Brief Cognitive Behavioral Therapy (B-CBT) For Suicidal Soldiers

Treatment Manual

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Phase 1

Objectives:

1. Conduct risk assessment / chain analysis of index episode
2. Cognitive-behavioral conceptualization
3. Crisis response planning
4. Means restriction
5. Basic distress tolerance / emotion regulation skills

Fidelity Checklist

The fidelity checklist provides specific actions and tasks that must be completed by the therapist during the first phase of B-CBT. Treatment should not progress to the second phase until all items from the Phase 1 are accomplished, and the patient has demonstrated mastery/competency of basic crisis management and emotion regulation skills.

No	Partial	Yes	*Discussion of treatment structure*
			Explained session-by-session structure for treatment
			Initial symptom/mood check
			Agenda-setting
			Review of homework and treatment log
			Skills building with practice
			Assignment of homework
			Three-phase model of treatment
			Discussed confidentiality and any identified limitations
			Discussed potential role of family members in treatment
			Explained role in crisis management, healthy social support, and skill building
			Gauged patient's understanding about structure for treatment
			Patient independently summarized understanding
			Elicited input and feedback about structure for treatment
			Provided opportunity for patient to ask questions about structure of treatment

No	Partial	Yes	*Assessment of index suicidal episodes*
			Facilitated narrative description of events leading up to index suicidal episode
			Elicited information about contributory/associated domains including:
			Role of developmental history and predisposing vulnerablities
			Triggers
			Distinguished between internal and external triggers
			Cognitions
			Explicitly discussed suicidal beliefs (e.g., motivations to die, reasons for dying)
			Emotions
			Explicitly discussed mixture of emotions (e.g., anxiety, agitation, fear, depression, guilt, shame, etc.)
			Distinguished between "learned" versus "earned" guilt and the role of forgiveness
			Behaviors / Motives
			Distinguished between behaviors that build resilience vs. those that facilitate despair and hopelessness
			Explain that the primary goal of suicidal behavior is to relieve emotional pain and suffering
			Physical symptoms
			Explicitly discussed role of physical symptoms (e.g. pain, sleep disturbance)
			Identified consistencies across suicidal crises or suicide attempts (where appropriate)
			Explicitly discussed the nature of patterned, learned behaviors

No	Partial	Yes	*Cognitive-behavioral conceptualization of suicidal crises*
			Explained concept of the suicidal mode using language that is understandable to the patient
			Integrated information from assessment into conceptualization in following domains:
			Role of developmental history and predisposing vulnerablities
			Triggers
			Distinguished between internal and external triggers
			Cognitions
			Explicitly discussed suicidal beliefs (e.g., motivations to die, reasons for dying)
			Emotions
			Explicitly discussed mixture of emotions (e.g., anxiety, agitation, fear, depression, guilt, shame, etc.)
			Distinguished between "learned" versus "earned" guilt and the role of forgiveness
			Behaviors / Motives
			Distinguished between behaviors that build resilience vs. those that facilitate despair and hopelessness
			Explain that the primary goal of suicidal behavior is to relieve emotional pain and suffering
			Physical symptoms
			Explicitly discussed role of physical symptoms (e.g. pain, sleep disturbance)
			Gauged patient's understanding of conceptualization (suicidal mode)
			Elicited agreement from patient that model is accurate reflection of patient's experience
			If patient disagreed, elicited feedback and reconceptualized model
			Encouraged patient to record written model of suicidal mode in treatment log
			Emphasized importance of using log within treatment to maintain accurate understanding of suicidality:
			Past events
			Regulating emotions
			Gaining a perspective of health

No	Partial	Yes	*Treatment planning*
			Explained rationale for treatment plan
			Elicited feedback and input from patient regarding treatment targets
			Core treatment targets emphasized skill development
			Established objective, measurable outcomes for treatment targets
			Identified symptom hierarchy when presented with a mix of prominent symptoms
			Gauged patient's understanding of treatment plan
			Set date for reviewing / revising treatment plan

No	Partial	Yes	*Commitment to treatment statement*
			Explained rationale for CTS
			Collaboratively reviewed the CTS with patient
			Must include written crisis response plan
			Elicited feedback and input from patient regarding CTS items and expectations
			Invited patient to add or modify CTS
			Gauged patient's understanding of CTS
			Set date for reviewing / revising CTS

No	Partial	Yes	*Crisis response plan*
			Written on card (or similar) that can be easily carried by patient (Written by [ ] Therapist [ ] Patient)
			Explained rationale for CRP
			Identify and discuss personal warning signs
			Explained concept of personal warning signs
			Allowed patient to generate personal warning signs themselves
			Assisted patient in identifying possible warning signs
			Listed personal warning signs on written CRP
			Self-management skills
			Explained rationale for self-management skills
			Explained role of emotion regulation and interpersonal relationship management
			Explained importance of skill development for identity, self-esteem and self-efficacy
			Collaboratively identified primary skills to be used
			[ ] Relaxation and self-soothing
			[ ] Mindfulness
			[ ] Behavioral Activation
			[ ] Active problem-solving
			[ ] Other:
			Explained how to effectively use skills
			Practiced skills in session
			External sources of support
			Explained rationale for external support
			Differentiated between healthy and unhealthy support
			Explained impact of social support on identity, self-esteem, self-efficacy
			Collaboratively identified sources of social support
			Listed names of social support
			Listed phone numbers of social support
			Listed names of professional support (e.g., health care providers)
			Listed phone numbers of professional support
			Crisis management steps
			Explained rationale for crisis management steps
			Listed phone numbers of crisis hotlines
			Listed "go to ER/hospital"
			Listed "call 911"
			Verbally reviewed all steps
			Gauged patient's understanding of CRP
			Elicited patient rating of likelihood for use
			If low patient rating, elicited feedback and revised CRP

No	Partial	Yes	*Means restriction counseling and planning*
			Explained rationale for means restriction
			Discussed impulsivity, cognitive confusion, & poor problem solving when highly distressed
			Identified potential methods for means restriction
			[ ] Firearms (disabling a weapon if unwilling to give up)
			[ ] Medications
			[ ]Other
			Explicitly asked about possession / availability of firearms
			Collaboratively engaged patient in discussion about means restriction
			Generated options for securing or disabling lethal means
			Elicited feedback and input from patient regarding preferred options for securing means
			Collaboratively agreed on plan for securing means
			Developed written plan for securing means
			Took and/or confirmed concrete steps for reducing or eliminating access to means
			Contacted social support or chain of command (where appropriate) to assist in securing means

No	Partial	Yes	*Crisis management interventions*
			Intervention selected:
			[ ] Relaxation
			[ ] Mindfulness
			[ ] Behavioral Activation
			[ ] Other:
			[ ] Active problem-solving
			Intervention delivery / skills training
			Explained rationale for skill
			Explicitly tied skill to suicidal mode / case conceptualization
			Demonstrated / modeled skill
			Practiced skill
			Gauged patient understanding and mastery of skill
			If patient was unable to master or understand, elicited feedback and retaught skill

No	Partial	Yes	*Homework*
			Explained rationale for homework
			Assigned homework equivalent to approximately 15 mins or more per day
			Used treatment journal, including role as a relapse prevention tool
			Encouraged patient to record lessons learned from the session in treatment journal
			Encouraged patient to write assignment in treatment journal

Risk Assessment Overprint

The risk assessment overprint should be used by therapists to document a patient's current level of risk at the time of intake / first appointment. Information for the risk assessment should be obtained from both self-report measures and clinical interview. Therapists should use the flow chart found on the subsequent page to assign risk level in a consistent manner within and between therapists over time.

The Beck Scale for Suicide Ideation – Current can be used to determine the absence / presence of the two factors of suicidality, suicidal desire and ideation (SDI) and resolved plans and preparations (RPP):

Suicidal Desire and Ideation (SDI)
Item 1: Wish to Live
Item 2: Wish to Die
Item 3: Reason for Living / Dying
Item 5: Passive Suicidal Desire
Item 6: Duration of Ideation
Item 7: Frequency of Ideation
Item 8: Attitude Towards Ideation
Item 10: Deterrents to Attempt

Resolved Plans and Preparation (RPP)
Item 4: Active Suicidal Desire
Item 11: Reason for Attempt
Item 12: Specificity of Planning
Item 13: Availability and Opportunity
Item 14: Capability
Item 15: Expectancy and Anticipation
Item 16: Actual Preparation
Item 17: Suicide Note
Item 18: Final Acts

S: A comprehensive suicide risk assessment was conducted due to: (check one)

__ Referral source identified suicidal symptoms or risk factors
__ Patient reported suicidal thoughts/feelings on intake paperwork/assessment tools
__ Patient reported suicidal thoughts/feelings during the appointment
__ Recent suicide-related event already occurred
__ Other: _____

Y N Suicide Ideation

- Frequency: Never Rarely Sometimes Frequently Always
- Intensity: Brief/fleeting Focused deliberation Intense rumination Other:
- Duration: Seconds Minutes Hours
- Content: _____

