

Cognitive behavioral therapy for suicide prevention (CBT-SP): Implications for meeting standard of care expectations with suicidal patients

Craig J. Bryan^{1,2}

¹National Center for Veterans Studies, Salt Lake City, UT, USA

²Department of Psychology, The University of Utah, Salt Lake City, UT, USA

Correspondence

Craig J. Bryan, National Center for Veterans Studies, The University of Utah, 260 S. Central Campus Dr., Suite 3525, Salt Lake City, UT 84112, USA
Email: craig.bryan@utah.edu

Abstract

Accumulating evidence supports the efficacy of cognitive behavioral therapy for suicide prevention (CBT-SP) as an empirically supported treatment approach for suicidal patients. In light of these findings, several procedures pulled from CBT-SP have been recommended for standard care with suicidal patients. The present article provides an overview of the procedures used in CBT-SP and discusses how these procedures meet, or even exceed, standard of care expectations for outpatient mental healthcare clinicians. Finally, the relevance of clinician fidelity to the CBT-SP model when evaluating standard of care expectations is discussed.

1 | INTRODUCTION

The US suicide rate has risen steadily over the past decade, claiming the lives of more than 40,000 individuals in 2016 (Centers for Disease Control and Prevention, 2018). Of those who die by suicide, half are actively engaged in mental healthcare at the time of their deaths (Fawcett, 1999), suggesting that a significant proportion of suicides could be prevented by improving the quality of mental healthcare for at-risk individuals. Emerging data accumulated over the past decade suggest that relatively brief variants of cognitive behavioral therapy for suicide prevention (CBT-SP) and procedures extracted from these treatments can lead to rapid and significant reductions in suicidal behaviors when used in a range of healthcare settings (Brown et al., 2005; Bryan et al., 2017; Miller et al., 2017; Rudd et al., 2015; Stanley et al., 2018). In recognition of these issues and emerging data, the National Action Alliance for Suicide Prevention (NAASP, 2018) recently published several recommendations for standard care with suicidal individuals across the following domains: identification and assessment, safety planning, means reduction, and caring contacts

(see Table 1). These recommendations address two key legal expectations related to clinicians' duty of care to their patients: foreseeability and reasonable care (Berman, 2006).

Negligence and liability in the case of a patient death by suicide are largely determined by *foreseeability*, which typically refers to the procedures used by the clinician to assess the likelihood and possibility of suicidal behavior prior to the act, and *reasonable care*, which typically refers to the procedures used by the clinician to reduce this risk (Berman, 2006). As discussed by Berman (2006), clinicians owe a duty of care to their patients, and if the court finds that this duty was breached via an act of omission or commission relative to the standard of care, and that this breach was proximally related to the patient's suicidal behavior, negligence may be found. To address the issues of foreseeability and reasonable care, clinicians are expected to conduct a reasonable assessment of a patient's suicide risk level and to provide appropriate interventions and treatments that are designed to mitigate this risk.

Central to the concept of the standard of care is the consideration of procedures and decision-making processes that are typically or routinely used by most clinicians when working with actively suicidal or other high-risk patients. Specific to outpatient mental health settings, there is an expectation that clinicians will screen for and/or assess patients for the presence of recent suicidal thoughts, plans, and behaviors, as well as other risk factors such as hopelessness, psychiatric disorders, and access to potentially lethal means for suicide (Berman, 2006; Bryan & Rudd, 2006). This expectation is often met through a combination of suicide risk screening measures, clinical judgement, and/or the implementation of standardized templates for documenting suicide risk. With respect to reasonable care, however, clinicians can vary considerably with respect to procedures and treatment approaches. This variability in practice approach is partly attributable to the limited training in empirically supported suicide prevention strategies received by most mental healthcare professionals, especially masters-level clinicians (Schmitz et al., 2012). Indeed, most mental healthcare professionals are not aware of newer, empirically supported treatment models and interventions (NAASP, 2018). As a result, a practice that remains common among outpatient mental healthcare professionals is referring suicidal patients for inpatient psychiatric treatment without considering the appropriateness of empirically supported outpatient therapy approaches like CBT-SP, which has been shown to significantly reduce suicidal behaviors among high-risk patients as compared with more traditional approaches to outpatient psychotherapy. CBT-SP can therefore enable clinicians to meet, and potentially even exceed, standard of care expectations associated with the care of suicidal and other high-risk patients in outpatient mental health care settings.

