COGNITIVE-BEHAVIORAL THERAPY FOR SUICIDE PREVENTION – CBT-SP
INTRODUCTIONS

- **Dr. Kennard**
  - Professor in Psychiatry, UT Southwestern Medical Center
  - Director, Children’s Health Suicide Prevention and Resilience at Children’s (SPARC) Intensive Outpatient Program (IOP)
  - Research includes: Treatment of Adolescent Suicide Attempters (TASA) Study, Treatment of Adolescent Depression Study (TADS), Treatment of Resistant Depression in Adolescents (TORDIA) Study, Relapse Prevention CBT for Depressed Youth, Adolescent Trials Network Health & Wellness CBT, As Safe As Possible: Brief Intervention for Suicide Attempters

- **Dr. Hughes**
  - Assistant Professor in Psychiatry, UT Southwestern Medical Center
  - Psychologist and Head of Risk and Resilience Network at the UT Southwestern Center for Depression Research and Clinical Care (Director, Madhukar H. Trivedi, MD)
  - Research includes: Treatment of Adolescent Suicide Attempters (TASA) Study, Relapse Prevention CBT for Depressed Youth, Collaborative Adolescent Research on Emotions and Suicide (CARES) Study, Family Focused Therapy for Childhood Depression, SAFETY Intervention for Youth with Recent Self-harm Behavior, As Safe As Possible: Brief Intervention for Suicide Attempters
AGENDA

- Overview of Treatment
  - TASA study
  - CBT-SP Structure
- Safety Planning
- Chain Analysis
- Case Conceptualization (Using the Chain Analysis)
- Phases of Treatment
- Family Involvement
The 2nd leading cause of death in youth ages 15-19
- In 15-24 year olds, males are 3.6 times more likely to die by suicide than females.

2015 Youth Risk Behavior Survey: in their lifetime,
- 17.7% of US adolescents reported seriously considering suicide,
- 14.6% had made a plan
- 8.6% had made an attempt
- 2.8% had required medical attention

In teens with depression...
- 35-50% of depressed teens have made a suicide attempt

Nock, Green, Hwang, et al., 2013; Hoyert, 2012; CDC 2016
Main focus: reduction of suicidal risk
- Can be added to ongoing treatment
- Goal: help patients use more effective ways of coping with stressors that precipitate suicidal crises

Coping through training in cognitive, behavioral, and interactional skills
This manual is informed by several original sources:


THE TREATMENT OF ADOLESCENT SUICIDE ATTEMPTERS (TASA) STUDY
A multi-site NIMH-sponsored study of depressed suicidal adolescents

Ages 12-18, with depression (MDD, Dysthymia, or Depression-NOS) and a suicide attempt within past 90 days

Treatment: medication alone vs. CBT alone vs. medication and CBT (randomization vs. choice)

A feasibility study
PILOT STUDY OF TASA

- N=124 depressed adolescent suicide attempters
- Mostly open trial, 110 received CBT-SP
- Mostly female, age 16, Caucasian
- Depressed, 2.3 attempts
TIME TO ONSET OF SUICIDAL EVENTS AND ATTEMPTS IN TASA*

*Brent et al., 2009
## Predictors of Onset/Time to Onset of Suicidal Events (OR’s)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Occurrence</th>
<th>Time to Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>2.6</td>
<td>2.2</td>
</tr>
<tr>
<td>Caucasian race</td>
<td>-----</td>
<td>2.6</td>
</tr>
<tr>
<td>Site</td>
<td>4.5</td>
<td>4.6</td>
</tr>
<tr>
<td>Family cohesion</td>
<td>-----</td>
<td>0.94</td>
</tr>
<tr>
<td>No. previous attempts</td>
<td>-----</td>
<td>1.5</td>
</tr>
<tr>
<td>Lethality</td>
<td>0.5</td>
<td>0.6</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>18.2</td>
<td>4.4</td>
</tr>
</tbody>
</table>
CONCLUSIONS