Y N Current Intent

- Subjective reports: _____
- Objective signs: _____

Y N Suicide plan

- When: _____
- Where: _____
- How: _____

Y N Access to means: _____

Y N Suicide Preparation: _____

Y N Suicide Rehearsal: _____

Y N History of Suicidality

- Ideation: _____
- Single Attempt: _____
- Multiple Attempts: _____

Y N Impulsivity

- Subjective reports: _____
- Objective signs: _____

Y N Substance abuse Describe: _____

Y N Significant loss Describe: _____

Y N Interpersonal isolation Describe: _____

Y N Relationship problems Describe: _____

Y N Health problems Describe: _____

Y N Legal problems Describe: _____

Y N Other problems Describe: _____

Y N Homicidal ideation Describe: _____

Protective factors :

Y N Hope for future
Y N Beliefs against suicide
Y N Other protective factors: _____
Y N Commitment to treatment
Y N Social support: _____

O: Mental Status Exam:

Alertness:	Alert	Drowsy	Lethargic	Stuporous	Other:		
Orientation:	X4	Person	Place	Time	Reason for evaluation		
Mood:	Calm	Elevated	Dysphoric	Agitated	Angry	Tearful	Other:
Affect:	Congruent	Appropriate	Flat	Blunted	Constricted	Labile	
Thinking:	Clear & Coherent		Loose	Tangential	Circumstantial		
Thought content:	WNL	Obsessions	Delusions	Death	Ideas of reference		
Speech:	WNL	Rapid	Pressured	Slow	Slurred	Incoherent	
Memory:	Grossly intact		Other:				
Reality testing:	WNL	Hallucinations		Other:			
Judgment:	WNL	Impaired					

A: DSM-IV-R Diagnosis:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

Suicide risk assessment (based on risk and protective factors above):

Category: **Baseline** **Acute** **Chronic high risk** **Chronic high risk w/ acute overlay**

Current risk level: **Not Elevated** **Mild** **Moderate** **Severe** **Extreme**

P: At the current time, outpatient care **can / cannot** provide sufficient safety and stability.

Hospitalization **is / is not** necessary based on factors above.

Patient agrees to written crisis response plan: Y N

Patient agrees to treatment plan: Y N

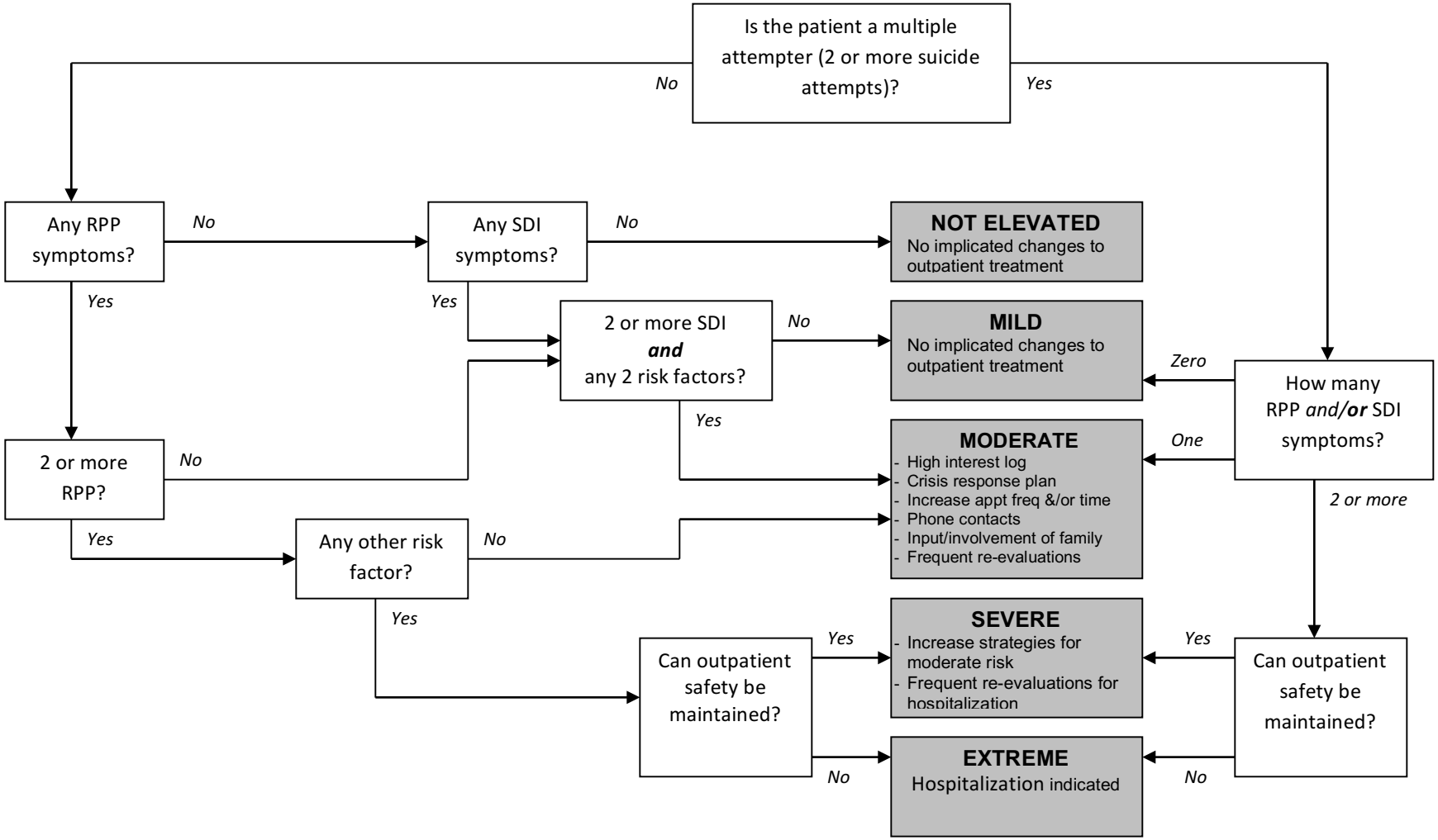
Persons notified of increased risk: Spouse / Commander / First Sergeant / PCM / Friend / Other / No one

Plan for securing access to means: _____

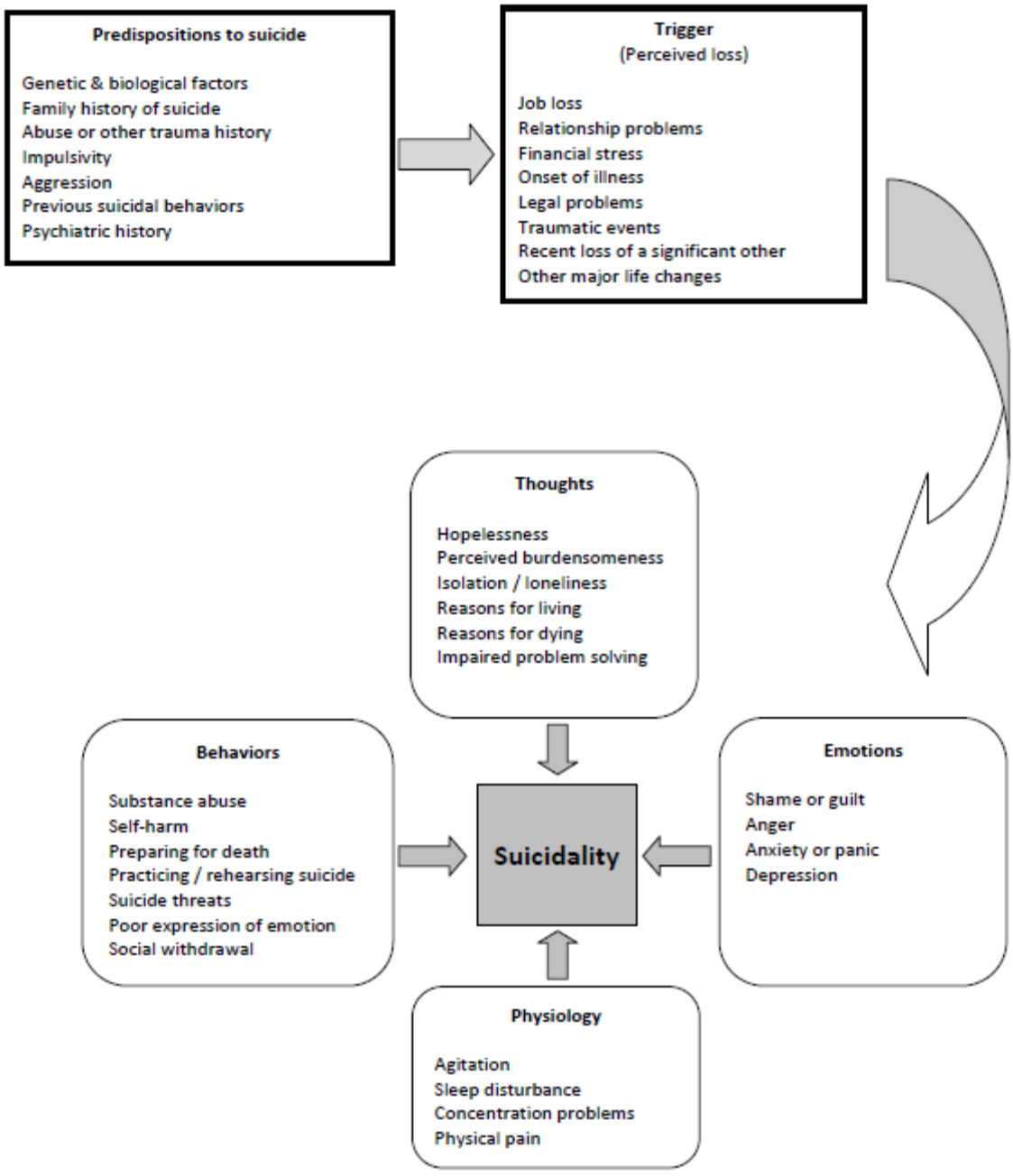
_____

_____

Additional Notes:


Is the patient a multiple attempter (2 or more suicide attempts)?
No
Yes
Any RPP symptoms?
No
Any SDI symptoms?
No
NOT ELEVATED
No implicated changes to outpatient treatment
Yes
Yes
2 or more SDI and any 2 risk factors?
No
MILD
No implicated changes to outpatient treatment
Zero
How many RPP and/or SDI symptoms?
Yes
MODERATE
- High interest log
- Crisis response plan
- Increase appt freq &/or time
- Phone contacts
- Input/involvement of family
- Frequent re-evaluations
One
2 or more RPP?
No
Yes
Any other risk factor?
No
Yes
SEVERE
- Increase strategies for moderate risk
- Frequent re-evaluations for hospitalization
Yes
Yes
Can outpatient safety be maintained?
Can outpatient safety be maintained?
EXTREME
Hospitalization indicated
No
No

The Suicidal Mode



Treatment Plan Template

The treatment plan outlines the problems to be targeted in therapy, the goals and objectives for therapy, behavioral indicators or methods for measuring progress, the interventions to be used to achieve these objectives, and the estimated number of sessions to accomplish these objectives. The treatment plan should also include a date for review, which should generally coincide with the estimated number of sessions to accomplish the goals and objectives.

Suicide potential should always be the #1 problem, with the #1 goal/objective being to reduce suicide risk and maintain outpatient safety. Interventions will include B-CBT, and should also explicitly include list the crisis response plan.

At the conclusion of each phase of treatment, a new treatment plan should be developed to reflect the new targets for treatment.

Treatment Plan for

_____

Problem #	Problem Description	Goals / Objectives & Evidence for Assessment	Intervention (Type / Frequency)	Estimated # Sessions	Outcome
1.					
2.					
3.					
4.					

Outcome: 0 – Not accomplished, 1 – Partially accomplished, 2 - Accomplished

Date established: _____ **Planned review date:** _____

Commitment to Treatment Statement

The commitment to treatment statement is intended to enhance the patient's commitment to the treatment process and living, rather than request that the patient essentially give up his or her right to die by suicide. In contrast to the notion of a contract, making a commitment to living rather than not dying sends a very different message to the patient about control and individual responsibility, both explicitly and implicitly. The focus is not on restraining or restricting rights, but on enhancing commitment to a treatment process, a process of recovery. It is also designed to facilitate increased and appropriate use of crisis services.

In addition to outlining expectations for the patient, the therapist should additionally ask the patient to identify any expectations they might have the treatment provider, so as to build a collaborative relationship. A review date for the commitment to treatment statement should be included on the form, at which time expectations can be renewed and/or modified. In general, it is recommended that the commitment to treatment statement be reviewed at the same time as the treatment plan.

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

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

I understand and acknowledge that, to a large degree, a successful treatment outcome depends on the amount of energy and effort I make. If I feel like treatment is not working, I agree to discuss it with my provider and attempt to come to a common understanding as to what the problems are and identify potential solutions.

I also understand and acknowledge that if I do not show up for an appointment without notifying my provider, my provider might contact individuals within my social support network, to include my chain of command, in order to confirm my safety.

In short, I agree to make a commitment to treatment, and a commitment to living.

This agreement will apply for the duration of our treatment plan, which will be reviewed and modified on the following date: _____.

Patient signature: _____ Date: _____

Provider signature: _____ Date: _____

Crisis Response Plan

Because the suicidal thought process is characterized by impaired problem-solving, absence of cognitive flexibility, and extreme cognitive distortions, patients often need decision-making aids when in a suicidal crisis. The crisis response plan (CRP) is such a decisional aid that outlines a set of specific instructions for the patient to follow during periods of crisis. The CRP is developed collaboratively between the provider and patient, and serves several primary purposes:

1. Facilitating honest and productive communication between the patient and provider about emotional distress by making it clear what the expectations are for both in terms of how suicidal crises will be addressed.

2. Assisting to establish and maintain a collaborative relationship by identifying the roles and responsibilities of both the patient and provider.

3. Facilitating active involvement of the patient in the treatment process, including readily accessing emergency procedures when and if needed.

The crisis response plan is comprised of four distinct sections:

1. **Identify personal warning signs.** Patients should be asked to list any thoughts, images, emotions, behaviors, physical sensations, or any symptoms or signs that they typically experience when in crisis. This should generally be based on the index suicidal episode assessment.

2. **Self-management strategies.** Patients should next be assisted in developing activities and strategies that can be utilized in response to these warning signs in order to reduce emotional distress. In order to foster the ability to *self-manage* crises and develop mastery of self-regulation skills, these initial coping strategies should include activities that do not require the involvement or assistance of others. These strategies typically involve strategies such as behavioral activation, relaxation, or mindfulness exercises that work to develop crisis management and emotion regulation skills.

3. **Social support.** If self-management strategies are not effective in reducing emotional distress or distracting patients from the distress, the next step is to contact external sources of support, typically family members and/or friends. Specific names and phone numbers should be written down on the CRP for each individual identified.

4. **Professional / crisis support.** Information for accessing health care providers and other crisis services should come last in the CRP. This entails current treatment providers, crisis hotlines, 911, and emergency departments.

I will use this crisis response plan when:
Things I will do on my own for 30 mins:
If that does not work, I will contact other people:
If I am still feeling upset, I will contact a medical professional:

Means Restriction Counseling

Means restriction counseling entails two distinct but interrelated actions, as outlined by the Harvard Injury Control Research Center: (1) assessing whether a person at risk for suicide has access to a firearm or other lethal means, and (2) working with them and their family and support system to limit their access until they are no longer feeling suicidal.

Therapists should always ask patients about the presence of firearms in the home, even if gunshot wound is not the intended method for suicide. This is because availability of means is perhaps the most important determinant of methodology, and self-inflicted gunshot wound is fatal approximately 85% of the time.

When providing means restriction counseling, therapists should always provide a "menu of options" for patients to choose from so that they maintain control and autonomy over the decision, and also so that they are given responsibility for their own safety. One of the options for securing lethal means should always include the therapist contacting the patient's commander for assistance. This provides some leverage to the therapist, and usually serves to motivate the patient to accept responsibility for securing the firearm themselves.

Tips and strategies for providing means restriction counseling on firearms are provided on the following pages, along with a "receipt" that therapists should provide to patients in order to confirm that lethal means (especially firearms) have been secured.

Tips and Critical Points for Means Restriction Counseling on Firearms

- Presence of a firearm in the home increases the chance that a suicide attempt will be fatal.
- Because suicidal desire can increase very rapidly, restricting access to lethal means can reduce the likelihood of bad outcomes in a crisis.
- Recommend removing firearms and other lethal means.
- Wherever possible enlist the support of a significant other.
- Ensure to ask about the presence of multiple firearms in multiple locations. In the case of joint custody situations for child or adolescent patients, ensure firearms are secured in all homes where the patient might reside.
- The safest option is to completely remove the firearm from the home until the situation improves.
- If complete removal is unacceptable, securing firearms with the following measures is a less safe alternative:

    1. Unloaded
    2. In a tamper-proof safe designed for firearms storage
    3. Lock ammunition separately or remove completely from home
    4. Ensure keys or combinations to locks are inaccessible to at-risk individuals

- Hiding unlocked firearms is discouraged since they can be found by at-risk individuals.

Means Receipt

Questions? Contact your provider: _____
Emergencies call: 911

Client Name	
Securer	
Address	
Email	
Work Phone	
Cell Phone	
Type of means	
Safety Measures	☐ Removed (Describe: _____) ☐ Secured (Describe: _____)
Release Terms	To be released to client upon notification by therapist.

Thank you for your cooperation!

Crisis management interventions

A number of crisis management interventions can be used and/or taught to patients in order to add to their crisis response plans. These skills are designed to enhance emotion regulation and distress tolerance, and to temporarily deactivate acute emotional crises. Crisis management interventions target various components of the suicidal mode, and should be selected by the therapist collaboratively with the patient to match the most pressing treatment needs. Therapists must train skills that patients do not yet possess, and in all cases must assess competency or mastery.

