 8 to 12, trend between subjects who received dialectical behavior therapy and control subjects (z = 1.49, P<.10); and year, significant difference between subjects who received dialectical behavior therapy and control subjects (z = 1.70, P<.05). The number of hospitalized subjects who received dialectical behavior therapy were as follows: 0 to 4 months (n = 6), 4 to 8 months (n = 5), 8 to 12 months (n = 3), and year (n = 8). The number of hospitalized control subjects were as follows: 0 to 4 months (n = 9), 4 to 8 months (n = 7), 8 to 12 months (n = 7), and year (n = 12).*

Linehan et al. (1991). Arch Gen Psychiatry, 48, 1060-1064

Dialectical behavior therapy

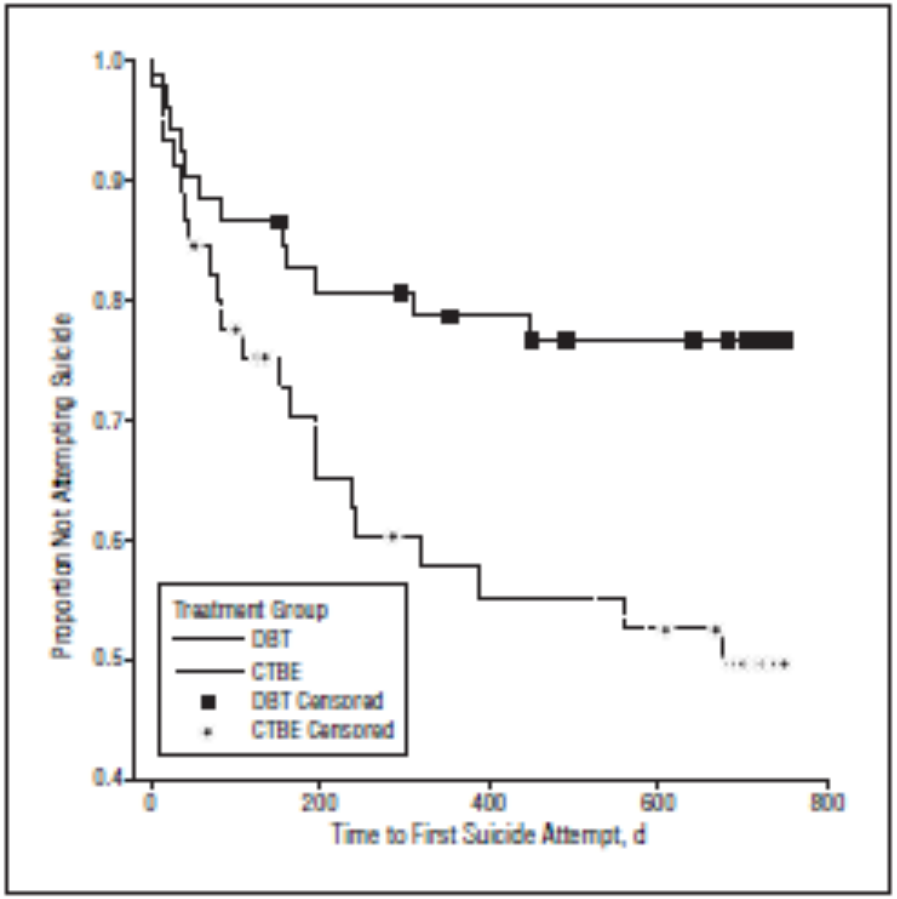


Figure 3. Survival analysis for time to first suicide attempt. The treatment period ended at 365 days, and the follow-up period ended at 730 days. CTBE indicates community treatment by experts; DBT, dialectical behavior therapy.