- CBT-SP feasible, well-accepted
- 40% of events occurring within first 4 weeks—may need more intense intervention then
- Importance of improving suicidal ideation and functioning early
- Role of trauma

CBT-SP: TREATMENT STRUCTURE
Time limited (18 sessions over 6 months)

Individualized case conceptualization
- Precipitants
- Vulnerabilities
- Thoughts and feelings

More adaptive thinking patterns

Problem-solving

Management of distress and emotion arousal
Primary treatment target: reducing suicidal risk
- Not a diagnostic-specific treatment
- For example, depression is the focus of the treatment to the extent that the depression drives the suicide attempt

Prioritizing treatment (similar to DBT)
- Life-interfering behaviors
- Therapy-interfering behaviors
- Quality of life issues
INTENSITY AND LENGTH OF TREATMENT

- **Acute Phase**
  - 12 weeks
  - 12 – 16 sessions
  - And, up to 6 family sessions

- **Continuation Phase**
  - Additional 12 weeks
  - 6 total sessions (suggested every other week)
  - And, up to 3 family sessions

- **Family “check-ins”** (5-15 minutes) can be done weekly at therapist discretion
Overall Schematic of Treatment Course

- **Acute Phase**: 12-16 sessions
  - Skills Acquisition and Practice: Module Choice Informed by Case Conceptualization: Patient Strengths and Chain Analysis
  - Relapse Prevention

- **Continuation Phase**: 6 sessions
  - Consolidation of skills: Optional addition of new skills

**Getting Started**:
- Psychoeducation
- Safety Planning
- Chain Analysis
- Patient Strengths
- Case Conceptualization
STRUCTURE OF SESSIONS

- 1 hour, except first 2 are 1.5 hours for chain analysis/safety plan
- Agenda: life-threatening, therapy-threatening
- Mood and suicide check
- Use of safety plan
- Recall of last session, homework
- Review skill or learn new skill, based on case conceptualization
CBT-SP CHECKLIST (Session 1)
Suggested Time: 1.5 hours (Individual and Family), **Bolded text** indicates priority items

- Set agenda
- Build rapport with the patient
- Review confidentiality
- Review the previous session (if “Meet and Greet” session occurred)
- Mood Check and screen for hopelessness and suicidality
- Get the patient’s “buy-in” on the session
- Safety Plan (with patient)
- Identify if there is a need to do an early session on emotional regulation/distress tolerance
SESSION CLOSURE

- Collaborate on homework assignment
- Elicit feedback
- Session summary
- Take home message
- Safety Plan review
- Emergency numbers
SAFETY PLANNING
SAFETY PLAN

- Plan to help patients stay safe until next treatment session
- Hierarchically arranged, prioritized, and specific set of written coping strategies and sources of support
  - Coping and commitment thoughts
  - Internal strategies (distraction, soothing, physiological)
  - External strategies (distraction vs. talk about urges)
  - Clinical contact information
- Shared with parents/caregivers to address any obstacles and to identify opportunities for support
Safety Plan: An agreement and commitment to use skills, safety plan, or seek support before trying to hurt self

- NOT a “no harm contract” or “no suicide contract” (evidence these aren’t effective; Range et al., 2002; Stanford, Goetz, & Bloom, 1994; Simon, 1999)
PURPOSE OF SAFETY PLAN

- Help get through period of high emotion/distress safely
- Have to get through the peak of wave of emotion

Diagram:

- Peak:
  - Self-harm
  - Take a pill
  - Get a drink
  - Eat
  - Avoid (distract)

- Experiencing the emotion
- Coping
Used approach developed in Treatment of Adolescent Suicide Attempters Study (Brent et al., 2009; Stanley et al., 2009), now also used in numerous studies (e.g., Stanley & Brown, 2012) and listed in the Suicide Prevention Resource Center/American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention (www.sprc.org).

### Patient Safety Plan Template

#### Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1. 
2. 
3. 

#### Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):
1. 
2. 
3. 