Therapists should direct patients to practice specific crisis management skills several times per day in addition to during crises in order to facilitate learning.

The following are common crisis management interventions, along with the primary mode components that they target:

1. Relaxation – physical, emotional
2. Mindfulness – cognitive, emotional
3. Behavioral activation (enjoyable activities) – behavioral
4. Reasons for living list – cognitive, emotional
5. Survival kit – emotional, cognitive

Therapists can also include social support networks by using the crisis support plan, which is designed to enlist the aid of significant others in supporting the treatment process, the use of crisis plans, and securing of lethal means.

Brief Relaxation Script

Go ahead and get yourself settled into your seat in a comfortable position with both feet on the floor and your hands resting in your lap. If you feel comfortable closing your eyes while doing this activity, go ahead and close them. If you'd prefer to keep your eyes open, that's fine, just fix your gaze on a point on the wall or the floor so that you're eyes aren't wandering around while we do this. I want you to begin by taking a slow, deep breath in, and then very slowly breathing out. Good. And repeat that: a slow, deep breath in, and then a very slow breath out. Very good. I want you to repeat this slow, rhythmic, deep breathing at this pace, and while you breathe in this way I'm just going to help you to relax even more.

As you're breathing in, I want you to notice how the air feels as it enters your body and fills you up, and then notice how the air feels as it leaves your body and you deflate. As you breathe out this next time I want you to let your shoulders slump, sort of like they have weights attached to them pulling them down. Good. Notice also how you might experience a sinking sensation, sort of like gravity is increasing and you're sinking into the seat. Good. Let yourself relax, sort of like you're going limp in your seat, and release the tension in your shoulders, your arms, your chest, and your legs. Good. Notice how you're heart rate slows down as you do this breathing as you become more relaxed and calm. Very good. Now let's just sit here for another minute or so, continuing to breathe slowly and deeply, and releasing even more tension from our muscles. [Sit in silence for 1 to 3 minutes, depending on time constraints]

And now I want you to take just two more very deep, very slow breaths, and when you're ready you can open up your eyes again.

Brief Mindfulness Script: Sensory Focus

Go ahead and get yourself settled into your seat in a comfortable position with both feet on the floor and your hands resting in your lap. If you feel comfortable closing your eyes while doing this activity, go ahead and close them. If you'd prefer to keep your eyes open, that's fine, just fix your gaze on a point on the wall or the floor so that you're eyes aren't wandering around while we do this. I want you to begin by taking a slow, deep breath in, and then very slowly breathing out. Good. And repeat that: a slow, deep breath in, and then a very slow breath out. Very good. I want you to repeat this slow, rhythmic, deep breathing at this pace, and while you breathe in this way I'm going to give you some directions to help you pay attention to some different sensations.

First I want you to pay attention to the sensation of breathing. I want you to notice how the air feels as you slowly breathe in and fill up, then notice how that air feels as it leaves your body and you deflate. Breathe in and fill up, and breathe out and deflate. Notice how your chest expands, and then deflates.

Next I want you to take just a moment to pay attention to the sense of sound. Pay attention to all the sounds that you can hear right now, even those that you might not typically pay attention to or you might ignore. [Sit in silence for several seconds] Notice all the sounds of the clinic in the background that you didn't notice before. [Sit in silence for several seconds] And now return your attention back to your breathing, slow and deep, in and out.

Next I want you to pay attention to the sensation of touch. Notice what it feels like to sit in your chair. [Sit in silence for several seconds] Notice the sensation of wearing your glasses [watch/shoes/necklace]. Notice how its weight feels resting on the bridge of your nose, and how the arms feel wrapped around your ears. [Sit in silence for several seconds] Notice the sensation of your hands resting on your legs. [Sit in silence for several seconds] And return again to your breathing, in and out.

Now just take a few moments to continue focusing your attention on whatever sensations you might experience in your body, just noticing them for a few moments then returning your attention to your breathing. Again and again, always returning to your breathing, over and over again. [Sit in silence for several seconds up to one minute]

And now I'd like for you to take just two more deep, slow breaths, and when you're ready you can open up your eyes again.

Brief Mindfulness Script: Conveyer Belt

Go ahead and get yourself settled into your seat in a comfortable position with both feet on the floor and your hands resting in your lap. If you feel comfortable closing your eyes while doing this activity, go ahead and close them. If you'd prefer to keep your eyes open, that's fine, just fix your gaze on a point on the wall or the floor so that you're eyes aren't wandering around while we do this. I want you to begin by taking a slow, deep breath in, and then very slowly breathing out. Good. And repeat that: a slow, deep breath in, and then a very slow breath out. Very good. I want you to repeat this slow, rhythmic, deep breathing at this pace, and while you breathe in this way I'm going to give you some directions to help you pay attention to some different experiences.

First I want you to pay attention to the sensation of breathing. I want you to notice how the air feels as you slowly breathe in and fill up, then notice how that air feels as it leaves your body and you deflate. Breathe in and fill up, and breathe out and deflate. Notice how your chest expands, and then deflates.

Next I want you to take just a moment to pay attention to the sense of sound. Pay attention to all the sounds that you can hear right now, even those that you might not typically pay attention to or you might ignore. [Sit in silence for several seconds] Notice all the sounds of the clinic in the background that you didn't notice before. [Sit in silence for several seconds] And now return your attention back to your breathing, slow and deep, in and out.

Next I want you to imagine a conveyer belt in your mind. Take a moment to look at this conveyer belt moving through your mind, from one side to another. Next I want you to imagine that your thoughts are on top of this conveyer belt, moving past you through your mind. Sometimes we have thoughts that are like pictures or images in our head. Place these images on the conveyer belt and watch them move past you. When they've moved past you return your attention to your breathing and the sense of sound. Sometimes we have thoughts that are like words or sentences, like someone is talking. Place these sayings on the conveyer belt and watch them move past you as well, and when they've moved past you return your attention to your breathing and the sounds. You might notice that some of the thoughts that move past you on the conveyer belt come back into your mind. That's okay, just place them back on the conveyer belt and watch them again, and then return your attention to your breathing and the sounds.

Take a moment to think about something that bothers you or a problem in life, and notice your thoughts about that problem moving past you on the conveyer belt, and then return your attention to your breathing and the sounds. Probably these bothersome thoughts will come back again. Just put them on that conveyer belt again and watch them move past another time, and then return to your breathing and the sounds. You can repeat this over and over as many times as you need to, always returning to your breathing and the sounds. Just watching your thoughts and ideas moving past you on the conveyer belt, every time returning your attention back to your breathing and the sounds, again and again and again. [Sit in silence for several seconds up to one minute]

And now I'd like for you to take just two more deep, slow breaths, and when you're ready you can open up your eyes again.

Crisis Support Plan

The crisis support plan (CSP) is a risk management strategy similar to the crisis response plan that explicitly incorporates the involvement and support of a significant other in the suicidal patient's life. The CSP is designed to increase the likelihood of patient adherence to risk management strategies and treatment recommendations, and to enhance social connectedness between the suicidal patient and a significant other.

There are no limits or restrictions on which supportive others can complete a CSP with the patient or how many supportive others to be identified. In some cases identification of a problematic source of social support contributing to the patient's emotional distress can actually be ideal for a CSP since this intervention directly targets and fosters social connectedness. For example, a suicidal patient's indifferent or disengaged spouse might be selected for the CSP in order to increase involvement and investment in the patient's treatment and care, which can contribute to enhanced sense of social support.

There are several steps to creating a CSP:

1. **Educate the significant other.** Therapists should discuss suicide risk using the suicidal mode as a model. Educating the supportive other about suicide in the presence of the suicidal patient also serves to enhance learning for the suicidal patient by reviewing the constructs and information an additional time. Therapists should include the suicidal patient in this educational step by asking the patient to elaborate or explain key concepts.

2. **Introduce the CSP to the suicidal patient and the supportive other.** Explain the CSP as a strategy designed to improve patient safety and maximize treatment outcomes.

3. **Identify helpful supportive actions.** Once the rationale for the CSP has been provided and buy-in obtained from the supportive other, the next step is to identify specific actions the supportive other can take to help the suicidal patient. The therapist's primary role in this process is to assist the suicidal patient in verbalizing these needs and expectations in terms that are behaviorally-oriented, achievable, and consistent with overall treatment goals.

4. **Provide means restriction counseling.**

5. **Review emergency procedures and obtain buy-in.**

Patient's Name: _____ Date: _____

I understand that suicide risk is to be taken very seriously. I want to help _____ find new ways to manage stress in times of crisis. I realize there are no guarantees about how crises resolve, and that we are all making reasonable efforts to maintain safety for everyone. In some cases hospitalization may be necessary.