Linehan et al. (2006). Arch Gen Psychiatry, 63, 757-766

Dialectical behavior therapy

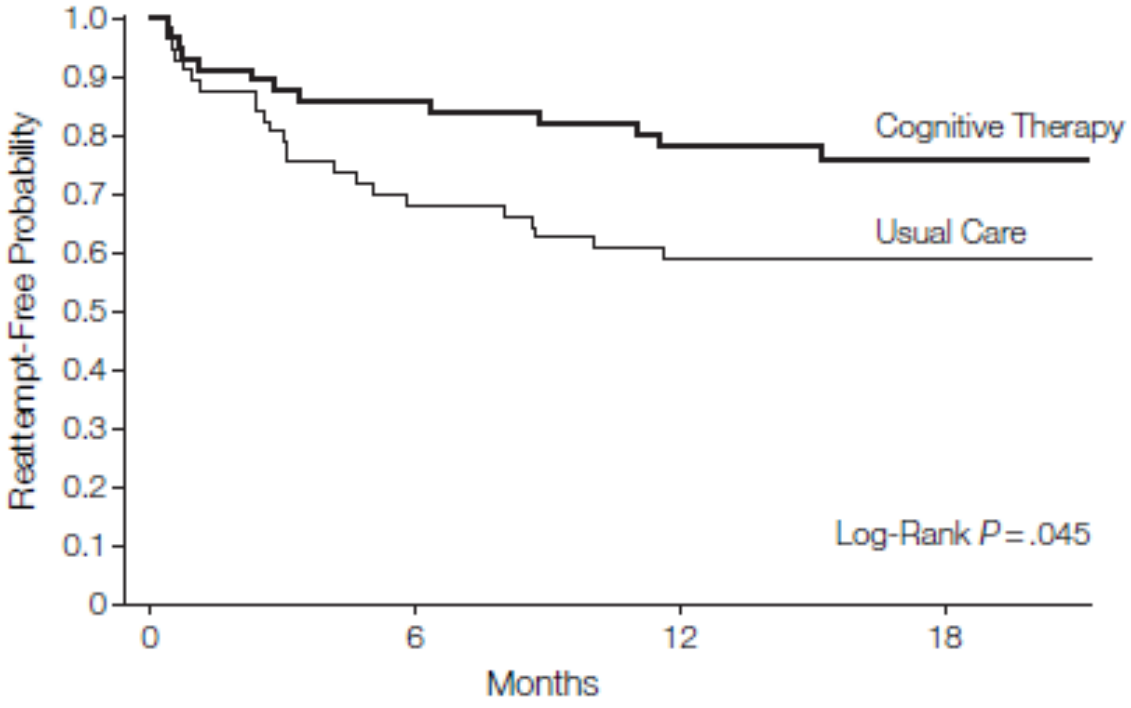
Table 4. Longitudinal Outcome Measures for the Dialectical Behavior Therapy (DBT) and Community Treatment by Experts (CTBE) Groups*

	Pretreatment		12-mo Posttreatment		24-mo Follow-up		Δ in Slopes	
Variable	DBT Group (n = 52)	CTBE Group (n = 49)	DBT Group (n = 50)	CTBE Group (n = 39)	DBT Group (n = 45)	CTBE Group (n = 35)	F	*P* Value
Highest medical risk†	7.1 ± 4.9	8.8 ± 4.9	5.0 ± 4.2	7.4 ± 5.6	. . .	. . .	3.2	.04
Suicide ideation	51.7 ± 20.3	59.9 ± 21.6	29.8 ± 24.5	32.8 ± 26.3	24.1 ± 19.8	31.92 ± 26.8	0.2	.31
Reasons for Living Inventory								
Mean total item score	2.8 ± 0.7	2.7 ± 0.9	3.2 ± 0.9	3.0 ± 0.8	3.3 ± 0.9	3.1 ± 0.8	0.9	.17
Survival and coping	2.7 ± 0.9	2.7 ± 1.0	3.4 ± 1.2	3.3 ± 1.2	3.7 ± 1.0	3.3 ± 1.4	1.4	.12
Hamilton Rating Scale for Depression–17 item	20.2 ± 5.9	21.7 ± 7.3	14.0 ± 7.3	17.0 ± 8.2	12.6 ± 6.8	14.4 ± 9.1	0.0	.43