2 | COGNITIVE BEHAVIORAL THERAPY FOR SUICIDE PREVENTION

Cognitive behavioral therapy for suicide prevention is a psychological treatment that typically spans 10–12 outpatient sessions, although additional sessions are recommended for patients who do not demonstrate sufficient skill

TABLE 1 National Action Alliance recommendations for standard care with suicidal patients receiving outpatient mental healthcare

Domain	Recommendation
Identification and assessment	<ul style="list-style-type: none"> Identify and assess suicide risk at admission and whenever patients are seen by using a standardized scale
Crisis response planning/ safety planning	<ul style="list-style-type: none"> Complete a crisis response plan or the safety planning intervention during the visit where elevated risk is identified With consent, discuss the plan with family members to gain support
Means reduction	<ul style="list-style-type: none"> Discuss any lethal means considered by and available to the patient Arrange and confirm removal or reduction of lethal means, as feasible
Caring contacts	<ul style="list-style-type: none"> Initiate caring contacts during care transitions or if appointments are missed

mastery within this window of time. Two similar versions of CBT-SP have been tested: cognitive therapy for suicide prevention (CT-SP; Wenzel, Brown, & Beck, 2009) and brief cognitive behavioral therapy for suicide prevention (BCBT; Bryan & Rudd, 2018a). CBT-SP is organized such that patients progress through three sequential phases. In the first phase, clinicians conduct a suicide risk assessment, develop a treatment plan, collaboratively create a crisis response plan or safety plan, and conduct skills training focused on emotion regulation and crisis management. In the second phase, clinicians and patients focus on identifying and challenging the patient's maladaptive beliefs and self-statements which contribute to suicidal behaviors (e.g., hopelessness, perceived burdensomeness, entrapment). In the third phase, clinicians and patients complete a relapse prevention task to facilitate the consolidation of skills and to prepare patients for effectively managing stressful situations in the future.

Results of two randomized clinical trials support the superiority of CBT-SP as compared with treatment as usual (Brown et al., 2005; Rudd et al., 2015). Treatment as usual entails the provision of active treatments at the discretion of the treating clinician under conditions of routine care. As such, treatment as usual in these studies typically included a combination of psychotherapy (most often individual therapy) and psychotropic medications, as well as other indicated treatment modalities, such as substance use counseling, psychotherapy groups, and inpatient hospitalization. As compared with patients who received treatment as usual, patients who received CBT-SP were 50–60% less likely to make a suicide attempt for up to 2 years after starting treatment (Brown et al., 2005; Rudd et al., 2015). Subsequent analyses have further suggested that CBT-SP maintains its superiority even when patients in this treatment have received fewer sessions (Bryan & Rudd, 2015). In other words, a smaller number of CBT-SP sessions yields greater reductions in suicide attempts than a larger number of treatment-as-usual sessions. In addition, the benefits of CBT-SP have been supported regardless of gender, history of suicide attempts, multiple psychiatric diagnoses, and severity of suicidal ideation and planning (Bryan, Peterson, & Rudd, 2018; Bryan & Rudd, 2018a). In light of these findings, clinicians might consider using CBT-SP (or referring to a CBT-SP provider) for a wide range of patients with current or recent suicidal ideation. To date, there are no known contraindications for CBT-SP, although acute intoxication, mania, and/or psychosis should be stabilized prior to initiating the treatment.