Things I can do to assist _____:

1. Provide encouragement and support in the following ways:
   -
   -
   -
2. Help _____ follow his/her Crisis Response Plan
3. Ensure a safe environment by doing the following:
   - REMOVE all firearms and ammunition
   - REMOVE or LOCK UP:
     - All knives, razors, and other sharp objects
     - All prescription and over-the-counter drugs (including vitamins & aspirin)
     - All alcohol, illegal drugs, and any related paraphernalia
   - Make sure someone is available to provide personal support and monitor the patient at all times during a crisis and afterwards as needed.
   - Pay attention to the patient's stated method of suicide / self-injury / intent to harm others and restrict access to vehicle, ropes, flammables, etc., as appropriate
   - Limit / restrict access to vehicle / car keys as appropriate
   - Identify people who might increase risk for the patient, and minimize their contact with the patient
   - Provide access to things the patient identifies as helpful, and encourage choices and behaviors that promote health, such as good nutrition, exercise, and rest

If I am unable to continue to provide these supports, or if I believe that the Crisis Response Plan is not helpful or sufficient, I will contact the patient's treatment provider to express my concerns.

If I believe _____ is a danger to self or others, I agree to:

- Call his/her mental health treatment provider: _____
- Call the national crisis hotline: 1-800-273-TALK (8255)
- Help _____ get to a hospital
- Call 911

I agree to follow this plan until _____

_____	_____	_____
Support signature	Patient signature	Provider signature

Reasons For Living List

The RFL list can be created using 3 x 5 index cards that the patient can easily carry with them in their pocket, purse, or backpack, or keep in an easily accessible location such as a drawer. On the index card are listed the patient's identified reasons for living. These might include people (e.g., family, friends, coworkers), meaningful activities (e.g., camping, favorite vacation spots, playing with children, cooking, movies), dreams or aspirations (e.g., graduating from college, promotions, retirement), ideals or values (e.g., love for others, not wanting to hurt loved ones), or any other factors that serve to reduce the desire for suicide and increase the desire for life.

Wherever possible, the patient should write the list themselves. The patient is then directed to read the RFL list both at regularly scheduled times during the day and as needed. The importance of reviewing the list on a regular basis, even when the patient is feeling relatively calm, should be stressed by the therapist because the automization resulting from overlearning is the very essence of cognitive fluidity. Patients should also be directed to write additional reasons for living on the RFL list as they are identified in daily life. As this list expands and grows, the patient's sense of the meaningful aspects of their life shifts dramatically. Suicidal patients also begin to develop the ability to pay attention to positive aspects of their lives instead focusing excessively on the negative aspects of life.

Cognitive constriction can often become very evident as a result of the RFL list intervention. This constriction frequently manifests in the form of cognitive "short cuts" or overgeneralizations when attempting to generate reasons for living. For example, a suicidal patient might report that "family" is their only reason for living; being able to identify only one (or a few) reasons for living can be discouraging to the patient and reinforce perceptions of isolation, worthlessness, unlovability, and other core suicidal beliefs. Overgeneralized responses such as "family," "friends," "work," "pets," or "religious beliefs" typically collapse many reasons for living into a single, broad category that masks the true extent of the positive features in the patient's life. Therapists can teach the patient to overcome this tendency by asking pointed questions designed to focus the patient on specific instances of family life that have positive emotional associations:

- What are the names of your family members?
- What types of things have you done with that family member that you enjoy?
- When is the next time you plan on seeing this person? What will you do together?

Such questions can effectively and very rapidly "convert" an RFL list with only a single item to a list with many items.

Survival Kit

The purpose of the survival kit is to centralize tangible objects that can prime positive emotional states and elicit thoughts that counter the suicidal belief system. Survival kits can be created using any form of a container (e.g., shoe box, manila envelope, tackle box) in which objects having positive associations can be stored. Objects commonly placed in survival kits include pictures of vacations, inspirational quotes, scripture passages, trinkets or souvenirs from important events, letters from loved ones, and family photos. Key to the selection of objects to be included in the survival kit is the ability of the object to prime a positive emotional experience, thereby reducing the intensity of aversive emotions sustaining the suicidal state.

Therapists should therefore require patients to bring in their survival kits to a follow-up appointment for review. When a patient returns to a follow-up appointment with their survival kit, BHCs can simply ask the patient to briefly "tell me the story" of each object. This reduces the likelihood that patients will select objects that trigger or sustain suicidal states, such as pictures of a "loving" parent who also abused the patient, or love letters from an intimate partner with whom the patient recently separated or broke up.

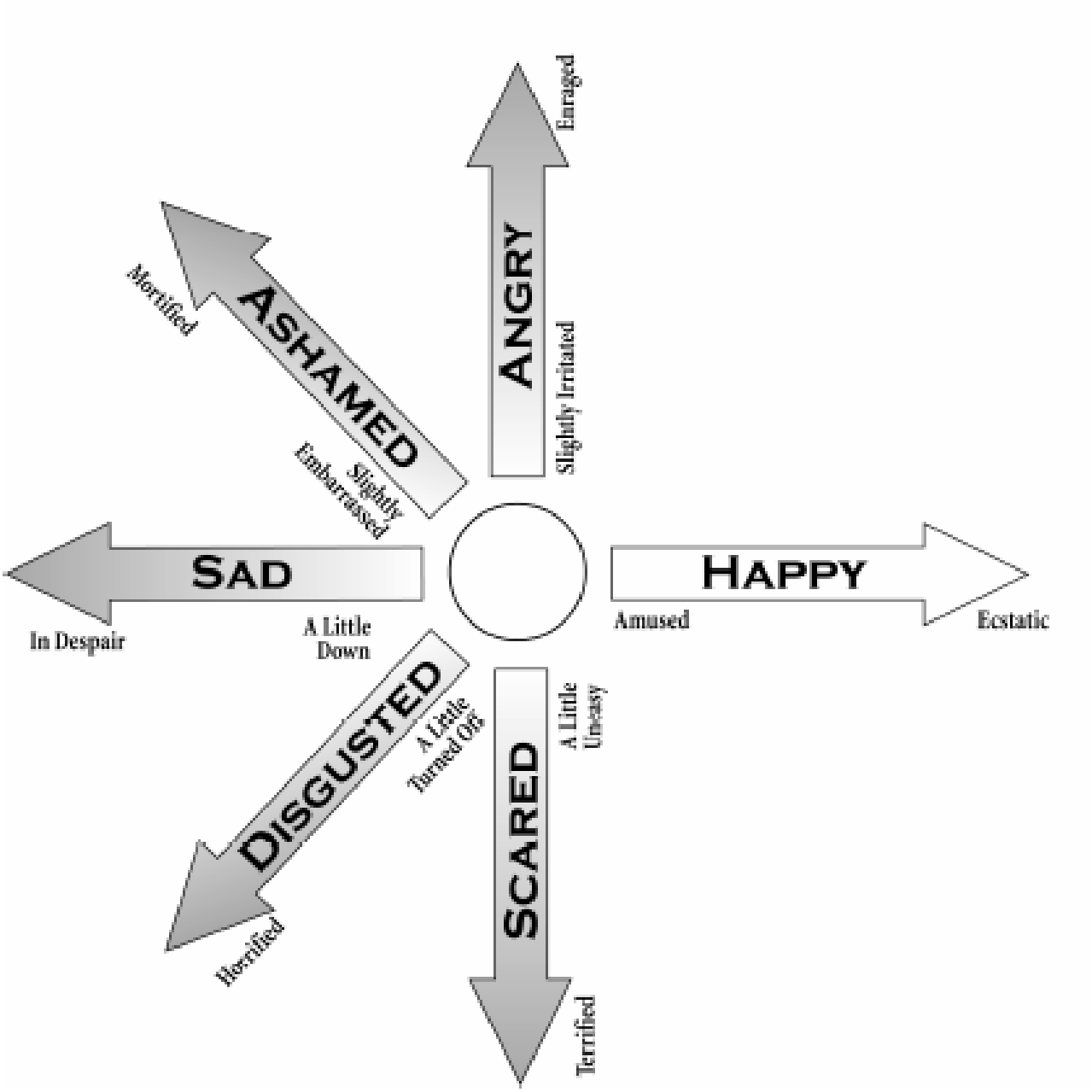
As the patient explains their rationale for including each object in the survival kit, the BHC should be mindful of the patient's emotional state and ask follow-up questions to further elicit positive emotions. For example, when "telling the story" of a picture from a family vacation at the beach, the suicidal patient might simply explain that she included the picture "because that was a fun trip" without providing any additional information or detail. This lack of detail is a unique feature of suicidal patients that seems to inhibit positive emotional states and effective problem solving. Therapists should therefore follow-up with questions such as, "What specifically made it fun? What was the best part of the trip? Why did you choose to go to the beach? Who went with you? Can you describe to me how the ocean sounded or smelled?" Similar questions can be asked about trinkets, souvenirs, or other heirlooms: "How did you get this object? What does this object mean to you personally? Why have you kept this object for all these years?" Such follow-up questions strengthen the intensity of the memory trace and heighten the emotional engagement associated with the objects.

By eliciting positive emotions, the survival kit intervention provides a direct functional alternative to suicidality for emotional relief: instead of reducing negative emotions and/or increasing positive emotions with suicidality, the patient can achieve the same outcome by using their survival kit.

Identifying Emotions Handout

Suicidal patients often had difficulty identifying and naming emotions. The Identifying Emotions Handout can be used for patients to develop the ability to (1) label emotions, and (2) recognize that emotions exist on a spectrum of intensity.