Linehan et al. (2006). Arch Gen Psychiatry, 63, 757-766

Cognitive therapy

Figure 2. Survival Curves of Time to Repeat Suicide Attempt



No. at Risk				
Cognitive Therapy	60	45	37	16
Usual Care	60	36	28	11

Brown et al. (2005). JAMA, 294, 562-570

Cognitive therapy

Table 2. Impact of Cognitive Therapy on Secondary Outcome Measures

		Assessment Period, mo				
	Baseline	1	3	6	12	18
Beck Depression Inventory II						
Cognitive therapy, mean (SD)	32.87 (12.03)	21.80 (15.48)	19.96 (14.82)	13.82 (12.34)	13.59 (13.40)	14.51 (12.90)
Usual care, mean (SD)	31.03 (15.70)	21.66 (15.14)	21.19 (14.92)	19.33 (15.61)	18.73 (14.87)	18.18 (13.75)
Effect (95% CI)		–0.3 (–5.1 to 4.5)	–2.2 (–7.0 to 2.60)	–6.0 (–10.9 to –1.1)	–6.7 (–11.7 to –1.7)	–5.4 (–10.6 to –0.1)
t Score		0.13	0.89	2.41	2.63	2.00
P value		.90	.37	.02	.009	.046
Hamilton Rating Scale for Depression						
Cognitive therapy, mean (SD)	26.88 (10.04)	19.89 (10.88)	17.40 (11.22)	14.70 (11.05)	15.08 (11.44)	13.09 (9.96)
Usual care, mean (SD)	26.08 (10.62)	19.05 (12.65)	19.33 (11.13)	17.83 (13.27)	16.27 (13.82)	14.55 (11.64)
Effect (95% CI)		0.9 (–3.2 to 5.0)	–2.1 (–6.2 to 2.1)	–3.5 (–7.7 to 0.7)	–3.0 (–7.3 to 1.3)	–3.0 (–7.5 to 1.5)
t Score		0.44	0.98	1.64	1.37	1.13
P value		.66	.33	.10	.17	.19
Beck Hopelessness Scale						
Cognitive therapy, mean (SD)	11.48 (5.45)	9.09 (5.91)	7.45 (4.99)	5.57 (4.47)	6.57 (5.76)	6.07 (5.28)
Usual care, mean (SD)	11.81 (6.25)	8.71 (6.59)	9.06 (6.98)	8.21 (6.96)	8.22 (6.77)	7.24 (6.35)
Effect (95% CI)		0.8 (1.1 to 2.6)	–1.3 (–3.5 to 0.9)	–2.0 (–4.0 to 0)	–1.7 (–4.0 to 0.5)	–1.3 (–3.7 to 1.0)
t Score		0.84	1.16	2.01	1.51	1.14
P value		.40	.24	.045	.13	.25
Scale for Suicide Ideation*						
Cognitive therapy, No. (%)	60 (65.0)	54 (44.4)	52 (38.5)	50 (24.0)	49 (20.4)	45 (15.6)
Usual care, No. (%)	60 (65.0)	56 (46.4)	54 (44.4)	52 (30.8)	49 (24.5)	40 (22.5)
OR (95% CI)		1.0 (0.4 to 2.7)	0.8 (0.3 to 2.1)	0.7 (0.2 to 2.4)	0.8 (0.2 to 2.4)	0.6 (0.2 to 2.2)
P value		.99	.66	.49	.63	.41

Abbreviations: CI, confidence interval; OR, odds ratio.
*Indicates greater than zero.

Brown et al. (2005). JAMA, 294, 562-570

Brief Cognitive Behavioral Therapy (BCBT)

ASPIRE-1 Team

(Army Suicide Prevention & Intervention Research at Evans)

University of Utah

M. David Rudd, PhD, ABPP (PI)
Craig J. Bryan, PsyD, ABPP (PM)
Kim Arne, LMSW (Therapist)
Sharon Stone, LCSW (Therapist)
Sean Williams, LMSW (Evaluator)

UTHSCSA

Alan L. Peterson, PhD, ABPP (Co-I)
Jim Mintz, PhD (Biostat)
Stacey Young-McCaughan, RN, PhD (Co-I)
Deanne Hargita (Regulatory)

Ft. Carson

Evelyn Wertenberger, PhD, LCSW (Site PI)
MAJ Jill Breitbach, PsyD (Collaborator)
Travis Bruce, MD (Collaborator)
LTC Erin Wilkinson, PsyD (Collaborator)
Kenneth Delano, PhD (Collaborator)

Army Warrior Resiliency Program

COL Bruce Crow, PsyD (Consultant)
MAJ Monty Baker, PhD (Consultant)

Phase I:

Crisis management, distress tolerance

Phase II:

Cognitive restructuring of suicidal belief system, problem solving, cognitive flexibility

Phase III:

Relapse prevention

How BCBT differs from TAU

TAU (*n* = 75)

- Suicide as symptom of psychiatric dx
- Focus on psych dx
- Emphasizes external sources of self-mgt, including hospitalization
- Clinician responsibility for preventing suicide

BCBT (*n* = 75)

- Suicide as problem distinct from psych dx
- Focus on suicide risk
- Emphasizes internal sources of self-mgt to minimize hospitalization
- Shared patient-clinician responsibility for preventing suicide

Competency-based progress

- Progress through treatment is determined based on patient skill mastery
- Patient must demonstrate skill mastery for each phase before progressing to next phase
- If patient demonstrates insufficient skills mastery at later phase, clinician returns to earlier phase
- Final competency check is relapse prevention task

(Bryan et al., 2011)

Phase I: Emotion Regulation

Primary tasks

1. Describe treatment
2. Conduct assessment of index suicidal episode
3. Educate patient about suicidal mode
4. Develop crisis response plan
5. Develop treatment plan & obtain commitment
6. Emotion regulation skills training

Session 1

Describing the treatment

- Cognitive behavioral session structure (mood checks, agenda setting, homework, skills training)
- 3 phases of treatment
- Confidentiality
- Role of family members and/or supportive others