#### Step 3: People and social settings that provide distraction:
1. **Name** Phone
2. **Name** Phone
3. Place

#### Step 4: People whom I can ask for help:
1. **Name** Phone
2. **Name** Phone
3. **Name** Phone

#### Step 5: Professionals or agencies I can contact during a crisis:
1. **Clinician Name** Phone
   Clinician Pager or Emergency Contact #
2. **Clinician Name** Phone
   Clinician Pager or Emergency Contact #
3. Local Urgent Care Services
   Urgent Care Services Address
   Urgent Care Services Phone
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

#### Step 6: Making the environment safe:
1. 
2.

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SAFETY PLAN: COMPONENTS

- Setting the Stage:
  - Making the environment safe
  - Identify warning signs

- Step 1: “On My Own” Coping

- Step 2: “With a Friend” Coping

- Step 3: “Tell Someone” Coping

- Clinical contact information
Think about ways in which the patient might play a role in making their environment safe, such as:

- Turning in or disposing of any hidden or collected pills/razors/etc.
- Making a plan with partner/spouse/friend/parents for room checks and/or “no questions asked” turn-in policy
- Creating “safe space” in room (i.e., removing any upsetting pictures, posters, music, etc.)
- Avoiding “risky” places where patient might feel increased self-harm urges (e.g., always cut alone in closet, avoid closet)
- Avoiding places where tempted to use drugs and alcohol
Best to tie to “emotion thermometer”, “feelings thermometer”, or “wave of emotion” concept

Help patient identify intensity of distress and more “at-risk” signs

Stick with CBT model:
  - Feelings (emotion words and body feelings)
  - Thoughts
  - Actions
Feel the Worst

Identify high-risk situations, feelings, thoughts, and physiological reactions for self-harm behavior

Feel the Best

• Develop Safety Plan for coping with high self-harm urges
<table>
<thead>
<tr>
<th>Situation</th>
<th>Reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Break-up with boyfriend</td>
<td>Thoughts: “I’ll never get another boyfriend,” “I’m worthless,” “If nobody loves me I might as well die”&lt;br&gt;Feelings: Anger, sadness, shame&lt;br&gt;Behaviors: Cry, suicide attempt&lt;br&gt;Body sensations: hot, flushed face, fatigue</td>
</tr>
<tr>
<td>Doing poorly in school</td>
<td>Thoughts: “I’m stupid,” “I am a loser.”&lt;br&gt;Feelings: Sadness, embarrassment&lt;br&gt;Behaviors: Stay in my room, give up&lt;br&gt;Body sensations: body feels heavy, tired</td>
</tr>
</tbody>
</table>
## SAMPLE: FEELINGS THERMOMETER

<table>
<thead>
<tr>
<th>Situation</th>
<th>Reactions</th>
</tr>
</thead>
</table>
| 5 Nothing to do   | Thoughts: “I’m bored”  
Feelings: Feel neutral, a little irritated, restless  
Behavior: Watch television, call friends or boyfriend  
Body sensations: no noticeable body sensations |
| 0 Chilling with friends | Thoughts: “This is fun,” “I like my life.”  
Feelings: Happy, content  
Behaviors: laughing, talking with friends, doing activities like movies and shopping  
Body sensations: a lot of energy, feeling light |
### SAMPLE: COPING PLAN

<table>
<thead>
<tr>
<th>Situation</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>See ex-boyfriend at school</td>
<td>• “It feels hard now AND it will get better.”</td>
</tr>
<tr>
<td></td>
<td>• “I wasn’t going to marry him anyway!”</td>
</tr>
<tr>
<td></td>
<td>• Take deep breaths (focus on pacing; notice temperature difference)</td>
</tr>
<tr>
<td></td>
<td>• Focus on school work</td>
</tr>
<tr>
<td></td>
<td>• Find best friend for support</td>
</tr>
<tr>
<td></td>
<td>• Talk to Mrs. P (English teacher) or Ms. C (counselor)</td>
</tr>
<tr>
<td></td>
<td>• Use SAFETY Plan or hope kit</td>
</tr>
<tr>
<td></td>
<td>• Call Mom</td>
</tr>
<tr>
<td></td>
<td>• Call Dr. Jenny for coaching</td>
</tr>
</tbody>
</table>
INTERNAL STRATEGIES: HOW CAN I COPE WHEN I AM ALONE?

