

Brief Cognitive Behavioral Therapy (BCBT) for Suicidality in Military Populations

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This article describes a set of “common elements” underlying a new approach to the clinical management and treatment of suicidality and provides a general description of brief cognitive behavioral therapy (BCBT) in treating suicidality in military populations. BCBT was developed and adapted to the unique treatment environment of a military setting, one that limits the ability to offer intensive and enduring psychotherapy. BCBT offers a unique alternative to traditional psychotherapy, to reduce suicidal behavior and improve the patient’s ability to more fully participate in longer-term therapy for targeted Axis I and II disorders like post-traumatic stress disorder and/or major depression.

SUICIDALITY IN ACTIVE DUTY MILITARY PERSONNEL AND VETERANS

Suicide is among the most challenging mental health issues faced by the military today. Suicide has been the second leading cause of death in the U.S. military, exceeding the number of combat-related losses in both Iraq and Afghanistan (U.S. Department of Defense, 2012). Since 2008, suicide rates for active-duty personnel exceeded those for comparable-age civilians (Kang & Bullman, 2008). This trend is noteworthy when we consider that the military accession process routinely screens out individuals with serious mental illness, rendering military service as a protective factor for suicide among males in the populations.

Other data indicate parallel trends in suicide risk among veterans, with veterans being twice as likely to die by suicide, regardless of whether or not they were receiving health care from the VA (U.S. Department of Veterans Affairs, 2008). More recent data indicate a marked increase in suicide risk among veterans being treated for depression, with the risk being seven to eight times greater than that for the general adult population in the United States (U.S. Department of Veterans Affairs, 2008). Similarly, recent revelations about suicide and suicide attempt rates among active duty personnel and veterans have been alarming, with estimates as high as 18 suicides a day among veterans (U.S. Department of Veterans Affairs, 2008). Recent data on traumatic brain injury (TBI) are also of concern, indicating suicide rates in the range of three to four times the general population, and lifetime suicide attempt rates of 8%, along with significant rates of suicidal ideation (23%) (Simpson & Tate, 2002).

Although risk factors identified in military populations and veterans have generally been consistent with those in comparable-age civilian populations (Boscarino, 2006; Jackupcak et al., 2009; Pietrzak et al., 2010; Rudd, under review; Rudd, Goulding, & Bryan, 2011), there are several critical points of divergence when considering implications for clinical care in military settings. First, the nature of post-trauma symptoms is remarkably different (i.e., predominantly combat-related specific during wartime) and appears to play a more profound role than originally thought, with many of the symptoms being consistent with previously identified “warning signs” for suicide (Rudd, under review; Rudd et al., 2006). Second, ease of access to weapons is a unique and considerable challenge in a military environment, potentially elevating risk in rare fashion. And third, the military setting itself offers a host of unique challenges for clinical management and treatment, with most revolving around access and availability for long-term, intensive, or frequent care given the heavy day-to-day demands of the unit mission during wartime and the consequences of deployed units on those remaining in garrison.

Cognitive therapy has a number of distinctive elements, including being short-term, active, directive, structured, and collaborative, with a core theme being the development of individual understanding, coping, and mastery of skills essential for day-to-day living (Beck, 1967; 1973; 1976). Brief Cognitive Behavioral Therapy (BCBT) represents a natural extension of cognitive behavioral therapy across a number of domains (Rudd & Bryan, under review). Most importantly, BCBT is a compact, time-limited treatment option that specifically targets suicidality (i.e., suicidal thoughts and related behaviors) regardless of diagnosis (Axis I or Axis II). BCBT can facilitate better long-term care for targeted Axis I disorders, since the patient will be able to more effectively self-manage and, accordingly, participate more fully in ongoing psychotherapy. As a result, BCBT has considerable potential as an adjunctive treatment for major depression and post-traumatic stress disorder, among a host of other Axis I diagnoses. BCBT

integrates the “common elements” of treatments that have been demonstrated to be effective with suicidality, with a particular focus on the development of self-management and emotion regulation skills, along with an emphasis on individual responsibility for care. In the section that follows, I provide an overview of the common elements of effective care underlying BCBT approaches to suicidality. Next, I provide an overview of BCBT and conclude with recommendations for research and practice.