Session structure facilitates emotion regulation for patients

Session 1

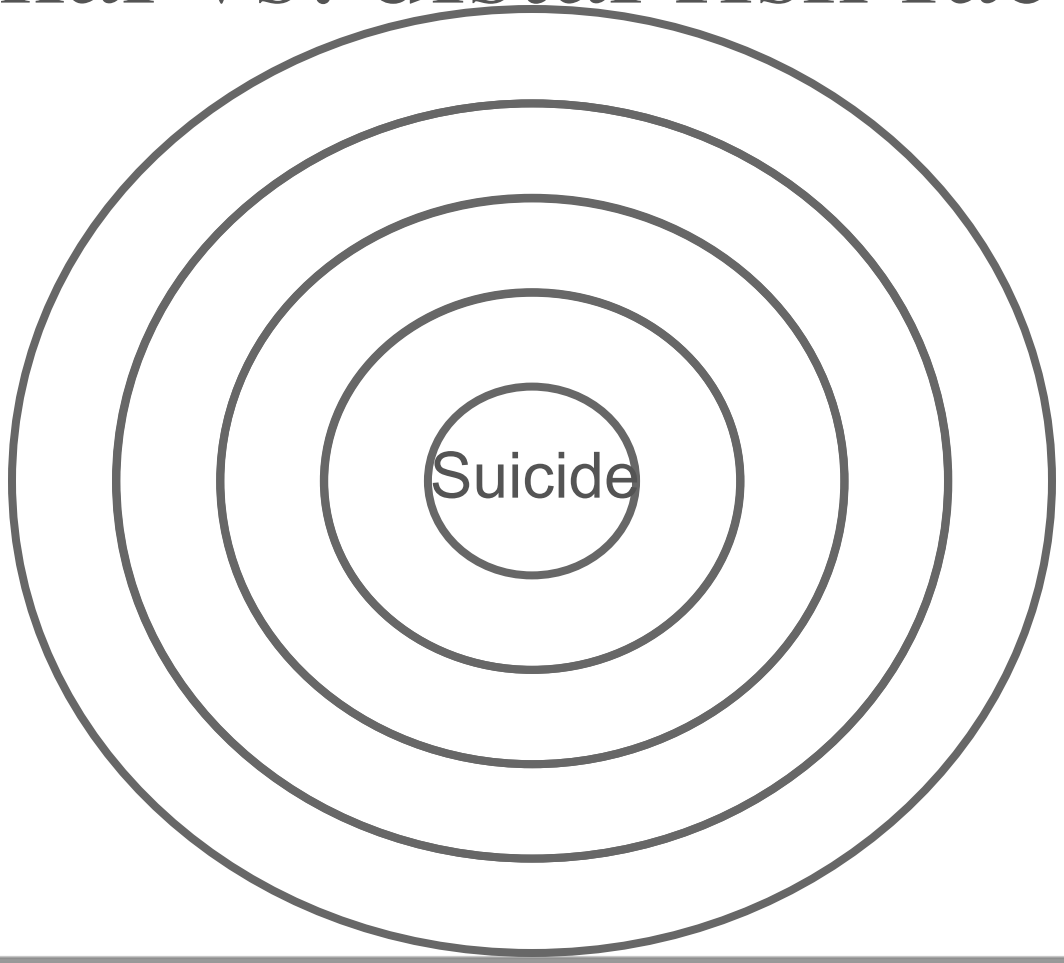
Index suicidal episode assessment

- Ask patient to describe the chronology of events for the suicidal episode that led up to treatment
  - "Let's talk about the day you attempted suicide. Can you tell me what happened on that day?"
- Assess events, thoughts, emotions, physical sensations, and behaviors in order
  - "What happened next?" / "And then what happened?"
- Remain focused on the index suicidal episode

Table 4. Factors Associated With an Increased Risk for Suicide

Suicidal thoughts/behaviors
Suicidal ideas (current or previous)
Suicidal plans (current or previous)
Suicide attempts (including aborted or interrupted attempts)
Lethality of suicidal plans or attempts
Suicidal intent
Psychiatric diagnoses
Major depressive disorder
Bipolar disorder (primarily in depressive or mixed episodes)
Schizophrenia
Anorexia nervosa
Alcohol use disorder
Other substance use disorders
Cluster B personality disorders (particularly borderline personality disorder)
Comorbidity of axis I and/or axis II disorders
Physical illnesses
Diseases of the nervous system
Multiple sclerosis
Huntington's disease
Brain and spinal cord injury
Seizure disorders
Malignant neoplasms
HIV/AIDS
Peptic ulcer disease
Chronic obstructive pulmonary disease, especially in men
Chronic hemodialysis-treated renal failure
Systemic lupus erythematosus
Pain syndromes
Functional impairment
Psychosocial features
Recent lack of social support (including living alone)
Unemployment
Drop in socioeconomic status
Poor relationship with family[a]
Domestic partner violence[b]
Recent stressful life event
Childhood traumas
Sexual abuse
Physical abuse
Genetic and familial effects
Family history of suicide (particularly in first-degree relatives)
Family history of mental illness, including substance use disorders
Psychological features
Hopelessness
Psychic pain[a]
Severe or unremitting anxiety
Panic attacks
Shame or humiliation[a]
Psychological turmoil[a]
Decreased self-esteem[a]
Extreme narcissistic vulnerability[a]
Behavioral features
Impulsiveness
Aggression, including violence against others
Agitation
Cognitive features
Loss of executive function[b]
Thought constriction (tunnel vision)
Polarized thinking
Closed-mindedness
Demographic features
Male gender[c]
Widowed, divorced, or single marital status, particularly for men
Elderly age group (age group with greatest proportionate risk for suicide)
Adolescent and young adult age groups (age groups with highest numbers of suicides)
White race
Gay, lesbian, or bisexual orientation[b]
Additional features
Access to firearms
Substance intoxication (in the absence of a formal substance use disorder diagnosis)
Unstable or poor therapeutic relationship[a]

Proximal vs. distal risk factors



Previous suicide attempts

- Emphasis on intent:
  - "What did you hope would happen?"
  - "Did you want to die?"
  - "Were you happy to be alive, or did you wish you were dead afterwards?"
- Establish patterns: first, worst, most recent
- "Worst-point" suicidal episode (Joiner, Steer, Brown, Beck, Pettit, & Rudd, 2003)

Precipitant / triggering event

- Almost always some sort of perceived loss

Symptomatic presentation

- Depressed mood
- Hopelessness
- Perceived burdensomeness
- Thwarted belongingness
- Agitation
- Insomnia

Nature of suicidal thinking

- Resolved plans & preparation
- Suicidal desire & ideation

RPP	SDI
Sense of courage	Reasons for living
Availability of means	Wish for death
Opportunity	Frequency of ideation
Specificity of plan	Desire and expectancy
Duration of suicidal ideation	Lack of deterrents
Intensity of suicidal ideation	Suicidal communication

Nature of suicidal thinking

– Suicidal intent: subjective vs. objective

Objective

- Isolation
- Likelihood of intervention
- Preparation for attempt
- Planning
- Writing a suicide note