- Coping and commitment thoughts
- Distress tolerance skills (skills to help you get through it without making it worse)
  - Distraction
  - Soothing
  - Physiological (temperature, intense exercise, paced breathing, progressive muscle relaxation)
INTERNAL STRATEGIES: HOW CAN I COPE WHEN I AM ALONE?

- Coping and commitment thoughts
  - “What could you say to yourself to remind you of your safety plan?” “You can do it; it works.”
  - “What could you say to yourself to motivate you to use the plan?” “I know it is hard, but I’ll be glad I did.”
  - “What commitments can you remind yourself about to help you use the plan?” “I told my Mom I’d use the plan.”

- Have patient write as many as needed on the Safety Plan
INTERNAL STRATEGIES: HOW CAN I COPE WHEN I AM ALONE?

- **Distraction**
  - Activities
  - Music
  - Volunteering/helping out
  - With other emotions (e.g., funny cards or Youtube clips, scary movie)
  - With other thoughts (e.g., counting, naming colors in the room, repeating poem or song in mind or writing, puzzles, reading)

- The trick is to be fully mindful of the distraction!
INTERNAL STRATEGIES:
HOW CAN I COPE WHEN I AM ALONE?

- Soothing
  - Vision (e.g., pictures in book, one flower, look out window, nature, art)
  - Hearing (e.g., music, nature sounds, city sounds, humming, playing music, listening to one instrument in song)
  - Smell (e.g., favorite lotion, scented candle, smell flowers)
  - Taste (e.g., favorite food, sample flavors in ice cream store, chew favorite gum)
  - Touch (e.g., long hot shower, pet animal, massage, hug someone, sit in comfortable chair, wear favorite soft shirt)
  - Movement (e.g., dance around, jumping jacks, wiggle foot, yoga, stretch)

- The trick is to be fully mindful of the sensation!
INTERNAL STRATEGIES: HOW CAN I COPE WHEN I AM ALONE?

- Physiological
  - Intense exercise
    - Helps to calm body
    - Brief and intense (e.g., jumping, sprinting, lift weights)
  - Paced breathing
    - Slow pace of breathing to 4/6 or 5/7 count, with out breath longer than in breath
    - Lowers heart rate; that time combination gets most people to resting heart rate
    - Breathing Apps to help with this (e.g., “Breathe2Relax” app)
EXTERNAL STRATEGIES: PEOPLE WHO CAN HELP DISTRACT ME

- Meant to be a list of activities patient can request to do with a person to help distract from suicidal urges
  - Want specific people listed
  - Want specific activities listed
  - E.g., “watch episodes of Sherlock with my best friend, Jess”
EXTERNAL STRATEGIES: PEOPLE WHO CAN HELP DISTRACT ME

- Role play how patient might ask person to do this activity
- Patient doesn’t necessarily have to ask this person for support related to emotions
  - E.g., “Mom, can we bake cookies today?”
  - E.g., “Sarah, want to go to a movie today? I really need to get my mind off work for awhile.”
Want a list of people the patient will really talk to.

For youth, need to have mostly adults on this list

- If another youth is on the list (e.g., best friend, boyfriend), youth agrees to discuss how other youth might get adult help if needed
  - E.g., youth agrees not to get mad if best friend calls Mom when concerned
  - Role play how youth might discuss this with friend
EXTERNAL STRATEGIES: ADULTS WHOM I CAN ASK FOR HELP

- Include Suicide Prevention Lifeline
  - Do practice call with patient so they know what to expect
- Phone numbers for other providers (e.g., outpatient therapist and/or psychiatrist, primary care physician)
Based on chain analysis, which identifies cognitive, behavioral, affective, and contextual problems