Common Elements of Effective Care for Treating Suicidality

Approximately 60 clinical trials have been conducted to target suicidality (Rudd, Williams, & Trotter, 2008). About 30 of these trials are grounded in a cognitive-behavioral orientation and only 1 has targeted suicidality in military personnel (Rudd et al., 1996). Given the variable nature of symptomatology associated with suicide risk, particularly suicidal ideation, the best and most accurate marker of lower risk following treatment is a reduction in suicide attempts during the follow-up period (cf. Rudd, Joiner, & Rajab, 2004). Rudd et al. (2004) identified nine studies with a cognitive behavioral therapy (CBT) focus or orientation (Brown et al., 2005; Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard 1991; Linehan, Comtois, & Korslund, 2004; McLeavey, Daly, Ludgate, & Murray, 1994; Nordentoft et al., 2002; Salkovkis, Atha, & Storer, 1990; van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005) that were effective in treating suicidality. In reviewing the treatment protocols for these studies, they identified a cluster of techniques, clinical management strategies, and targeted interventions that provide the empirical foundation for BCBT. These common elements include: (1) developing an easy-to-understand model of suicidality; (2) focusing on treatment compliance; (3) targeting identifiable skills; (4) ensuring patients take responsibility for treatment; (5) guaranteeing access to crisis and emergency services; (6) documenting patient-therapist agreement on treatment strategy. The sections below elaborate on the common elements we identified that we believe can save lives in clinical practice with suicidal patients.

1. Develop an easy-to-understand model of suicidality. Effective treatments have clearly articulated, well-defined, and understandable theoretical models of suicidality that are derived from empirical research. These models are simple, straightforward, and easily understood by the patient. Models identify cognitions, emotional processing, and associated behavioral responses critical to understanding motivation to die, and they identify associated distress (and symptoms) that can ultimately change the suicidal process. These models distill thoughts, feelings, and behaviors associated with suicide risk and hopelessness for patients. Models also recognize the role of developmental history and provide a developmental context for suicidal behavior that helps patients understand that

suicidality is often the result of a lifelong trajectory of poor coping, and not just an acute response to wartime stress (e.g., Ritchie, Keppler, & Rothberg, 2003).

An easy-to-understand model of suicidality can facilitate understanding, the collaborative nature of care, and eventual compliance. An example of one such model, developed by Rudd, Joiner, and Rajab (2004) is depicted in Figure 1. Such a model can be useful in prompting key questions and topics for treatment. When a treatment model is simple, straightforward, easy to understand, and provides developmental context, does it facilitate hope, improve motivation, and result in better compliance? If so, the net outcome would be enhanced skill development, reduced symptom severity, and fewer subsequent suicide attempts. Since this is one of the common elements of treatments that work, current data would suggest this may well be the case.

As previously noted, Figure 1 identifies the developmental trajectory that generated “natural vulnerabilities” or predispositions to suicidal behavior as a coping response when significantly stressed. In short, having a graphical representation of

