Practice Innovations

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Online First Publication, April 6, 2026. https://dx.doi.org/10.1037/pri0000327

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ISSN: 2377-889X
https://doi.org/10.1037/pri0000327

Brief Cognitive–Behavioral Therapy+ as a Suicide-Specific Treatment Add-On

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Brief Cognitive–Behavioral Therapy+ is a brief, evidence-based, suicide-specific treatment add-on that can be utilized across the full spectrum of clinical settings when elevated suicidality emerges. Although the four modules are specific to elevated suicidality, the treatment model and theoretical foundation are ones that are complementary to general models of human emotional functioning and, accordingly, can be integrated into treatment as usual without disrupting ongoing psychotherapy. The considerable empirical support for Brief Cognitive–Behavioral Therapy+ is reviewed, along with a detailed review of each module, and fidelity checklists for each are provided. Of importance, the issue of emotional salience and efficacy is discussed, including clinical examples for developing a reasons for living list as part of the crisis response plan. Finally, clinical integration issues are discussed, identifiable limitations are noted, and related recommendations are offered.

Clinical Impact Statement
Brief Cognitive–Behavioral Therapy+ offers the practicing clinician an evidence-based, brief, and effective option for the management of elevated suicidality. In addition to the possible application across the full spectrum of clinical settings, the Brief Cognitive–Behavioral Therapy+ framework offers a theoretical perspective that is easily integrated into the most common problems and clinical diagnoses typical of those struggling with elevated suicide risk.

Keywords: brief cognitive–behavioral therapy for suicide prevention, evidence-based treatment, randomized clinical trials, elevated suicide risk, treatment fidelity

Brief cognitive–behavioral therapy for suicide prevention (BCBT-SP) is a robust suicide-specific intervention that has been rigorously tested in multiple randomized clinical trials (RCTs; see Table 1) as both a stand-alone outpatient treatment and as an abbreviated treatment add-on intervention, Brief Cognitive–Behavioral Therapy+(BCBT+), for individuals at elevated suicide risk already receiving treatment as usual (TAU; Rudd, 2025; Rudd et al., 2015). BCBT+ is an abbreviated adaptation (4.5 hr) of the BCBT-SP protocol, representing a 62.5% reduction from the full protocol. Table 1 provides a summary of the BCBT-SP RCTs completed to date, with consistent findings and significant reductions in posttreatment suicide attempts relative to TAU. Despite the brief and targeted nature of BCBT+, a recent inpatient RCT found it reduced 6-month postdischarge suicide attempts by 61%, subsequent emergency department visits by 75%, and hospital readmissions by 71% compared to TAU (Diefenbach et al., 2024).

Even with consistent findings across multiple RCTs demonstrating the efficacy of BCBT-SP with high-risk suicidal individuals, a recent implementation pilot study using the full BCBT-SP protocol reported significant challenges in expanding the use of BCBT-SP in routine clinical practice (McLaughlin et al., 2025). Although clinicians who completed BCBT-SP training viewed the

Linda Campbell served as action editor.
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Table 1
Summary of BCBT-SP Randomized Clinical Trials

Study	Design	Treatment	Session	Comparison condition	Clinical setting	Follow-up (month)	Finding[a] (RR)
Brown et al. (2005) $n = 120$	RCT	CBT-SP	10	TAU	Outpatient	18	CBT-SP: 24% TAU: 42% (50%)
Rudd et al. (2015) $n = 152$	RCT	BCBT-SP	12	TAU	Outpatient	24	BCBT: 14% TAU: 40% (60%)
Sinyor et al. (2020) $n = 24$	Pilot RCT	BCBT-SP	10	TAU	Outpatient	12	BCBT: 0% TAU: 25% (100%)
Diefenbach et al. (2024) $n = 200$	RCT	BCBT-I[b]	4	TAU	Inpatient	6	BCBT-I: 25% TAU: 63% (60%)
Baker et al. (2024) $n = 85$	RCT	BCBT-SP Telehealth	12	PCT	Telehealth	12	BCBT: 29% PCT: 40% (45%)
Bryan et al. (2025) $n = 108$	RCT	BCBT-SP	12	PCT	Outpatient	12	BCBT: 5.6% PCT: 27.9% (80%)

Note. BCBT-I also reduced relative risk for inpatient readmission by 71% and 75% for emergency department visits for those without substance use disorders. BCBT-SP = BCBT for Suicide Prevention; RR = relative rate; RCT = randomized clinical trials; CBT-SP = Cognitive–Behavior Therapy for Suicide Prevention; TAU = treatment as usual; BCBT-I = BCBT–Inpatient; BCBT = Brief Cognitive–Behavioral Therapy; PCT = person-centered therapy.
[a] Relative reduction in risk for suicide attempt during follow-up period. [b] BCBT-I is the abbreviated protocol, synonymous with BCBT+.

protocol favorably, only 27% used it with a suicidal patient in their day-to-day clinical practice over the following year. Among those who implemented the suicide-specific evidence-based treatment (EBT), the majority only did so with a single patient, citing significant real-world clinical challenges, including (a) the length of the protocol, (b) related scheduling difficulties for patients, (c) clinical needs and demands of the patient that disrupted coherent delivery of the full protocol, and (d) related overall workload demands that prevented them from integrating the protocol into their day-to-day clinical work.