Comprised of interventions based on product of likelihood of success and willingness of patient/family to carry out a particular intervention
Firearms used by 66.4% male suicide victims; 48.3% female suicide victims (McIntosh, 2000)

Availability of firearms in home differentiates adolescent suicide victims (74.1%) from hospitalized suicidal adolescents (33.9%) (Brent et al., 1998)
LETHAL MEANS RESTRICTION

4 out of 10 suicides may be prevented by limiting access to means

AMERICAN FOUNDATION FOR Suicide Prevention | afsp.org/DidYouKnow
LETHAL MEANS RESTRICTION

- **LOCK UP ALL MEDICATIONS**
  - Over-the-counter and prescription medications, as well as vitamins
  - Dispose of medications you no longer need, and keep track of quantities of medication

- **SECURE FIREARMS**
  - Outside of the home, secured in a gun safe
  - If this is not possible, lock unloaded firearms securely and separately from ammunition

- **LOCK UP ALL SHARPS AND OTHER POTENTIALLY DANGEROUS ITEMS**
  - Sharps include knives, scissors, razors, pencil/eye-liner sharpeners, removable corners of picture frames, safety pins, screws, nails, and needles
  - Car keys, ropes, ties, scarves, belts, extension cords, household cleaners, and bleach
  - Consider items in the home and in the garage
  - Do not allow access to alcohol or drugs within the home
LETHAL MEANS RESTRICTION

- WORK WITH YOUR CHILD/FAMILY MEMBER TO ADDRESS SAFETY AND THEIR BELONGINGS
  - room, favorite rooms in the home, school locker and desk
  - Backpack/purse, desks/drawers, closets, corners of carpet, hollow curtain rods, inside pillow cases and zippered pillows, pants and jacket pockets, and soles of shoes

- TAKE THE SAME PRECAUTIONS IN THE HOMES OF FRIENDS AND FAMILY, AS NEEDED

- RESOURCES
  - https://www.hsph.harvard.edu/means-matter/
  - http://www.yspp.org/about_suicide/means_restriction.htm
  - Common places to purchase lock boxes include Amazon.com, Walmart, Home Depot, Target, Sears, Staples, and Lockmed.com.
CHAIN ANALYSIS
Reconstruct events, thoughts, feelings leading up to the suicide attempt

Freeze frame (Wexler, 1991)

Identifies precipitants, motivation, intent, current reaction, reaction of environment

Identified stressors and vulnerabilities, in order to develop a case conceptualization
1.10.06 Chain Analysis

Angry

Argument with mom or boyfriend (Angi) or boyfriend (Oscar)

Problem-solving

School upgraded drug teachers ask what's going on

Try to be independent; don't like adult people telling me

Want to die

Thought about suicide

Thought: I want to die

Told self

Friend

3.14.06

Other people look at me as if I didn't really want to get me

Reviewed 1/25/01

Reviewed 2/14/06
CHAIN ANALYSIS: EXAMPLE WITH SKILLS

Argument with mom

- irritable
- angry

“I wish they would leave me alone; I’m fine.”

Cognitive restructuring, Problem solving

“I’m sick of this!”

Drop in grades and teacher’s asking “what’s wrong”

Try to be independent; don’t like people feeling sorry for me

Asking for Support

Family therapy, High Expressed Emotion

“I wish they would leave me alone; I’m fine.”

“I’m sick of this!”
Thought about summer and molestation

Sad, crying

Thought about wanting to die

“This is too much!”

Cognitive restructuring, Talking back to thoughts

Cut self with razor

Expressed Emotion

Reasons for Living

Self talk; Affect Regulation

Affect Regulation
CHAIN ANALYSIS

- Describe the specific problem behavior (e.g., suicidal behavior, over-eating, yelling a Mother, late to session)
- Be specific and detailed
  - Identify EXACTLY what you did, said, thought, or felt
  - Identify what you DID NOT do
  - Describe intensity of behavior/thought/feeling
  - Describe in enough detail so that an actor could “play it out”
- Prompting Event: environmental event that started the chain
  - What started this chain reaction?
  - When did the problem start?
  - Why did the problem behavior happen that day, instead of the day before?
Vulnerability factors: what made you more vulnerable to reacting to the prompting event with a problem behavior?
- Physical illness, eating or sleeping difficulties, pain
- Drug/alcohol use or abuse
- Stressful events in the environment (negative or positive)
- Intense emotions

Chain of events: write out all of the links
- Actions
- Body sensations/feelings
- Cognitions
- Events in the environment or things other people did
- Feelings/emotions
TIPS FOR CHAIN ANALYSIS

- Ask questions of what, where, when, how, who—don’t ask why!