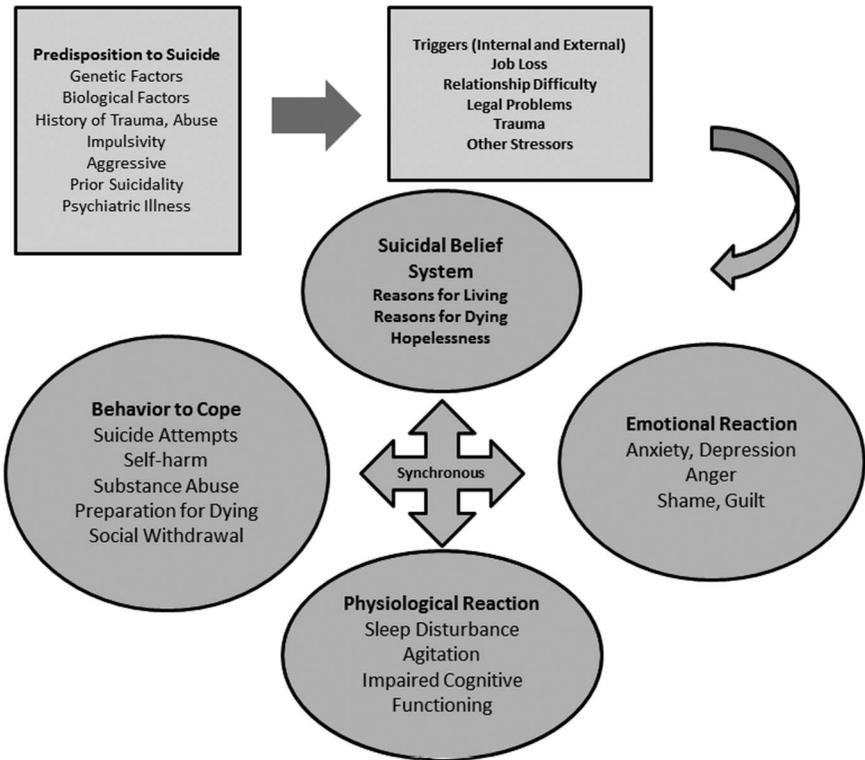


FIGURE 1 The suicidal mode for BCBT.

the suicidality model makes it easy to sit down with a patient and explain in understandable language why they have tried or are thinking about killing themselves, readily identifying treatment targets in each of the domains, and recognizing the role of developmental history. It is worth noting that the data required to construct such models can be obtained from a suicide risk assessment interview.

2. Focus on treatment compliance. Effective treatments target treatment compliance in a specific and consistent fashion. Treatment should include specific interventions and techniques that target poor compliance and motivation for treatment. When a patient is disengaged, noncompliant, and not participating in care, that very dynamic can become the primary focus of treatment. Treatment is only effective if the patient is active, involved, and invested. Just as suicidal behavior needs to be a primary target, motivation and investment in care is important. When motivation, investment, and involvement drop, they need to become a primary treatment target until effectively resolved. Therefore, effective treatments should include clear plans about “what to do” if noncompliance emerges. Often, noncompliance is simply a function of inadequate skills on the part of the patient. Additionally, effective treatments integrate developmental history factors into the model to help patients see that suicidal behavior develops and becomes entrenched over the course of many years, not just the current episode or crisis.

3. Target identifiable skills. Effective treatments target clearly identifiable skill sets (e.g., emotion regulation, anger management, problem solving, interpersonal relationships, cognitive distortions) that enable patients to understand what is “wrong” and “what to do about it” in order to reduce suicidal thinking and behaviors. Effective treatments also provide patients with the opportunity to practice and build skill sets over time, with a long-term goal being skill generalization. BCBT targets two primary skill domains including self-management and emotion regulation.

4. Ensure patients take personal responsibility for treatment. Effective treatments emphasize self-reliance, self-awareness, self-control, and issues of personal responsibility. Effective treatments clarify that if patients develop appropriate skills, the distress and upset caused by early events can be diminished and associated suicidal urges will eventually subside. Consistent with these goals, patients assume a considerable degree of personal responsibility for their care, to include crisis management and individual safety (i.e., means restriction), which are consistent with the issue of improved compliance and motivation for care. Although there are a range of models available for facilitating compliance and crisis management, clinicians should consider use of the commitment to treatment agreement (CTA) and the crisis response plan (CRP), as both are essential elements in BCBT (Rudd, Mandrusiak, & Joiner, 2006).

5. *Guarantee easy access to crisis and emergency services.* Effective treatments emphasize the importance of crisis management and accessibility to available emergency services during and after treatment, with a clear plan of action being identified. Additionally, effective treatments more often than not dedicate time to practicing the skills sets necessary to effective crisis management, with patients learning to identify what characterizes a “crisis or emergency,” using a “safety” or “crisis management plan,” and learning to use these services in judicious and appropriate fashion.

6. *Document patient-therapist treatment plan in plain writing.* Effective treatments consistently document what happens in treatment, from the initial model of suicidality, to the commitment to treatment agreement, to the crisis response plan, along with session by session notes. BCBT recognizes this common element by documenting every single aspect of care with the use of a treatment journal and repeated use of coping cards (e.g., “reasons for living” cards). Suicidal patients are highly distressed and, more often than not, functioning at nonoptimal levels, all of which impairs cognitive processing. Accordingly, an easy and effective solution is to make frequent and ready use of writing in treatment.