The observed effects of CBT-SP mirror those observed in earlier trials of dialectical behavior therapy (DBT; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 2006), an alternative CBT-SP model that is much longer in duration (i.e., 6–12 months) and includes a combination of individual therapy and group skills training classes (Linehan, 1993). DBT similarly reduces suicide attempts among high-risk patients by 50% as compared with patients receiving treatment as usual, with recent evidence suggesting these effects are largely driven by DBT's focus on skills training classes (Linehan et al., 2015). Other studies have supported the efficacy of treatment protocols containing various combinations of the procedures contained within CBT-SP. For example, the crisis response plan (also known as the safety planning intervention) has been found to reduce suicide attempts by 45–76% among suicidal patients as compared with treatment as usual when used as a stand-alone intervention (Bryan, Mintz, Clemans, Burch, et al., 2017) or in combination with follow-up phone calls (Stanley et al., 2018). In addition, the Attempted Suicide Short Intervention Program (ASSIP; Michel & Gysin-Maillart, 2015) has been shown to reduce suicide attempts by 80% among patients who recently attempted suicide (Gysin-Maillart, Schwab, Soravia, Megert, & Michel, 2016). Underlying each of these treatments and interventions is a focus on teaching patients how to identify signs of an emerging crisis and how to use self-regulatory strategies to more effectively respond to stressful situations and/or emotional distress (Bryan & Rozek, 2018). From a clinical science perspective, this pattern suggests the possibility that treatments other than CBT-SP which emphasize procedures designed to facilitate self-monitoring and self-regulatory skills may contribute to reductions in suicide risk. For example, a psychodynamically oriented treatment called mentalization-based psychotherapy similarly focuses on self-monitoring and self-regulation and has demonstrated preliminary efficacy for the reduction of suicide attempts (Bateman & Fonagy, 2009). Several key components of CBT-SP relevant to standard of care expectations are discussed next.

2.1 | Informed consent

Informed consent involves the process by which clinicians discuss with their patients the potential risks and potential benefits associated with treatment. At a minimum, patients should be informed about the name of the treatment being provided, how the clinician learned to administer the treatment, how the treatment compares with other treatments (e.g., the proportion of patients who improve, the proportion of patients who get worse, and the magnitude of effect for the treatment), how the treatment works, and the possible risks associated with the treatment (Pomerantz & Handelsman, 2004). Although most mental health clinicians engage in the process of informed consent to some degree, clinicians rarely have direct and straightforward discussions with patients regarding the prevalence of suicide and suicidal behaviors among individuals who receive outpatient mental healthcare (Rudd et al., 2009). For example, an estimated 2% of patients with major depressive disorder who receive outpatient mental healthcare will die by suicide (Bostwick & Pankratz, 2001) and up to 50% of patients who start treatment with active suicidal ideation or a recent suicide attempt will engage in suicidal behavior during or soon after treatment (Rudd, Joiner, et al., 2009). Suicide death and suicidal behaviors are therefore common among patients engaged in outpatient mental healthcare, especially among those who begin treatment with elevated suicide risk.

In CBT-SP, these points are included as a routine part of the informed consent process. In the BCBT manual (Bryan & Rudd, 2018a), for example, a patient information sheet detailing these points is available, and is intended to facilitate a conversation between the clinician and patient about the realities of risk associated with this particular treatment as compared with alternative treatment models (including the option of receiving no treatment). With respect to risks associated with BCBT, this patient handout identifies and describes the possibility of increased emotional distress due to discussing difficult topics during treatment, which could increase the patient's desire to attempt suicide. Although the risk for suicidal behaviors is not necessarily caused by the treatment, this risk is nonetheless associated with treatment. In this way, CBT-SP directly acknowledges the potential for suicide death and suicidal behaviors from the very beginning of treatment and encourages open dialogue with patients about the issue, thereby addressing foreseeability in a way that extends beyond typical clinical practice. Given the elevated risk for suicide attempts and suicide death among patients with acutely elevated suicide ideation or a history of suicide attempts, outpatient clinicians may benefit from obtaining written consent in addition to verbal consent.