Subjective

- Self-report of desired outcome
- Expectation of outcome
- Wish for death
- Low desire for life

Intent

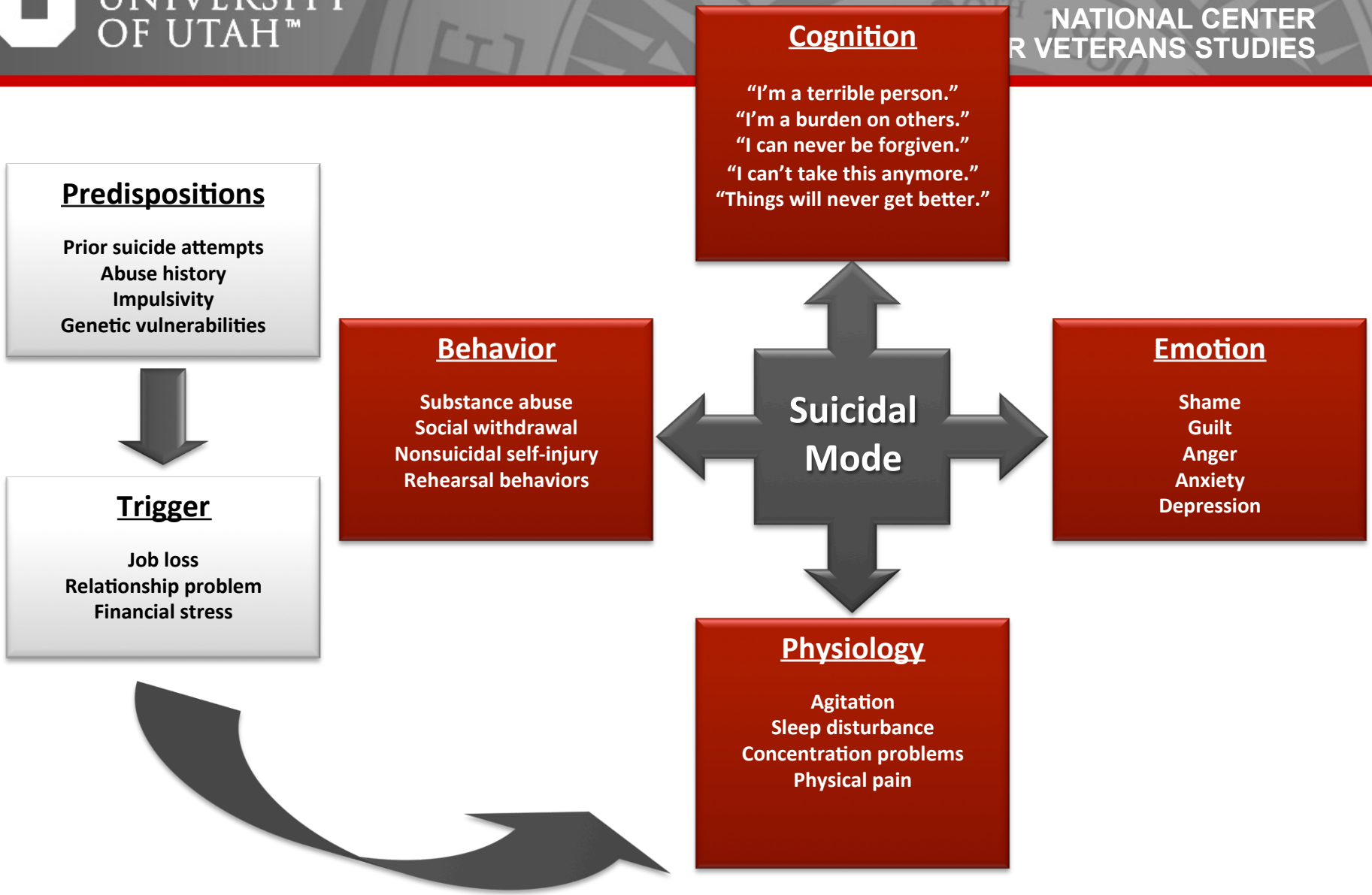
Ideation

Objective

- Sensation seeking
- Availability of means
- Preparatory behavior
- Planning
- Writing a suicide note
- Intensity of suicidal ideation