Identifying Emotions



Phase 2

Objectives:

1. Cognitive restructuring to undermine suicidal belief system
2. Skills training to refine emotion regulation, distress tolerance, and problem solving

Fidelity Checklist

The fidelity checklist provides specific actions and tasks that must be completed by the therapist during the second phase of B-CBT. Treatment should not progress to the third phase until the patient has demonstrated mastery/competency of basic cognitive-behavioral skills that can effectively deactivate the suicidal mode and reduce the likelihood of subsequent suicidal behaviors.

No	Partial	Yes	*Cognitive-behavioral conceptualization and adherence*
▲	▲	▲	Readdressed suicidal mode conceptualization
▲	▲	▲	Modified / revised conceptualization where needed
▲	▲	▲	Identified potential sources of nonadherence
▲	▲	▲	Elicited input and feedback from patient regarding nonadherence
▲	▲	▲	Directly targeted nonadherence for intervention
▲	▲	▲	Prioritized nonadherence if present

No	Partial	Yes	*Cognitive-behavioral interventions (new)* *Total # new: _____*
			Primary domain targeted by intervention
▲	▲	▲	[ ] Cognitive (Specific belief targeted: _____)
▲	▲	▲	[ ] Emotional (Specific emotion targeted: _____)
▲	▲	▲	[ ] Behavioral (Specific behavior targeted: _____)
▲	▲	▲	[ ] Physical (Specific physical symptom targeted: _____)
▲	▲	▲	Explained rationale for intervention (tied skill to suicidal mode)
▲	▲	▲	Emphasized emotion regulation and interpersonal problem solving
▲	▲	▲	If shame/guilt present, emphasized forgiveness
▲	▲	▲	Explained how to effectively use skill
▲	▲	▲	Demonstrated skill
▲	▲	▲	Practiced skill
▲	▲	▲	Elicited feedback about skill use
▲	▲	▲	Assessed likelihood to use skill
▲	▲	▲	Identified barriers to skills utilization
▲	▲	▲	Gauged patient's understanding of skill
▲	▲	▲	Modified skill (where necessary) to improve likelihood of utilization
▲	▲	▲	Assigned homework for skills practice between sessions
▲	▲	▲	Encouraged patient to write assignment in treatment journal
▲	▲	▲	Explicitly tied new interventions to other interventions
▲	▲	▲	Explicitly discussed generalization of skills across contexts and situations

No	Partial	Yes	*Cognitive-behavioral interventions (follow-up)* *Total # reviewed: _____*
▲	▲	▲	Assessed adherence to recommendations / use of skill since last session
▲	▲	▲	Identified barriers to adherence
▲	▲	▲	Collaboratively engaged patient in activee problem solving of identified barriers
▲	▲	▲	Explicitly reinforced adherence and skills utilization
▲	▲	▲	Reviewed treatment journal entries
▲	▲	▲	Assigned new homework / skills practice that builds upon prior gains

Coping Cards

Coping cards are a simple strategy for teaching and reinforcing the skills required to respond to suicidal thoughts in more adaptive ways. Coping cards can be created using 3 x 5 index cards that the patient can carry with them in a pocket, purse, or backpack, or keep nearby in a desk drawer or on a refrigerator.

On the front side of the coping card the suicidal or maladaptive belief should be written down in the patient's exact words. These thoughts and beliefs are generally identified during the risk assessment process. On the reverse side a more adaptive response is written.

Wherever possible the patient should write on the cards themselves to fully engage them in the process and truly create a coping card that is "in the patient's own words." The patient is then directed to read the coping card both at regularly scheduled times during the day and as needed. Coping cards should be read on a regular basis *even when the patient is not feeling suicidal* so that overlearning occurs, resulting in increased internalization and automatic processing of the adaptive response. Coping cards should additionally be read by the patient as needed whenever they notice themselves thinking the suicidal or maladaptive belief (e.g., during suicidal crises or other periods of emotional distress) to directly apply the skill to the target problem of suicidality.

Coping cards can take several forms depending on the specific needs of the patient, the two most common forms being a direct counterpoint to suicidal beliefs or a cue for engaging in alternative coping behaviors. Sample coping cards are on the following pages.

	Front	Back
A)	I can't take this anymore.	This is only temporary, and I can endure.
B)	I screw everything up. I'm a failure.	Mistakes happen. It's okay to make mistakes. I can figure this out.
C)	I don't want to get out of bed.	1. Get up and stand next to the bed. 2. Count to 10. 3. Decide whether to get back into bed or not.
D)	I can't do anything when I'm thinking about suicide.	1. Set a time limit for doing the activity (5-30 mins). 2. Do the activity for the full length of time *even if suicidal*. 3. After doing the activity for the time limit, decide whether or not to continue it.

Behavioral Activation

Behavioral activation focuses on setting short-term behavior change goals and delineating the steps required to achieve these goals, the assumption being that by achieving specific behavior changes the patient will accomplish the goal of "feeling better." The therapist serves as the patient's coach by setting realistic and attainable goals and by encouraging the patient to reach these goals. Early behavioral activation interventions are typically designed to undermine the avoidance patterns that disrupt daily functioning. Such interventions might include:

- Increased exercise
- Engagement in hobbies
- Participation in social activities

In cases of more severely distressed patients, behavioral activation plans might be much more basic or fundamental: showering in the morning, putting on make-up, changing out of pajamas, getting out of bed, cooking a meal.

When developing BA plans the therapist should follow a series of steps to maximize success:

1. **Conduct a functional analysis.** In the functional analysis, the therapist and patient work together to identify what contributes to and sustains their avoidant behavioral patterns by considering the following dimensions of the behavior: timing and location, frequency, associated situational factors, duration, onset, impact on daily functioning.

2. **Collaboratively identify desired behavioral alternatives.** Behaviors and activities to be included in the behavior change plan should be relevant to the suicidal mode and easy for the patient to implement. Behaviors should therefore be selected for their ability to reduce negative emotions, increase positive emotions, challenge or defy suicidal thoughts or beliefs, or reduce aversive physical symptoms or experiences.

3. **Set realistic goals.** To be achievable, behavioral activation plans should be specific (e.g., running or walking vs. "exercise"; where; when), measurable (e.g., how often, how many times), and realistic (e.g., fewer times or lower intensity initially to increase likelihood of success).

ABC Worksheets

ABC worksheets can be used to help patients identify the link between triggers, suicidal beliefs, emotions, and behaviors. They are also designed to help patients practice challenging maladaptive beliefs and developing more adaptive responses.

ABC Worksheet

Name: _____ Date: _____

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

The Challenging Beliefs Worksheet assists patients in questioning the accuracy or adaptability of specific suicidal beliefs. Patients are directed to identify a core suicidal belief and then to answer the questions listed underneath in order to develop the ability to more realistically and reasonably respond to suicidal beliefs.

Challenging Beliefs Worksheet

Date: _____

Below is a list of questions for helping you challenge problematic or bothersome thoughts and beliefs about yourself. Not all of the questions will be appropriate or useful for every thought or belief, but answer as many of the questions as you can.

Thought/belief: _____

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 I am 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?

Problematic Thinking Handout

The Problematic Thinking Handout can be used by therapists to teach patients about different patterns of maladaptive thoughts and beliefs that contribute to the suicidal mode. Being able to label problematic thought patterns enables patients to recognize patterns of suicidal beliefs and to more rapidly deactivate thoughts contributing to the suicidal crisis.

Problematic Thinking

Filtering

We take the negative details and magnify them while filtering out all positive aspects of a situation. For instance, a person may pick out a single, unpleasant detail and dwell on it exclusively so that their vision of reality becomes darkened or distorted.

All-or-Nothing Thinking

Things are either "black-or-white." We have to be perfect or we're a failure–there is no middle ground. You place people or situations in "either/or" categories, with no shades of gray or allowing for the complexity of most people and situations. If your performance falls short of perfect, you see yourself as a total failure.

Overgeneralizing

We come to a general conclusion based on a single incident or piece of evidence. If something bad happens once, we expect it to happen over and over again. A person may see a single, unpleasant event as a never-ending pattern of defeat.

Jumping to Conclusions

Without individuals saying so, we know what they are feeling and why they act the way they do. In particular, we are able to determine how people are feeling toward us. For example, a person may conclude that someone is reacting negatively toward them and don't actually bother to find out if they are correct. Another example is a person may anticipate that things will turn out badly, and will feel convinced that their prediction is already an established fact.

Catastrophizing

We expect disaster to strike, no matter what. This is also referred to as "magnifying or minimizing." We hear about a problem and use *what if* questions (e.g., "What if tragedy strikes?" "What if it happens to me?"). For example, a person might exaggerate the importance of insignificant events (such as their mistake, or someone else's achievement). Or they may inappropriately shrink the magnitude of significant events until they appear tiny (for example, a person's own desirable qualities or someone else's imperfections).