2.2 | Suicide risk assessment

As noted previously, suicide risk screening and assessment comprise a minimum standard of care expectation for all patients initiating outpatient mental healthcare, and speaks directly to the issue of foreseeability (Berman, 2006). The NAASP's (2018) recommendations for standard care build upon this basic expectation by specifying that suicide risk assessments should use a standardized instrument or scale. In addition, the NAASP recommends that suicide risk screening occur more frequently than at intake only, with increased suicide risk implicating the need for more frequent reassessments. These recommendations contrast with usual practice in outpatient mental healthcare settings, which typically includes an in-depth suicide risk assessment at intake only based on clinical interview methods that are not augmented by data collected from standardized risk assessment scales.

In addition to the suicide risk assessment conducted at the time of intake, in CBT-SP, suicide risk is assessed at every follow-up treatment session using a standardized instrument or scale of suicidal ideation, thereby meeting and exceeding the NAASP's recommendations. Although many different instruments and scales exist, Bryan and Rudd (2018a) noted that general symptom scales that measure a broad range of relevant symptoms and constructs in addition to suicidal ideation (e.g., insomnia, hopelessness, alcohol use, depression) may be especially useful and practical. Patients are asked to complete these assessment scales when they arrive and check in for each appointment so they can be reviewed together. Notable symptom change from the previous appointment as well as overall temporal trajectories are then discussed within the context of homework assignments and skills learned within

treatment. In this way, clinicians can reinforce effective skills use and positive progress, as well as quickly identifying problem areas or setbacks that warrant a shift in treatment planning. Using standardized assessment scales in this manner provides the benefit of using objective data sources to assess the potential for suicidal behavior and to inform clinical decision-making appropriately, thereby meeting expectations related to foreseeability.

2.3 | Crisis response planning

The NAASP (2018) also recommends for standard care the use of the crisis response plan (CRP), also known as the safety planning intervention (SPI), for short-term suicide risk management. The CRP is a brief procedure in which the clinician and patient collaboratively develop a written checklist of strategies that the patient can use to better recognize early indicators and precursors of suicidal crises and to employ effective self-regulatory strategies intended to reduce emotional distress (Bryan & Rudd, 2018a; Rudd, Mandrusiak, & Joiner, 2006). Typically written on an index card (or, in the case of the SPI, on a paper form), the CRP includes several key sections, as summarized in Table 2. In addition to playing a prominent and central role in CBT-SP, the CRP has been tested as a stand-alone intervention, with results of two separate clinical trials indicating that the procedure reduces suicidal behaviors by 45–76% as compared with treatment as usual among acutely suicidal patients (Bryan, Mintz, Clemans, Leeson, et al., 2017; Stanley et al., 2018). A self-guided version of the intervention, in which patients create a plan without the assistance or input of a trained healthcare professional, also reduces suicidal behavior as compared to treatment as usual, although to a lesser degree (i.e., 20% relative reduction; Miller et al., 2017).

Reductions in the severity of suicidal ideation post-intervention are significantly correlated with two components of the CRP, self-management strategies and social support networks (Bryan et al., 2018), a finding that suggests these procedures are key to reducing suicide risk. Evidence also suggests that the CRP's efficacy might be enhanced with the addition of a component focused on identifying a suicidal patient's reasons for living (Bryan, Mintz, Clemans, Burch, et al., 2017). In this enhanced version of the CRP, clinicians ask patients to identify their reasons for living (or for not killing oneself) and then engage patients in a brief discussion about these reasons for living. Similar to the CRP, the reasons for living task was initially developed as a procedure contained within CBT-SP, but was subsequently merged with the CRP in light of empirical evidence suggesting that a stronger wish to live can offset the wish to die and reduce the risk for suicidal behaviors (Brown et al., 2005; Bryan, Rudd, Peterson, Young-McCaughan, & Wertenberger, 2016). The integration of the reasons for living task into the CRP has been shown to result in significantly larger reductions in suicidal intent and significantly larger increases in hope and optimism in the short term (Bryan et al., 2017a; Rozek et al., 2018). A negative correlation between severity of suicide ideation over time and the frequency with which patients use the enhanced CRP has also been observed (Bryan et al., 2018), suggesting that the inclusion of the reasons for living component within a CRP provides an accumulative benefit for patients over time.