Subjective

- Perception of burden
- Expectation of outcome
- Wish for death
- Desire and expectancy
  - Lack of deterrents
  - Suicidal communication

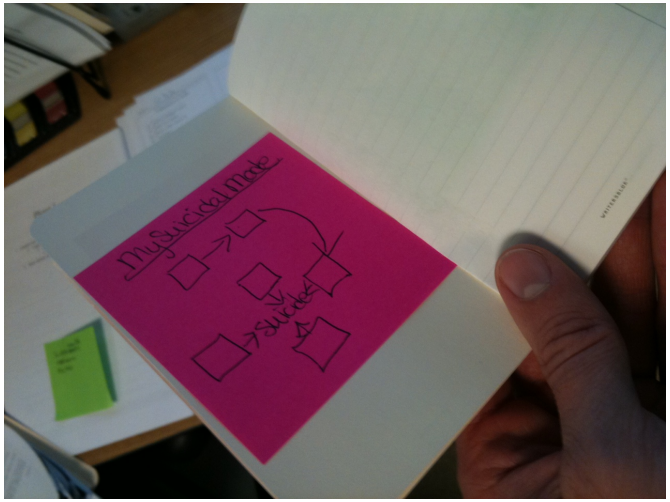

Cognition
"I'm a terrible person."
"I'm a burden on others."
"I can never be forgiven."
"I can't take this anymore."
"Things will never get better."
Predispositions
Prior suicide attempts
Abuse history
Impulsivity
Genetic vulnerabilities
Behavior
Substance abuse
Social withdrawal
Nonsuicidal self-injury
Rehearsal behaviors
Suicidal Mode
Emotion
Shame
Guilt
Anger
Anxiety
Depression
Trigger
Job loss
Relationship problem
Financial stress
Physiology
Agitation
Sleep disturbance
Concentration problems
Physical pain

Session 1

Educate patient about suicidal mode

- Describe suicidal mode in understandable language
- Diagram suicidal mode for patient and “fill in” based on information obtained from patient
- Direct patient to draw mode in treatment log

Session 1



Treatment log

- Provide treatment log to patient
- Explain rationale:
  - Understanding patterns in past events
  - Regulating emotions
  - Maintaining perspective of health
  - Relapse prevention
- Patients should record their “lessons learned” from each session in the log

Session 1

Crisis response plan

- Explain rationale for CRP
- Provide card for patient to record CRP
- Identify personal warning signs
- Identify self-management strategies
- Identify social supports
- Provide crisis / emergency steps
- Verbally review and rate likelihood of use

Other Phase I components

Means restriction counseling

- Ask every patient about access to lethal means
- Specifically ask every patient about firearms access
- Provide means restriction counseling
- Develop a written plan for means restriction
- Be cautious about engaging in power struggles with patients about access to means
  - Emphasize shared goal of pain reduction and suffering alleviation, not suicide prevention or means restriction

(Bryan, Stone, & Rudd, 2011)

Other Phase I components

Commitment to treatment statement

- Review in detail with patient – approach as discussion, not as lecture or "contract"
- Discuss how treatment is defined and what is expected of patients
- Allow patient to add their personal expectations of you as the clinician
- Keep copy, give original to the patient

Other Phase I components

Treatment plan

- Suicide risk should be #1 priority – couch in terms of suffering reduction and goal acquisition
- Prioritize symptom hierarchy to be targeted
- Create goals that are specific, measurable, and behavioral in nature

Remember that the primary goal of Phase I is emotional regulation, not cognitive restructuring

Patients must first learn how to manage their suffering before they can change how they view themselves and others

When teaching patients new skills, always be sure to explain the rationale for the skill, and explicitly tie it to the suicidal mode (i.e., suffering reduction)

Always practice skills in session to facilitate mastery, and assist patients in recognizing how skills serve to reduce suffering

Emotion regulation strategies

- Relaxation training
- Mindfulness training
- Reasons for living list
- Survival kit
- Sleep hygiene / stimulus control

Reasons for living (RFL) list

- Provide patient with an index card
- Ask them to think about what is worth living for
- Ask follow-up questions to increase the emotional vividness and specificity of the memory
- Record the RFL onto the card
- Practice thinking about the RFL
- Ask patient to think about a stressful situation and then think about their RFL

