Brief Interventions to Prevent Suicide: An Introduction

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Essential Ingredients of Effective Interventions

1. Based on a simple, empirically-supported model
2. High fidelity by the clinician
3. Adherence by the patient
4. Emphasis on skills training
5. Prioritization of self-management
6. Easy access to crisis services

Rudd et al. (2009)
# Outpatient Suicide-Focused Treatment Trials

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Tx</th>
<th># of Sessions</th>
<th>Comparison Condition</th>
<th>Setting</th>
<th>Sample</th>
<th>Follow-Up</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown et al. (2005)</td>
<td>RCT</td>
<td>CT-SP</td>
<td>10</td>
<td>TAU</td>
<td>Outpt MH</td>
<td>Attempters, 40% male, 35 y</td>
<td>18 months</td>
<td>24% CT-SP vs. 42% TAU (50% rel. reduction)</td>
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<tr>
<td>Rudd et al. (2015)</td>
<td>RCT</td>
<td>BCBT</td>
<td>12</td>
<td>TAU</td>
<td>Outpt MH</td>
<td>Military, 87% male, 27 y</td>
<td>24 months</td>
<td>14% BCBT vs. 40% TAU (60% rel. reduction)</td>
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<tr>
<td>Gysin-Maillart et al.</td>
<td>RCT</td>
<td>ASSIP</td>
<td>3</td>
<td>TAU</td>
<td>Outpt MH</td>
<td>Attempters, 45% male, 38 y</td>
<td>24 months</td>
<td>5% ASSIP vs. 27% TAU (80% rel. reduction)</td>
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<tr>
<td>Sinyor et al. (2020)</td>
<td>Pilot RCT</td>
<td>BCBT</td>
<td>10</td>
<td>TAU</td>
<td>Outpt MH</td>
<td>Youths, 29% male 18 y</td>
<td>12 months</td>
<td>0% BCBT vs. 25% TAU</td>
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</tbody>
</table>
# Crisis Response Plan / Safety Plan Trials

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Tx</th>
<th>Comparison Condition</th>
<th>Setting</th>
<th>Sample</th>
<th>Follow-Up</th>
<th>Attempt Rates</th>
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</thead>
<tbody>
<tr>
<td>Bryan et al. (2017)</td>
<td>RCT</td>
<td>Standard CRP &amp; Enhanced CRP</td>
<td>TAU</td>
<td>ED, Outpt MH</td>
<td>Military, 78% male, 26 y</td>
<td>6 months</td>
<td>5% CRP vs. 19% TAU (76% rel. reduction)</td>
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<tr>
<td>N=97</td>
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<tr>
<td>Miller et al. (2017)</td>
<td>Quasi</td>
<td>Self-guided Safety Plan + f/u phone calls</td>
<td>TAU</td>
<td>ED</td>
<td>ED patients, 55% male, 56 y</td>
<td>12 months</td>
<td>18% SP vs. 23% TAU (20% rel. reduction)</td>
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<tr>
<td>N=1376</td>
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<tr>
<td>Stanley et al. (2018)</td>
<td>Cohort</td>
<td>Safety Plan + f/u phone calls</td>
<td>TAU</td>
<td>ED</td>
<td>Veterans, ED, 88% male, 49 y</td>
<td>6 months</td>
<td>3% SP vs. 5% TAU (45% rel. reduction)</td>
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<tr>
<td>N=1640</td>
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</tbody>
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## Functional Model of Suicide

<table>
<thead>
<tr>
<th>Reinforcement</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automatic (Internal)</td>
<td>Adding something desirable (&quot;To feel something, even if it is pain&quot;)</td>
<td>Reducing tension or negative affect (&quot;To stop bad feelings&quot;)</td>
</tr>
<tr>
<td>Social (External)</td>
<td>Gaining something from others (&quot;To get attention or let others know how I feel&quot;)</td>
<td>Escape interpersonal task demands (&quot;To avoid punishment from others or avoid doing something undesirable&quot;)</td>
</tr>
</tbody>
</table>

(Bryan, Rudd, & Wertenberger, 2012; Nock & Prinstein, 2004)
Stable and Dynamic Aspects of Suicide Risk