TABLE 2 Components of the crisis response plan

Component	Description
Warning signs	Indicators of a severe emotional or suicidal crisis
Self-management	Strategies that can be used to reduce emotional distress or distract oneself from the situation
Reasons for living	Positive aspects of life that elevate mood and provide a sense of purpose or meaning
Social support	People who can be contacted during times of need, or who elevate one's emotional state
Professional and crisis services	Contact information for mental healthcare providers, crisis hotlines, and emergency services

The CRP's efficacy for reducing suicidal behaviors is attributable in large part to its focus on identifying and strengthening patient's self-regulatory processes in response to stressful events and intense emotional distress. It therefore directly targets two key vulnerabilities for suicidal behavior: emotion dysregulation and cognitive rigidity (Bryan & Rozek, 2017). In this way, the CRP (and, by extension, CBT-SP) prioritizes suicide risk as a treatment target and provides the foundation for meeting standard of care expectations related to reasonable care.

2.4 | Means safety counseling

Although the restriction of access to potentially lethal means for suicide has been a recommended suicide risk management practice for many years, practical recommendations for approaching this challenging clinical task have only recently emerged and been articulated (Britton, Bryan, & Valenstein, 2016; Bryan, Stone, & Rudd, 2011). The approach to means safety counseling used in CBT-SP uses a combination of reflective listening, open-ended questions, affirmations, and summary statements intended to guide the patient to develop and implement a personalized plan for reducing easy access to potentially lethal means for suicide. The approach was developed with a particular eye towards patients who are firearm owners, but the method can be used for patients considering any potential method for suicide.

In CBT-SP, means safety counseling progresses through four phases: engaging, focusing, evoking, and planning. In the engaging phase, clinicians can raise the topic of firearms (or other methods) by asking an open-ended question in a nonjudgmental and nonthreatening way (e.g., "You mentioned you owned firearms. What types of guns do you have?"). Next, the clinician shifts to the focusing phase by redirecting or narrowing the patient's focus towards the topic of safety, again using a nonthreatening open-ended question (e.g., "What are the safety procedures you use at home for your gun?"). The clinician next transitions to the evoking phase, during which he or she asks follow-up questions to further understand the patient's practices and perspectives (e.g., "Are there times when you take extra precautions? What are your reasons for using those particular safety strategies? What are your thoughts about individuals having easy access to a gun when they are struggling with suicidal thoughts? If it's not safe to have access to a gun while suicidal, how would that apply to you?"). The evoking process encourages the patient to talk freely about means safety in a manner that respects his or her opinion and preserves his or her autonomy. Finally, the clinician shifts to the planning phase once the patient has expressed an openness to enact or enhance means safety procedures (e.g., "Given the importance of safety to you, what are some of the changes you think you could make at home to increase your safety?").

Once a plan has been established, the clinician and patient create a written means safety plan together, and the clinician asks the patient to identify someone in their lives who might be able to help enact or otherwise support the plan (e.g., a family member or friend). This supportive person can be invited to the next CBT-SP session to review the means safety plan with the patient and clinician, and to ask any questions he or she might have about how best to support the patient during treatment. In CBT-SP, means safety counseling can be integrated with the CRP, consistent with the SPI approach described by Stanley and Brown (2012). Alternatively, means safety counseling can be conducted as a separate procedure, consistent with the BCBT model described by Bryan and Rudd (2018a). No matter which approach is employed, means safety counseling enables the clinician to meet standard of care expectations for reasonable care because it directly targets a critical risk factor for suicidal behavior (i.e., easy access to potentially lethal means).