Survival kit

- Direct patients to obtain a container (e.g., shoe box, envelope, tackle box)
- Patient should fill container with items that cue positive emotional states (e.g., quotes, pictures, souvenirs, gifts, etc.)
- Patient brings container into therapy and reviews each item with clinician
  - "Tell me about this item."
  - Screen out potentially harmful or iatrogenic items

Sleep hygiene & stimulus control

- Educate patient about healthy sleep habits
- Identify sleep behaviors for potential modification
- Develop plan and commitment for changing sleep behaviors
- Provide sleep diaries to track progress

Phase II: Problem Solving & Cognitive Reappraisal

Primary tasks

1. Review and rehearse emotion regulation strategies in order to generalize across situations
2. Target core beliefs and behaviors that contribute to the suicidal mode
3. Undermine shame and guilt
4. Teach patients how to consider alternatives to learned behavioral and cognitive patterns

Phase II strategies

- ABC worksheets
- Challenging beliefs worksheets
- Behavioral activation
- Coping cards

ABC worksheet

A **Activating Event** *What is going on?* *What happened?*	B **Belief** *What do I say to myself?* *What goes through my mind?*	C **Consequence** *What do I feel as a result?* *What emotion to I feel?*

Are the thoughts in "B" reasonable? Why or why not?_____

_____

_____

What is something else I can tell myself in the future when I'm having these thoughts or am in this situation again? _____

_____

_____

Challenging beliefs worksheet

1. What is the evidence for and against this belief?
   FOR:
   AGAINST:
2. Is this belief based on facts, or is it something you've just gotten used to saying?
3. Is it possible that you are misinterpreting or misunderstanding the situation?
4. Are you thinking in all-or-none terms?
5. Are you using words or phrases that are extreme or exaggerated (i.e., always, forever, never, need, should, must, can't, and every time)?
6. Are you ignoring the bigger picture by focusing on only one aspect of what happened?
7. Is your belief based on a reliable source of information?
8. Are you confusing a low probability event with a high probability event?
9. Are your judgments based on feelings or on facts?
10. Are you focused on factors that don't have much to do with the situation?

Behavioral Activation

- Identify enjoyable or meaningful activities
  - "Are there things you used to enjoy doing that you no longer do?"
- Develop a specific plan for resuming or increasing activities (location, date, time, with whom, etc.)
- Problem solve potential barriers
- Ask patient to rate likelihood of doing it

Coping cards

- Build off of previous cognitive and behavioral interventions
- Similar to crisis response plan
- Ask patient to record thought, behavior, or skill onto index card to cue rehearsal
- Card should be rehearsed regularly, even in situations not being targeted

Phase III: Relapse Prevention

Primary tasks

1. Conduct relapse prevention task repeatedly
2. Review index suicidal episode several times until patient demonstrates ability to problem solve
3. Develop hypothetical future crises and conduct imaginal exposure with patient imagining effective use of problem solving skills

Relapse prevention task

- Educate patient about relapse prevention task
- Answer questions and address concerns
- Instruct patient to remain in present tense
- Prompt patient during task to increase emotional vividness and specificity
- As patient demonstrates competency, increase complexity and difficulty of task
- Process task following completion

Final session

1. Review treatment log contents
2. Determine final “lesson learned” for treatment log
3. Educate patient on follow-up procedures as needed
4. Provide patient with token of treatment completion (e.g., coin, certificate, etc.)


Commitment is the stuff character is made of
THE
UNIVERSITY
OF UTAH

Early observations

- Service members take numerous medications
- Providing patients with treatment log (or “smart book”) is a highly effective method for obtaining buy-in, skills training, and relapse prevention
- Framing treatment as occupational skills training
- Phase I must target emotion regulation
- Guilt/shame common themes & targets of Phase II
- BCBT appears to retain patients at a higher rate
- Combat exposure /trauma are distal contributors

Questions?

Craig J. Bryan, PsyD, ABPP
craig.bryan@psych.utah.edu

NCVS website: veterans.utah.edu
Like us on Facebook: www.facebook.com/Veterans.Studies

NATIONAL CENTER FOR VETERANS STUDIES
THE UNIVERSITY OF UTAH