The implementation problems encountered by the full BCBT-SP protocol are not unusual and are fairly common in efforts to expand the use of empirically informed clinical interventions. The complexity and nuanced nature of psychological treatments make their integration into clinical practice particularly challenging when compared to treatments in other health care domains (McHugh & Barlow, 2010). McHugh and Barlow (2010) posited that both didactic training (e.g., written materials, workshops) and sustained competence training (e.g., skills training, role plays, supervision) are required in order for clinicians to successfully deliver EBTs skillfully, consistently, and with fidelity. Because integration of targeted psychotherapy and psychosocial protocols into clinical practice is often resource-dependent and unique to a range of organizational factors, successful implementation of new treatment protocols requires substantial effort and faces a number of consistent obstacles (Stein et al., 2013).

Examples of the complexity of this challenge can be seen across a variety of treatment modalities. In a literature review examining the implementation of dialectical behavior therapy, factors such as extensive training, supervision, consultation, and clinician commitment to the therapy were essential for successful implementation (Toms et al., 2019). However, pointed out that costs associated with dialectical behavior therapy training may be difficult to recoup for organizations and that fidelity to the protocol requires ongoing and sustained training, consultation meetings, and data collection, none of which are billable services. Furthermore, they reported that clinicians already trained in one treatment modality may not see the value of a new one and that clinicians working with certain clinical populations (e.g., severe illness and high-risk

contexts) may be too burned out to dedicate sufficient energy to learning a new treatment. In a study examining the implementation and adherence to interpersonal therapy and cognitive–behavioral therapy (CBT) for depression, several clinician factors, such as age, education, and supervisor attitudes, played significant roles in how well protocols were followed and utilized in day-to-day clinical practice (Bruijniks et al., 2018).

The maintenance of treatment or intervention fidelity is a consistent challenge in expanding the use of empirically informed approaches. Therapists trained in multiple techniques were more likely to modify treatment protocols in day-to-day practice, and older therapists with more experience were less strict in their overall protocol adherence (Bruijniks et al., 2018). Additionally, patient factors such as being in crisis, low motivation for treatment, and comorbid diagnoses (e.g., post-traumatic stress disorder, anxiety disorders, mood disorders, and personality disorders) also influenced clinicians' decisions to modify interpersonal therapy or CBT protocols (Bruijniks et al., 2018). In a recent systemic review, Ackland et al. (2023) found that the implementation of cognitive processing therapy and prolonged exposure in Veterans Health Administration settings were difficult due to perceived protocol inflexibility, complicated referral procedures, overall case complexity, and diagnostic comorbidity. Similarly, in a survey of clinicians who received cognitive processing therapy training, the two most common reasons provided for not using the treatment were having no room in their schedule and their clinical workload being too heavy (Chard et al., 2012).

Why BCBT+ as a Treatment Add-On Is Unique

BCBT+ addresses many of the implementation barriers summarized above. In contrast to the full protocol, the BCBT+ adaptation includes only four treatment modules, is dramatically less time-consuming (a total of 4.5 hr and a 67% reduction from the full protocol), and demonstrates comparable efficacy compared to the full protocol (Diefenbach et al., 2024). BCBT+ is conceptualized as a suicide-specific treatment add-on that targets elevated suicide risk and recognizes that it often co-occurs with a range of diagnoses, including most frequently mood, anxiety, and personality disorders (Rudd et al., 1993). Although problem-specific, BCBT+ provides a conceptual model that is integrative in nature and views suicide risk as part of a general model of human emotional functioning—one that applies to the full range of problems often found to co-occur with elevated suicide risk (Rudd, 2025). This is not necessarily the case when isolated suicide prevention interventions are used in outpatient or inpatient settings, of which safety planning (Stanley & Brown, 2012) is arguably the most common.

As a treatment add-on, BCBT+ was not intended to replace the existing TAU protocol; rather, it was developed to target a specific clinical problem with an EBT. Accordingly, BCBT+ offers a flexible conceptual model that is easily integrated into the theoretical foundation of TAU typical in most clinical settings. In short, when someone receiving BCBT+ completes a session or module during a period of elevated suicide risk, they are unlikely to be confronted with information that conflicts with the broader treatment regimen and problem conceptualization. Finally, as a strategic treatment add-on, BCBT+ can be delivered in a manner that complements and avoids disrupting TAU. As McLaughlin et al. (2025) reported, time demands in one way or another were at the heart of implementation problems. As a suicide-specific treatment add-on, BCBT+ was developed not only to strategically target elevated suicide risk but also to do so in a flexible manner that can accommodate the unique scheduling demands of a general clinical setting.