Personalizing

Thinking that everything people do or say is some kind of reaction to us. We also compare ourselves to others trying to determine who is smarter, better looking, etc. A person sees themselves as the cause of some unhealthy external event that the were not responsible for. For example, "We were late to the dinner party and *caused* the hostess to overcook the meal. If I had only pushed my husband to leave on time, this wouldn't have happened."

Control Fallacies

If we feel *externally controlled*, we see ourselves as helpless a victim of fate. For example, "I can't help it if the quality of the work is poor, my boss demanded I work overtime on it." The fallacy of *internal control* has us assuming responsibility for the pain and happiness of everyone around us. For example, "Why aren't you happy? Is it because of something I did?"

Fallacy of Fairness

We feel resentful because we think we know what is fair, but other people won't agree with us. As our parents tell us, "Life is always fair," and people who go through life applying a measuring ruler against every situation judging its "fairness" will often feel badly and negative because of it.

Blaming

We hold other people responsible for our pain, or take the other track and blame ourselves for every problem. For example, "Stop making me feel bad about myself!" Nobody can "make" us feel any particular way — only we have control over our own emotions and emotional reactions.

Shoulds

We have a list of ironclad rules about how others and we should behave. People who break the rules make us angry, and we feel guilty when we violate these rules. A person may often believe they are trying to motivate themselves with shoulds and shouldn'ts, as if they have to be punished before they can do anything. For example, "I really should exercise. I shouldn't be so lazy." *Musts* and *oughts* are also offenders. The emotional consequence is guilt. When a person directs *should statements* toward others, they often feel anger, frustration and resentment.

Emotional Reasoning

We believe that what we feel must be true automatically. If we feel stupid and boring, then we must be stupid and boring. You assume that your unhealthy emotions reflect he way things really are — "I feel it, therefore it must be true."

Fallacy of Change

We expect that other people will change to suit us if we just pressure or cajole them enough. We need to change people because our hopes for happiness seem to depend entirely on them.

Global Labeling

We generalize one or two qualities into a negative global judgment. These are extreme forms of generalizing, and are also referred to as "labeling" and "mislabeling." Instead of describing an error in context of a specific situation, a person will attach an unhealthy label to themselves. For example, they may say, "I'm a loser" in a situation where they failed at a specific task. When someone else's behavior rubs a person the wrong way, they may attach an unhealthy label to him, such as "He's a real jerk." Mislabeling involves describing an event with language that is highly colored and emotionally loaded. For example, instead of saying someone drops her children off at daycare every day, a person who is mislabeling might say that "she abandons her children to strangers."

Always Being Right

We are continually on trial to prove that our opinions and actions are correct. Being wrong is unthinkable and we will go to any length to demonstrate our rightness. For example, "I don't care how badly arguing with me makes you feel, I'm going to win this argument no matter what because I'm right." Being right often is more important than the feelings of others around a person who engages in this cognitive distortion, even loved ones.

Heaven's Reward Fallacy

We expect our sacrifice and self-denial to pay off, as if someone is keeping score. We feel bitter when the reward doesn't come.

Insomnia Handout

The Insomnia Handout provides basic information about sleep hygiene and stimulus control, which are the most effective interventions for insomnia. Therapists should educate patients about contributors to insomnia and simple strategies for reducing insomnia using non-medical treatments.

The Sleep Diary can be used in conjunction with the Insomnia Handout in order to better assess patterns of sleep disturbance over time, as well as providing a mechanism for tracking improvement.

INSOMNIA

Results of insomnia	What leads to insomnia?	What maintains insomnia?
• Physiological arousal • Worrisome thinking • Anxiety • Depression • Family conflict • Work problems • Loss of motivation	• Acute stress • Personal loss (death, separation, divorce, etc) • Medical problems • Work problems • Family problems • Irregular sleep schedule	• Incorrect sleeping habits • Inaccurate thoughts about sleep • Sleeping pills • Myths about duration of sleep • Daytime napping • Excess time in bed • Performance anxiety • Medications for health problems

How can I improve my sleep? *Change your sleep behavior*

Go To Bed Only When You Are Sleepy

There is no reason to go to bed if you are not sleepy. When you go to bed too early, it only gives you more time to become frustrated. Individuals often ponder the events of the day, plan the next day's schedule, or worry about their inability to fall to sleep. These behaviors are incompatible with sleep, and tend to perpetuate insomnia. You should therefore delay your bedtime until you are sleepy. This may mean that you go to bed later than your scheduled bedtime. However, stick to your scheduled rising time **regardless** of the time you go to bed.

Get Out Of Bed When You Can't Fall Asleep or Cannot Go Back To Sleep In 15 Min

When you recognize that you've become a clockwatcher, get out of bed. If you wake up during your sleep and you've tried falling back to sleep for 15 minutes and can't, get out of bed. Remember, the goal is to fall to sleep quickly. Return to bed **only** when you are sleepy (i.e., yawning, head bobbing, eyes closing, concentration decreasing). The goal is for you to reconnect your bed with sleeping rather than frustration. You will have to repeat this step as often as necessary.

Use Your Bed Or Bedroom For Sleep And Sex Only

The purpose of this guideline is to associate your bedroom with sleep rather than wakefulness. Just as you may associate the kitchen with hunger, this guideline will help you associate sleep and pleasure with your bedroom. Follow this rule both during the day and at night. **DO NOT** watch t.v., listen to the radio, eat or read in bed. You may have to temporarily move the t.v. or radio from your bedroom to help you regain a stable sleep cycle.

Sleep Guidelines

1. **NO CAFFEINE:** No caffeine 6-8 hours before bedtime
   Yeap, its true caffeine disturbs sleep; even for people who do not think they experience a stimulation effect. Individuals with insomnia are often more sensitive to mild stimulants than normal sleepers. Caffeine is found in items such as coffee, tea, soda, chocolate, and many over-the-counter medications (e.g., Excedrin).

2. **AVOID NICOTINE:** Avoid nicotine before bedtime
   Nicotine is a stimulant. It is a myth that smoking helps you "relax." As nicotine builds in the system it produces an effect similar to caffeine. DO NOT smoke to get yourself back to sleep.

3. **AVOID ALCOHOL:** Avoid alcohol after dinner
   Alcohol often promotes the onset of sleep, but as alcohol is metabolized sleep becomes disturbed and fragmented. Thus, a large amount of alcohol is a poor sleep aid and should not be used as such. Limit alcohol use to small quantities to moderate quantities.

4. **NO SLEEPING PILLS:** Sleep medications are effective only temporarily
   Scientists have shown that sleep medications lose their effectiveness in about 2 - 4 weeks when taken regularly. Over time, sleeping pills actually make sleep problems worse. When sleeping pills have been used for a long period, withdrawal from the medication can lead to an insomnia rebound. Thus, after long-term use, many individuals incorrectly conclude that they "need" sleeping pills in order to sleep normally.

5. **REGULAR EXERCISE:** Preferably 40 minutes each day
   Exercise in the late afternoon or early evening can aid sleep, although the positive effect often takes several weeks to become noticeable. Do not exercise within 2 hours of bedtime because it may elevate your nervous system activity and interfere with falling asleep.

6. **BEDROOM ENVIRONMENT:** Moderate temperature, quiet, dark and comfortable
   Extremes of heat or cold can disrupt sleep. Noises can be masked with background white noise (such as the noise of a fan) or with earplugs. Bedrooms may be darkened with black-out shades or sleep masks can be worn. Position clocks out-of-sight since clock-watching can increase worry about the effects of lack of sleep. Be sure your mattress is not too soft or too firm and that your pillow is the right height and firmness.

7. **EATING**
   You should avoid the following foods at bedtime: anything caffeinated like chocolate, peanuts, beans, most raw fruits and vegetables (they may cause gas), and high-fat foods such as potato chips or corn chips. Be especially careful to avoid heavy meals and spices in the evening. Do not go to bed too hungry or too full. Avoid snacks in the middle of the night because awakening may become associated with hunger. A light bedtime snack, such a glass of warm milk, cheese, or a bowl of cereal can promote sleep.

8. **AVOID NAPS**

The sleep you obtain during the day takes away from your sleep needed at night resulting in lighter, more restless sleep, difficulty falling asleep or early morning awakening. If you must nap, keep it brief, and try to schedule it before 3:00 pm. It is best to set an alarm to ensure you don't sleep more than 15-30 minutes.

9. **UNWIND**

Allow yourself at least an **hour** before bedtime to wind down. The brain is not a light switch that you can instantly cut on and off. Most of us cannot expect to go full speed till 10:00 pm then fall peacefully to sleep at 10:30 pm. Take a hot bath, read a novel, watch some TV, or have a pleasant talk with your spouse or kids. Find what works for you and make it your routine before bed. Be sure not to struggle with a problem, get into an argument before bed or anything else that increases your body's arousal.

10. **REGULAR SLEEP SCHEDULE**

Spending excessive time in bed has two unfortunate consequences - (1) you begin to associate your bedroom with arousal and frustration and (2) your sleep actually becomes shallow. Surprisingly, it is very important that you cut down your sleep time in order to improve sleep! Set the alarm clock and get out of bed at the same time each morning, weekdays and weekends, regardless of your bedtime or the amount of sleep you obtained on the previous night. You probably will be tempted to stay in bed if you did not sleep well, but try to maintain your new schedule. This guideline is designed to regulate your internal biological clock and reset your sleep-wake rhythm.