- Start with target behavior and go backwards in time

- Use routine times throughout the day to anchor event (ie. Dinner time, TV shows, school time, etc.)

- Trying to assess if issue was a problem in orientation to treatment, commitment, skill deficit, or aspect of classical/operant conditioning

- Highlight/reinforce any skillful behavior
CASE CONCEPTUALIZATION USING THE CHAIN ANALYSIS
IDENTIFY TREATMENT TARGETS

- Manage Crisis first
  - Truce at home?
  - School plan or Work plan

Vulnerabilities: What was different that day? Why that day and not another day?
  - Sleep
  - Alcohol, substance use

Protective Factors:
  - Reasons for living
  - Support
  - Skills Deficits
PRIORITIZING

1. Life threatening
2. Therapy threatening
3. Quality of Life (things that are functionally impairing)
Remember collaborative approach:
- What does the patient and therapist BOTH see as what is needed to prevent suicidal behavior?
- What would have prevented this past attempt?
- What intervention builds upon existing strengths and resources of patient and family?
- What is the patient/family WILLING to try?
COMORBIDITY

- Multiple problems are common
- Focus is on reducing suicidality
- Can work on other problems if related to attempt (example, bulimia trigger attempt; skin picking, etc.)
THERAPY-THREATENING

- Hopelessness
- Lack of agreement/participation with treatment plan
- Not doing homework
- Transportation
- Late to session
- Coming in under the influence of drugs/alcohol
FUNCTIONAL IMPAIRMENT

- Links in chain will point to areas to target
- Discuss these with individual to agree on skills to focus on
- Discuss with parents/family
- Finalize treatment plan
INITIAL TREATMENT (FIRST 3 SESSIONS)

- Chain analysis
- Safety Planning
- Psychoeducation
- Developing Reasons for Living and Hope Kit
- Case conceptualization
INTRODUCING CBT-SP TO THE TEEN/FAMILY

- Focus is on preventing future suicidal behavior
- Educate that risk is high because of risk factors (event history, NSSI, vulnerabilities)
- Focus on what patient can do to stay safe (Safety plan, communication)
- Focus on what parents/family can do (Environment safety, communication, truce, adjust expectations).
- Agreement to attend therapy, take medications
- Parents/family must take care of themselves, seek treatment if needed.
- Frequent review and modification of safety plan
- Early on in treatment identify reasons for living; hope kit
Encourage patients to identify small and large RFL.
  - For example, getting a good grade on a test might be a small or short-term reason; whereas graduating college might be a large or long-term reason for living.
  - Explain the importance of having a variety of RFL.

Encourage patient to identify any interests/hobbies/goals/activities that have personal meaning or interest and any other reasons for living that come to mind

How might they practice RFL this week?
Depression as illness, not anyone’s fault
Risks/benefits of treatment options
Expectable course and outcomes, including possibility of reversal and recurrence
Depression runs in families; untreated depression in parents makes child less likely to respond to treatment
HOPE KIT

- Specific (tangible) reasons for living
  - Pictures of loved ones
  - Religious reminders (if have moral objection to suicide)
  - Places that give pleasure (beach, mountains)
  - Aspirations (business card in chosen profession)
Take your time.