2.5 | Emotion regulation skills training

As previously noted, the two primary vulnerabilities for suicidal behavior that are targeted in CBT-SP are emotion dysregulation and cognitive rigidity (Bryan & Rozek, 2018). Emotion dysregulation involves two primary dimensions: difficulty identifying or naming one's emotions, and difficulty changing one's emotional state (Gross, 2014). CBT-SP

aims to undermine emotion dysregulation through training in several emotion regulation skills designed to reduce negative emotional states. For example, relaxation and mindfulness exercises aim to reduce emotional distress by targeting, respectively, autonomic arousal and rumination. The procedures can be complemented by interventions designed to promote positive emotional states and/or the wish to live (e.g., the survival kit or hope box). In combination, these procedures help patients to be more effective at influencing their internal psychological state, thereby reducing their propensity for suicidal behavior. Owing to the strong correlations among suicidal behaviors and various indicators of disrupted sleep and evidence indicating that sleep-focused interventions are associated with significant reductions in suicidal ideation (Trochel, Karlin, Taylor, Brown, & Manber, 2015), empirically supported strategies for reducing sleep disturbance (e.g., stimulus control) have also been recently integrated into CBT-SP. By using emotion regulation skills training, clinicians are able to meet standard of care expectations for reasonable care by directly addressing emotion dysregulation, a core vulnerability for suicide that facilitates the emergence of numerous emotional and behavioral risk factors for suicide.

2.6 | Cognitive flexibility skills training

Cognitive rigidity (or inflexibility) is the second key vulnerability for suicidal behavior that is targeted in CBT-SP (Bryan & Rozek, 2017). Cognitive rigidity involves three related dimensions: a lack of awareness of available options and alternatives in a given situation; an unwillingness to be flexible within the situation; and a lack of perceived self-efficacy regarding one's ability to flexibly adapt to the situation (Martin & Rubin, 1995). Cognitive rigidity provides the foundation for the full spectrum of suicide-related thoughts and beliefs that have played a prominent role in many theories of suicide: hopelessness, perceived burdensomeness, thwarted belongingness, entrapment, defeat, and self-hatred. CBT-SP aims to undermine cognitive rigidity through skills training in a range of cognitive flexibility skills designed to foster perspective-taking and problem-solving. For example, CBT-SP includes worksheets that were adapted from cognitive processing therapy (Resick, Monson, & Chard, 2017), an empirically supported treatment for individuals diagnosed with posttraumatic stress disorder, another psychological condition characterized by overly rigid thought processes and beliefs. These worksheets aim to teach patients how to recognize and categorize their automatic thoughts and underlying beliefs in various situations (e.g., *ABC Worksheets*, *Patterns of Problematic Thinking Worksheets*), how to critically evaluate these thoughts and beliefs (e.g., *Challenging Questions Worksheets*), and how to generate alternative interpretations and perspectives that are more balanced and less emotionally charged. In this way, patients learn how to reduce reactivity to stressful situations and to weaken suicide-specific beliefs that serve to maintain elevated suicide risk states. Cognitive flexibility training therefore enables clinicians to meet standard of care expectations for reasonable care by targeting a second core vulnerability for suicidal behavior, cognitive rigidity, which gives rise to host of empirically supported risk factors for suicide.

2.7 | Relapse prevention

An especially high-risk period of time for patients engaged in mental healthcare is during transitions to lower levels of care (Appleby et al., 1999). In order to ease this transition and to reduce the likelihood of recurrence of suicidal behavior, CBT-SP concludes with a relapse prevention task. This task entails a visualization-based exercise in which the patient is asked to recount the thoughts, emotions, behaviors, and physiological sensations leading up to and surrounding the suicidal episode (or suicide attempt) that was most proximally related to the initiation of outpatient treatment. As they recount this sequence of events, patients are instructed to visualize themselves successfully using a skill or strategy learned during the course of treatment to successfully resolve the situation. In other words, patients are asked to imagine themselves effectively responding to a suicidal crisis. This visualization task is repeated multiple times to facilitate skill consolidation and mastery. Once the patient has successfully completed this task, the patient

and clinician collaboratively identify hypothetical future situations and circumstances that are likely to activate intense emotional distress and/or a suicidal crisis, and then repeat the exercise.