BCBT for Suicidality

In contrast to the majority of traditional approaches to psychotherapy, BCBT is driven by a phased approach to treatment, consistent with the skill mastery intent of cognitive therapy as originally conceptualized by Beck (1967; 1973; 1976). It is important to note, however, that a phased approach to care has been empirically supported with other clinical problem areas (Callahan, Swift, & Hynan, 2006). As noted above, suicide risk is associated with a myriad of psychiatric diagnoses, symptom constellations, and a potentially confusing array of factors. One of the most attractive features of BCBT is that it distills the focus of care into three identifiable phases, with associated treatment strategies and targeted skills, all derived from empirically supported approaches. Skill mastery revolves around two primary domains, self-management and emotional regulation. Naturally, comprehensive risk assessment and ongoing clinical management are an essential part of care (for a comprehensive review see Rudd & Bryan, under review). However, in this article we provide a general overview and discuss critical elements of BCBT for clinical practitioners.

BCBT treatment is conceptualized as having three distinct phases, each with unique treatment strategies and targeted skills (see Table 1). Progression through the identified phases is dependent on skill mastery. Skill mastery is a function of the patient’s ability to (a) demonstrate an understanding of the purpose and function of the targeted skill within the identified model of suicidality; (b) demonstrate

TABLE 1
BCBT Treatment Phases, Strategies, and Targeted Skills

<i>Treatment Phase</i>	<i>Treatment Strategies</i>	<i>Targeted Skill Set</i>
Phase I: Orientation	Commitment to treatment Crisis response and safety planning Means restriction Survival kit Reasons for living card Model of suicidality Treatment journal Lessons learned	Self-management Self-management Self-management Emotion regulation Emotion regulation Emotion regulation Emotion regulation
Phase II: Skill focus	Skill development worksheets Coping cards Demonstration Practice Skill refinement	Emotion regulation skill cluster Problem solving Mindfulness Cognitive appraisal Relaxation
Phase III: Relapse prevention	Skill generalization Skill maintenance	Problem solving Mindfulness Cognitive appraisal Relaxation

mastery in a role play with the clinician; (c) demonstrate mastery by using the targeted skill outside of session; and (d) apply the skill set to real life circumstances with consistency between clinical contacts. As a result of the mastery emphasis, patients make progress at variable rates rather than simply as a function of “sessions completed.” The BCBT treatment protocol was designed for a maximum of 12 hours of clinical contact.

Phase I: Orientation

The focus of phase I (orientation) is on the following: (a) development of basic self-management skills, (b) agreement on a model for understanding the function of the patient’s suicidal behavior, (c) motivating the patient for treatment, and (d) development of basic emotion regulation skills essential for self-management and active participation in treatment. The various treatment strategies have been described elsewhere (Rudd & Bryan, under review; Rudd, Joiner, & Rajab, 2004), so only a general description is provided here. A critical outcome of this phase involves the commitment to treatment agreement (CTA). The CTA frames the entirety of the treatment process and provides the foundation by which the patient

can take personal responsibility for care. The CTA is remarkably different from the traditional no-suicide contract, with an entirely different focus and clinical intent (Rudd, Mandrusiak, & Joiner, 2006). Although there is considerable variability across treatment agreements in clinical settings, when working with suicidal patients such an agreement should, at a minimum, include:

1. A clear statement of patient responsibilities in treatment (e.g., being on time, completing homework, actively participating during sessions, being honest, letting the clinician know in advance when he/she will not be able to make a scheduled session).
2. Integrate a crisis response and safety plan (as described below); a stated commitment to using it when a suicidal crisis emerges; and identify thresholds or behavioral markers for when a patient needs to employ the plan (e.g., “when I start looking for a method”). It is also useful to have the patient rate the “likelihood” that they will use the plan in the future (e.g., the patient can rate the likelihood of use on a five-point response scale).
3. Articulate a “commitment to living” agreement (e.g., “I understand and agree to make a commitment to living for the next 6 months, which means I will be actively involved in treatment and use my crisis response plan when necessary”), with a specific expiration date that can be renegotiated prior to the expiration date (i.e., if the agreement is in place only for a limited period of time, like 6 months). This is in sharp contrast to traditional “no-suicide contracts.”
4. Articulate specific common goals (e.g., feeling better, finding a life worth living, improving emotional regulations skills) beyond the general goal of reducing suicidal behavior in the agreement. The common goal should be consistent with the identified clinical model explaining the patient’s suicidality.
5. Articulate behaviors for which the patient has demonstrated competence and behaviors or skills that are impaired and/or facilitate repeated suicide attempts, if a patient has made multiple suicide attempts.
6. The agreement should be individualized, not formulaic, and be signed by the patient and clinician. Both should receive a copy of the signed agreement and it should become part of the treatment journal.