* Make sure you're not making a big deal out of a small issue.
* Use skills from coping cards.
* Look at hope kit.
* Talk to God.
MIDDLE PHASE OF TREATMENT

- Individual and/or Family Skill Modules
  - Behavioral Activation
  - Cognitive Restructuring
  - Problem Solving
  - Communication and Compromise
  - Emotional Regulation and Distress Tolerance

- Individual Skill Modules
  - Mobilizing Social Support
  - Social Skills:
    - Social Interaction
    - Assertion
  - Motivational Interviewing
  - Relaxation
SESSION AGENDAS/CHECKLIST

CBT-SP CHECKLIST (Session 3)
Suggested Time: 1.5 hours (Individual and Family), Bolded text indicates priority items

1. _____ Collaboratively set agenda
2. _____ Review of previous session (elicit feedback and summary)
3. _____ Review session number and review self-reports (including Mood Check and screen for hopelessness)
4. _____ Screen for current suicidality and reaffirm the SAFETY PLAN.
   a. Problem solve any “Life and therapy interfering behaviors”, including missed appointments, self-harm, or suicidality.
5. _____ Review Homework from previous session.
6. _____ Collaborative Treatment Planning
7. _____ Introduce and explore new skill.
8. _____ Collaboratively develop a homework assignment with the teen
9. _____ Elicit feedback and ask the parents and teen to summarize the session

10. ____ INVITE PARENTS INTO THE SESSION:
    i. Set agenda
    j. Discussion of Collaborative Treatment Planning
    k. Elicit feedback and have the family summarize the session.
    l. Review Family Homework (if applicable). Collaborate on new homework.

11. ____ Confirm that the teen and family have emergency contact numbers and procedures

In the early part of the session:

Set agenda
Check mood/suicidal ideation
Make connections from last session
(See pg. 118 for full session checklist)
MODULE SELECTION BASED ON...

- Chain analysis
- Case conceptualization
- Collaboratively developed treatment plan
FINAL PHASE OF TREATMENT

- Relapse Prevention
- Continuation Treatment
RELAPSE PREVENTION TASK

- Toward end of acute treatment
- In vivo guided imagery to reconstruct events and induce feelings leading up to the attempt
- Get to re-do the attempt but using new skills
The Relapse Prevention Task consists of five steps:

- Preparation
- Review the Past Attempt
- Review the Past Attempt with Skills
- Review a Future High Risk Scenario
- Debriefing and Follow-up
ADDRESSING PATIENT RESISTANCE TO RP TASK

- Give strong rationale
- Prepare ahead of time
- Practice imagery ahead of time
- Review any hesitancy
  - Validate
  - Address any cognitive distortions
  - Highlight helpful thought, “This will be a chance to review all of the hard work you have done/skills you have learned!”
- Leave time at end for “closing up”
Let family member know ahead of time (particularly with teens, let parent know)

- Give rationale for the task
- Remind of safety plan
- Consider family session where patient shares about experience and shares about effective skills use
CONTINUATION PHASE

- 6 sessions over the next 3 months
- New skills, as needed
- Skills consolidation
- Address relapse prevention
  - Anticipation of future crises and strategies to cope with them
  - Warning signs of suicidal crises, goals achieved by therapy, skills learned, anticipate future crises, identify need for further treatment

- Plan for next steps
  - Discharge planning begins early and often with these patients!
  - Transition points are often difficult!
  - Goal to have follow-up appointments in place prior to end of CBT-SP
FAMILY INVOLVEMENT
INDIVIDUAL AND/OR FAMILY SKILL MODULES

- Behavioral Activation
- Cognitive Restructuring
- Problem Solving
- Communication and Compromise
- Emotional Regulation and Distress Tolerance

- Remember, you can use these modules as family sessions
FAMILY SKILL MODULES

- Contingency Management
- High Expectations and Positive Reinforcement
- Attachment and Commitment
- Negative Emotions
THANK YOU

- Thank you to Dr. Molly Lopez, Erica Shapiro, and the ZEST initiative for inviting us!

- Thank you all for listening!

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Books:
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- CBT for Depression in Children and Adolescents: A Guide to Relapse Prevention, 2016, by Betsy Kennard, Jennifer Hughes, and Alex Foxwell

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