Another recommended strategy that has not yet been formally integrated into CBT-SP is the use of periodic caring contacts following treatment completion. Caring contacts involve simple, nondemanding expressions of care, concerns, or interest about the patient (e.g., "I hope you're having a good day today; I hope life is treating you well; Just wanted to say hello and hope things are going okay"). Caring contacts can be delivered to patients on a regular basis via a range of communication methods, including phone call, email, postcard, and/or text message. Multiple randomized clinical trials indicate that caring contacts significantly reduce psychiatric hospitalizations, suicide attempts, suicidal ideation, and suicide death (Carter, Clover, Whyte, Dawson, & D'Este, 2007, 2013; Hassanian-Moghaddam, Sarjami, Kolahi, & Carter, 2011; Motto & Bostrom, 2001). In most cases, caring contacts are delivered on a monthly basis for up to 1 year post-treatment. Although caring contacts have not yet been formally integrated into CBT-SP protocols, they provide a simple and low-cost method for supplementing (and potentially enhancing) CBT-SP's effects after treatment has concluded.

Both the relapse prevention task and caring contacts address standard of care expectations with respect to both foreseeability and reasonable care because they acknowledge the possibility that suicide risk could re-emerge after treatment has ended and provide interventions that directly address this risk.

3 | CLINICIAN FIDELITY

In order for CBT-SP to be effective, clinicians should administer the treatment with a high degree of fidelity. Fidelity refers to the degree of specificity and reliability with which a clinician administers the various procedures and interventions contained within a psychological treatment. Whereas high fidelity means the clinician has administered the treatment in a manner that closely adheres to its original design, low fidelity means the clinician has administered the treatment in a way that departs from the treatment's original design. As has been noted elsewhere (Rudd, 2009, 2012), high fidelity is a common element of all empirically supported treatments for suicide prevention and is associated with reductions in suicidal behaviors (Gamarra, Luciano, Gradus, & Stirman, 2015; Green, Kearns, Rosen, Keane, & Marx, 2017). Unfortunately, fidelity tends to be poor to moderate among clinicians using the procedures and interventions contained in CBT-SP. For example, Gamarra et al. (2015) found that only half of clinicians who created a CRP discussed how to use the intervention with their patient, 29% reviewed the CRP in an ongoing manner, and only 10% asked their patient if it had been used and/or solicited feedback for their patients about the plan. Green et al. (2017) similarly found that most CRPs created by a clinician were only partially completed and were generally of poor quality. Although these studies investigated only one of CBT-SP's components, the findings nonetheless suggest that partial or incomplete administration of an empirically supported intervention for suicide prevention diminishes the intervention's efficacy.

These findings also suggest that typical practice in mental healthcare is characterized by considerable variability and low fidelity. To this end, clinicians who administer CBT-SP with high fidelity could reasonably be characterized as practicing in a manner that exceeds the standard of care. When evaluating the quality of care provided by a clinician in suicide death cases, fidelity is an important but under-recognized consideration because it can help to distinguish treatment failure from clinician failure. As noted previously, studies of CBT-SP and several of its constituent components have supported $\geq 50\%$ reductions in suicidal behavior among patients who receive this treatment model as compared with typical mental healthcare services delivered under routine conditions. Despite its superiority relative to usual care, however, it is critical to highlight published data indicating that c. 15–25% of patients who receive CBT-SP make a suicide attempt and c. 2% die by suicide during or soon after treatment (Brown et al., 2005; Rudd et al., 2015). CBT-SP therefore does not ensure that a given patient will never engage in suicidal behavior or die by suicide, even when the treatment is administered with high fidelity by clinicians who are being closely monitored and supervised. Rather, CBT-SP reduces the likelihood of these outcomes occurring, with the greatest reductions occurring when the treatment is delivered with high fidelity.

If a suicide death occurs during or soon after CBT-SP and the clinician can demonstrate that he or she has administered the treatment with high fidelity, it therefore becomes much more difficult to demonstrate negligence. Consequently, administering CBT-SP with high fidelity can benefit both patients and clinicians: for patients, high fidelity contributes to improved clinical outcomes; for clinicians, high fidelity helps to meet (and exceed) standard of care expectations.