As mentioned above, the CTA should include a crisis response or safety plan. As with the CTA, the crisis response plan (CRP) needs to be in writing and, ideally, in a format that can be easily carried and accessed by the patient (e.g., a business card or 3 x 5 card). The crisis response plan should always have a series of steps that move from self-management to external intervention. For patients early in treatment, it is recommended that the CRP include only four steps: (1) use of a survival kit or reasons for living coping card (described in more detail below),

(2) an agreement to restrict access to methods, (3) an emergency phone number (e.g., the National Suicide Helpline at 1-800-273-TALK), and (4) a specifically identified emergency room to access if suicide risk does not resolve in the first three steps. As the patient develops additional skills, the complexity of the CRP can be modified. Means restriction counseling should always be a part of any CRP (Bryan, Stone, & Rudd, 2011).

The “survival kit” included in Table 1 is simply a collection of items that help generate hope (broadly defined) for the patient. This can include letters, photos, images, or literally an item identified by the patient. It is important for the clinician to review all items included in the survival kit, as initial efforts to compile a kit are often plagued by the patient’s lack of awareness and poor self-management skills, and then the net result is inclusion of potentially destructive items in the kit. I would encourage clinicians to always include a “reasons for living coping card” in the kit. The “reasons for living coping card” (RFL) is simply a list of reasons for living in written and accessible format. Identifying specific and multiple reasons for living helps undermine suicide intent, capitalizing on ambivalence about death that persists for the overwhelming majority of suicidal patients in active treatment. It is important to point out that if the patient has difficulty identifying reasons for living, the clinician should be directive and help compile a meaningful list, even when they are not spontaneously offered by the patient. Simply having an RFL coping card can facilitate hope, regardless of who generated the list.

The remaining treatment strategies employed during the first phase of treatment include a treatment journal and articulating a model for understanding the patient’s suicidality (both ideation and any associated behaviors). The treatment journal provides a permanent written record of care, one that is essential to effective relapse prevention. It is important for the clinician to recognize that use of the treatment journal starts in the very first session, with identification and discussion of a model for understanding the patient’s suicidality. This should be summarized in the treatment journal and complemented with session-by-session “lessons learned.” Both the clinician and patient should make frequent and ready use of the treatment journal, with it serving as an essential repository of insight, self-awareness, and skill development. The treatment journal should be an ever-present and concrete symbol of hope for the patient, the very foundation of relapse prevention.

Phases II and III focus on skill development, with the process facilitated by some simple and straightforward strategies. As mentioned above, the two primary skill domains targeted in BCBT are self-management and emotion regulation. Every single strategy used in treatment has implications for skill development in one or both of these areas. The approach to skill development, refinement, and eventual generalization is straightforward and simple. As illustrated in Table 1, the emotion regulation skill cluster includes the following skill sets: problem solving, mindfulness, cognitive appraisal, and relaxation. The clinician provides

the patient a rationale for each within the original model of suicidality; that is, demonstrating how the particular skill impacts each domain in the suicidal mode (see Figure 1). The clinician also demonstrates each skill and participates in subsequent role plays. Worksheets and coping cards are also used, particularly for cognitive appraisal and problem solving. Patient competence is determined if the patient can do the following: articulate the rationale for the targeted skill, demonstrate ability with a role play, and provide evidence of generalization and use in real-life situations. In session demonstration and practice are the cornerstones of BCBT skill development, refinement, and eventual generalization.

Summary and Conclusions

The empirical literature on treatment outcomes for suicidality is remarkably limited and relatively straightforward, with one simple conclusion: a core collection of common elements has been demonstrated to be effective with suicidal patients. BCBT integrates all of those elements into a simple approach that is easily understood by patients, making use of a combination of targeted clinical strategies and skill development exercises. The detailed treatment manual is available elsewhere (Rudd & Bryan, under review). The targeted and time-limited nature of BCBT offers unique potential for military populations given the constraints and demands of psychotherapy during high operational tempo in wartime, regardless of whether or not the soldier is deployed. BCBT has potential not only as a primary treatment for suicidality but also as an adjunctive treatment for those struggling with PTSD and major depression. In many cases, suicidality limits the patient's ability to fully engage in psychotherapy. Engaging in BCBT as a first step in an effort to reduce suicidality prior to targeted therapies like prolonged exposure or cognitive processing therapy for PTSD would certainly be intriguing to explore.

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