Multiple Attempter
Non-multiple attempter

(Bryan & Rudd, in press)

(Bryan & Rudd, 2016)
The Suicidal Mode

**Stable**

- Emotion Regulation
- Cognitive Flexibility

**Dynamic**

- Cognitive: “This is hopeless” “I'm trapped” “I'm a burden”
- Behavioral: Substance use, Social withdrawal, Preparations
- Emotional: Depression, Guilt, Anger
- Physical: Agitation, Insomnia, Pain

*Activating Events*
- Relationship problem
- Financial stress
- Perceived loss
- Physical sensation
- Negative memories

Bryan & Rudd (2018)
Brief Cognitive Behavioral Therapy for Suicide Prevention (BC BT)
Structure of BCBT

**Phase I**
- Emotion Regulation

**Session 1**
- Intake
- Narrative Risk Assessment
- Crisis Response Plan
- Means Safety Counseling

**Sessions 2-5**
- Treatment Plan
- Sleep Disturbance
- Relaxation / Mindfulness
- Reasons for Living
- Survival Kit

**Phase II**
- Cognitive Flexibility

**Sessions 6-10**
- ABC Worksheets
- Challenging Questions
- Patterns of Problem Thinking
- Activity Planning
- Coping Cards

**Phase III**
- Relapse Prevention

**Sessions 11-12**
- Relapse Prevention Task
General Structure of BCBT Session

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

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

Relapse prevention task serves as final competency check.

If patient is unable to effectively complete relapse prevention task, continue therapy until mastery is achieved.
Crisis Response Planning (CRP)
Narrative Assessment

Ask patient to describe the chronology of events for the suicidal episode that led up to the crisis

- “Let’s talk about your suicide attempt/what’s been going on lately.”
- “Can you tell me the story of what happened?”

Assess events, thoughts, emotions, physical sensations, and behaviors

- “What happened next?”
- “And then what happened?”
- “What were you saying to yourself at that point?”
- “Did you notice any sensations in your body at that point?”
Crisis Response Plan

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

Warning Signs:
- pacing
- feeling irritable
- thinking "I'll never get better"

- go for a walk 10 mins
- watch Friends episodes
- play with my dog
- think about my kids
  - vacation to beach in Florida
  - Christmas Day 2012
- call/text my Mom
  or Jennifer
- call Dr. Brown: 555-555-5555
  - leave msg w/ name, time, phone #
- 1-800-273-TALK
- go to hospital
- call 911

Crying
- wanting to hit things
- getting angry
- argument w/ wife

- play video games
- photography
- woodwork in garage
- writing
- go for walk
- games on phone
- breathing 10 mins
- listen to music
- talk to Bill
- Dr. Smith: 555-555-5555 (voicemail)
- Hot line: 1-800-273-2755
- Hospital or 911

Reasons to live:
- photography
- motorcycle rides
- kids (Matt, Katie)
- wife
-axon
- baseball
Counseling Phases

1. **Engaging**: establish collaborative working relationship

2. **Focusing**: adopt a guiding approach that is balanced between directive and following approaches

3. **Evoking**: after agreeing to discuss means safety, elicit the individual’s reasons for restricting their access

4. **Planning**: identify options, discuss multiple possibilities, weigh pros and cons of each, put it in writing

Britton, Bryan, & Valenstein (2015)
**Engaging**
I see here that you’re a gun owner. What types of guns do you own?

**Focusing**
That reminds me of something I wanted to talk about: safety. Would you be willing to talk a bit about the safety procedures you follow as a gun owner?

**Evoking**
Research suggests that households that do not follow safe storage procedures such as locking up or securing a firearm are much more likely to have gun-related fatalities. What are your thoughts about securing or locking up firearms at home?

What are your thoughts about secure gun storage in homes with children?

What are your thoughts about secure gun storage in homes with someone who is struggling with depression, PTSD, or suicidal thoughts?

**Planning**
Where does this leave you?

What do you think you might want to do about this?

A lot of people find that it’s helpful to write down their safety plan. Can I help you to create one for you and your home?
Questions?

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