4 | ADDITIONAL CONSIDERATIONS FOR CLINICAL PRACTICE

The CBT-SP was designed to progress through three phases focused on emotion regulation, cognitive flexibility, and relapse prevention. Within each phase, clinicians select from a menu of interventions and procedures designed to directly target each of these targets. CBT-SP therefore allows for the flexible administration of strategies selected because of their known effects on reducing risk factors and promoting protective factors (Bryan & Rudd, 2018). For example, relaxation strategies are used during the first phase of CBT-SP to reduce physiological arousal, emotional distress, and/or sleep disturbance, whereas in the second phase, worksheets are used to teach cognitive reappraisal skills designed to reduce suicidogenic cognitions like hopelessness and perceived burdensomeness. CBT-SP may therefore be best understood as a principles-focused treatment rather than a more traditional “manualized” therapy.

Research suggests that the majority of patients in CBT-SP are taking psychotropic medications at the time they start treatment, the most common of which are antidepressants (Brown et al., 2005; Linehan et al., 2006; Rudd et al., 2015). Unfortunately, no studies have yet examined how various combinations of psychotropic medication with CBT-SP (or other psychotherapeutic approaches) influence suicide risk. As a result, expert consensus panels like the National Action Alliance Clinical Care and Intervention Task Force (2012) have concluded that psychotropic medications do not play a direct role in managing suicide risk, but may play an important role for managing psychiatric symptoms that contribute to suicide risk (e.g., depression, psychosis). Clinicians are therefore encouraged to discuss the possible benefits and risks of psychopharmacological treatment with each patient at the outset of CBT-SP as well as during the course of treatment. In addition, continual monitoring of psychiatric symptoms and potential side-effects is recommended (Rudd, Cordero, & Bryan, 2009). Agitation and psychomotor restlessness, in particular, warrant particular attention (Rihmer, 2007). Patients already taking psychotropic medications who report or manifest these symptoms should be encouraged to contact a prescriber for consultation and guidance. Patients who report or manifest these symptoms, even if they are not taking psychotropic medications, might also benefit from an evaluation for possible pharmacotherapy.

These issues highlight the dynamic nature of suicide risk. Although, on the whole, CBT-SP reduces suicide risk over time, patients can nonetheless experience fluctuations in suicide over the course of CBT-SP (Bryan & Rudd, 2018b), further highlighting the importance of continual monitoring of risk during treatment. During periods of increased suicide risk, clinicians can respond by increasing session frequency (e.g., from once per week to twice per week) and/or by supplementing scheduled appointments with phone-based check-ins. If, in the clinician's judgment, a patient's level of suicide risk exceeds the safety constraints of outpatient care, the clinician should consider the possibility of higher levels of care including psychiatric inpatient hospitalization. After a patient is discharged from inpatient care, clinicians are encouraged to assess how contextual factors, symptoms, and behaviors interacted with each other in the days and hours leading up to the hospitalization to determine the appropriateness of adjustments to the treatment plan (for further discussion, see Bryan & Rudd, 2018a).

5 | SUMMARY AND CONCLUSION

CBT-SP is an empirically supported treatment modality that reduces suicidal behaviors by 50% or more when delivered in outpatient mental healthcare settings. The treatment's efficacy is attributable in part to its use of procedures that focus on reducing two core vulnerabilities for suicidal behavior: emotion dysregulation and cognitive

inflexibility. Key components of CBT-SP directly address standard of care expectations with respect to foreseeability and reasonable care. Of these components, the crisis response plan (also known as the safety planning intervention) and the use of standardized questionnaires for the purposes of suicide risk screening and assessment have since been recommended as standard care procedures when working with suicidal patients in outpatient mental healthcare settings (NAASP, 2018). Clinicians who administer the CBT-SP and its procedures as designed (i.e., high fidelity) can maximize patient outcomes as well as ensure they meet, and even exceed, standard of care expectations.

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