It usually takes 2-3 months for a sleep problem to get totally better, but most people see improvements within 2-3 weeks if they consistently follow the guidelines.

Sleep Diary Instructions

Before you go to sleep at night, please answer Questions 1 - 6.
After you get up in the morning, please answer the remaining questions, Questions 7 - 13.

It is very important that you complete the diary every evening and morning!!! Please don't attempt to complete the diary later.

It's often difficult to estimate how long you take to fall asleep or how long you're awake at night. Keep in mind that we simply want your best estimates.

If any unusual events occur on a given night (e.g., emergencies, phone calls) please make a note of it on the diary (at the bottom of the sheet).

Below are some guidelines to help you complete the Sleep Diary.

1. *Napping*: Please include **all** times you slept during the day, even if you didn't intend to fall asleep. For example, if you fell asleep for 10 minutes during a movie, please write this down.
2. *Sleep Medication*: Include both prescribed and over-the-counter medications. Only include medications used as a sleep aid.
3. *Alcohol as a sleep aid:* Only include alcohol that you drank as a sleep aid.
4. *Bedtime*: This is the time you physically got into bed, with the intention of going to sleep. For example, if you went to bed at 10:45 p.m. but turned the lights off to go to sleep at 11:15 p.m., write down 10:45 p.m.
5. *Lights-Out Time:* This is the time you actually turned the lights out to go to sleep.
6. *Time Planned to Awaken:* This is the time you plan to get up the following morning.
7. *Sleep-Onset Latency*: Provide your best estimate of how long it took you to fall asleep after you turned the lights off to go to sleep.
8. *Number of Awakenings*: This is the number of times you remember waking up during the night.
9. *Duration of Awakenings*: Please estimate how many minutes you spent awake for each awakening. If this proves impossible, then estimate the number of minutes you spent awake for all awakenings combined. Don't include your very last awakening in the morning, as this will be logged below (#10).
10. *Morning Awakening*: This is the very last time you woke up in the morning. If you woke up at 4:00 a.m. and never went back to sleep, this is the time you write down. However, if you woke up at 4:00 a.m. but went back to sleep for a brief time (for example, from 5:00 a.m. to 5:15 a.m.), then your last awakening would be 5:15 a.m.
11. *Out-of-Bed Time*: This is the time you actually got out of bed for the day.
12. *Restedness upon Arising*: Rate how rested you feel on the scale of the diary sheet.
13. *Sleep Quality*: Rate the quality of your sleep using the scale on the diary sheet.

SLEEP DIARY

Name: _____

Week: _____ (Beginning date) to _____ (Ending date)

	Example ↓ M*on.*	*Fill in the Day of the Week above each column* ↓						
1. I napped from ____ to ____ (note times of all naps).	2:00 to 2:45 pm							
2. I took ____ mg of sleep medication as a sleep aid.	ProSom 1 mg							
3. I took ____ oz. of alcohol as a sleep aid.	Beer 12 oz.							
4. I went to bed at ____ pm/am.	10:30							
5. I turned the lights out at ____ pm/am.	11:15							
6. I plan to awaken at ____ am/pm.	6:15							
7. After turning the lights out, I fell asleep in ____ minutes.	45							
8. My sleep was interrupted ____ times (specify number of nighttime awakenings).	3							
9. My sleep was interrupted for ____ minutes (specify duration of each awakening).	15 20 30							
10. I woke up at ____ o'clock (note time of last awakening).	6:15							
11. I got out of bed at ____ o'clock (specify the time).	6:40							
12. When I got up this morning I felt ____ . (**1** = Exhausted, **2** = Tired, **3** = Average, **4** = Rather Refreshed, **5** = Very Refreshed)	2							
13. Overall, my sleep last night was ____ . (**1** = Very Restless, **2** = Restless, **3** = Average, **4** = Sound, **5** = Very Sound)	1							

NOTES:

Phase 3

Objectives:

1. Educate patient about the relapse prevention task
2. Relapse prevention task

Fidelity Checklist

The fidelity checklist provides specific actions and tasks that must be completed by the therapist during the third phase of B-CBT. Treatment should not be terminated until all items from the Phase 3 are accomplished, and the patient has demonstrated mastery/competency in using emotion regulation and distress tolerance skills to problem solve their way out of the index suicidal episode and possible future suicidal crises developed collaboratively by the patient and therapist.

No	Partial	Yes	***Relapse prevention task (first session, index)*** *Total # rehearsals: _____*
			Explained rationale for intervention
			Elicited feedback and questions about RPT
			Elaborated on original CTS
			Explicitly discussed new commitment to living
			Explicitly discussed removing suicide as a problem solving option
			Discussed the potential for negative emotional reactions to RPT
			Identified coping strategies and skills for use during RPT
			Obtained patient's consent to conduct the RPT
			Encouraged patient to recount index episode
			Strategically prompted patient to increase memory vividness
			Encouraged patient to imagine use of learned skills
			Focused on suicidal beliefs, emotions, behaviors, and circumstances directly related to crisis
			Debriefed patient
			Assigned homework for skills practice between sessions
			Encouraged patient to write assignment in treatment log
			Emphasized use of treatment log as a relapse prevention tool

No	Partial	Yes	***Relapse prevention task (follow-up session, index)*** *Total # rehearsals: _____*
			Explained rationale for intervention
			Elicited feedback and questions about RPT
			Identified coping strategies and skills for use during RPT
			Encouraged patient to recount index episode
			Strategically prompted patient to increase memory vividness
			Facilitated problem solving by introducing new challenges / barriers to skills use
			Encouraged patient to imagine use of learned skills
			Focused on suicidal beliefs, emotions, behaviors, and circumstances directly related to crisis
			Debriefed patient
			Assigned homework for skills practice between sessions
			Encouraged patient to write assignment in treatment journal

No	Partial	Yes	***Relapse prevention task (follow-up session, future scenario)*** *Total # rehearsals: _____*
			Explained rationale for intervention
			Elicited feedback and questions about RPT
			Addressed questions / concerns about RPT
			Collaboratively identified likely triggers for future suicidal episodes
			Identified coping strategies and skills for use during RPT
			Encouraged patient to recount future suicidal episode
			Strategically prompted patient to increase memory vividness
			Facilitated problem solving by introducing new challenges / barriers to skills use
			Encouraged patient to imagine use of learned skills
			Focused on suicidal beliefs, emotions, behaviors, and circumstances directly related to crisis
			Debriefed patient
			Assigned homework for skills practice between sessions
			Encouraged patient to write assignment in treatment journal

Relapse Prevention Task

When preparing for the relapse prevention task, it is important to thoroughly explain the intervention and technique to the patient. The relapse prevention task contains two separate but related components:

1. Mental rehearsal of the index suicidal episode

2. Mental rehearsal of possible future suicidal episodes

Therapists should be certain to address the following points when describing the relapse prevention task to patients:

- The patient has learned many new skills and strategies in treatment that have improved their ability to effectively manage emotions and crises.

- The patient has demonstrated increase competency in the use of these skills by successfully completing the first two phases of treatment.

- In the next phase of treatment, we want to make sure that the patient has truly gained mastery of these skills specific to the issue of emotional crises in general and suicidal episodes in particular.

- In order to assess mastery, we are going to complete a relapse prevention task.

- In the relapse prevention task, the patient will recall the circumstances of the original suicidal episode that brought the patient in for treatment by imagining the details of the situation, thoughts, and feelings they experienced at that time.

- The therapist will ask questions and provide prompts to increase the vividness of the memory. Increasing the memory's vividness is important because it puts the patient in a state of mind that is close to the original episode.

- During the task, the patient will imagine using new skills learned in treatment that can break the chain of the suicidal episode and prevent a suicide attempt.

- This task can be emotionally distressing for the patient. The therapist will be available to support the patient and help them to manage any emotional distress they experience, just like they have done throughout the course of treatment.

- Following the task, the therapist and patient will discuss the exercise together.

- The task will repeated several times to ensure mastery. With each additional task the patient therapist will provide challenging situations that will require problem solve in order to successfully use their skills.

- After several successful task completions, the therapist and patient will discuss potential suicidal episodes that are likely to occur in the future based on the patient's history and conceptualization.

- The relapse prevention task will be repeated in the same manner with the patient imagining these possible future scenarios, with the therapist again increasing the difficulty with each successive iteration.

- Upon successful completion of the relapse prevention task, treatment is concluded, and a follow-up plan will be discussed.

Sample prompts to help patients generate alternative ways of coping:

- How would you cope with this thought using the skills you learned?
- Is there an alternative explanation for this idea?
- How else might you solve the problem?
- Picture yourself thinking of other options right now. What might those be?
- Who might you call on the telephone?
- What would you do differently?
- What on your crisis response plan might be helpful?
- Picture yourself using your crisis response plan right now. What does it say?