The clinical utility of the BCBT+ modular approach as a suicide-specific treatment add-on is also supported by several recent meta-analyses. Janssen et al. (2025) found that CBT interventions including a narrative suicide risk assessment were associated with a significantly reduced risk of a subsequent suicide attempt, while CBT without this component did not reduce the risk of a suicide attempt during the follow-up period. Narrative assessment is foundational to BCBT+ and is the core component of the first module implemented (and described below). Similarly, Homan et al. (2026) completed a meta-analysis of 36 trials that assessed 9,552 individuals, finding that brief suicide-specific interventions, including components that are included in BCBT+, can reduce postintervention suicide attempts. In summary, the modules included in BCBT+ have evidenced significant and consistent findings across multiple RCTs regarding their ability to reduce postintervention suicide attempts. The modules

included in BCBT+ also have broader support across multiple meta-analytic studies. It is important to recognize, though, that the four modules included in BCBT+ were only tested in this abbreviated and integrated format in Diefenbach et al.'s (2024) RCT. The other RCTs summarized in Table 1 included the extended, full 12-hr protocol (including all four of the modules comprising BCBT+).

Session-by-Session Guidelines for BCBT+

Module 1

When elevated suicide risk is noted by the clinician, regardless of whether it is recorded at intake or any other point in the delivery of clinical care, Module 1 can be implemented. Module 1 includes completion of the narrative suicide risk assessment and an overall case conceptualization for the patient. Integrated into the conceptualization is a discussion about the "suicide mode" (Rudd, 2000) model for treating suicidal behavior, including helping patients recognize identifiable stressors that activate the mode, associated suicide cognitions, related emotional and physiological symptoms (Axis I symptoms), and subsequent behaviors that have been ineffective in efforts to manage their upset (e.g., self-harm, suicidal behavior, substance use). The most common suicide cognitions tend to fall into three identifiable themes: unlovability (e.g., I am a failure, I am worthless, I am unlovable), unbearability (e.g., I cannot live with these feelings), and unsolvability (e.g., I cannot solve my problems; Rudd & Bryan, 2021).

Patients complete a narrative review, or "story," describing the details of the most recent suicidal crisis that precipitated the need for BCBT+. The distinctive aspect of a narrative approach to assessment is it allows a patient to tell a step-by-step story of how their suicidal crisis emerged (Bryan & Rudd, 2018). An individualized case conceptualization is constructed collaboratively, followed by the development of a crisis response plan (CRP; see Module 2 below), which includes step-by-step guidelines to follow during a suicidal crisis (see Table 2). In order to promote between-session practice, integrate and consolidate material into memory, and improve accessibility of the session content, patients create a treatment log, which can be done on their phone or in written format. The treatment log includes critical elements of each module. For Module 1, this includes the suicide mode, their CRP, and "lessons learned." Use of the treatment log is continued for each BCBT+ module.

Given that Module 1 includes two critical tasks (i.e., the narrative assessment and case conceptualization), a minimum of 90 min is likely needed to accomplish both elements.

Module 2

The primary goal of Module 2 is to enhance cognitive flexibility and ambivalence toward suicide by completing the CRP, coupled with creating and discussing how to strategically utilize the "reasons for living" (RFL) list via repeated and regular exposure to the list, along with creation of a survival kit/hope box.

The development of a CRP includes identifying simple steps to follow when a suicidal crisis re-emerges. Table 2 provides an example of a CRP. Because it is important to limit the number of steps in the first iteration of the CRP, the initial CRP routinely incorporates only 3–4 simple steps to follow, although it can be expanded later on as the patient demonstrates competence with each step in the first version. It is critical to define the idea of a "suicidal crisis" with the patient. Ordinarily, a suicidal crisis is more significant than the simple presence of suicidal thoughts, as, for many individuals with chronic risk, suicidal thoughts come and go with some frequency. As ecological momentary assessment studies have demonstrated over the past decade, suicidal thoughts vacillate with great frequency and are a poor predictor of

Table 2
Example of Identified Steps Included in a Crisis Response Plan

Identified threshold for using CRP: When I feel like I need to look for my method (can name method specifically)
Step 1: Review my reasons for living list
Step 2: Manage my upset feelings by going for a walk (identify the specific area, along with how to respond to suicide cognitions while walking)
Step 3: If I am still feeling motivated to act on my suicidal thoughts, call the national helpline: 9-8-8
Step 4: If I am still feeling motivated to act on my suicidal thoughts, go to the emergency department (identify hospital and address)

Note. CRP = crisis response plan.

suicide attempts (Franklin et al., 2017). A frequent threshold for using the CRP is the presence of suicide intent (elevated motivation to die) and/or actively looking for a method. As Table 2 details, we frequently use a RFL for Step 1 in the CRP, followed by an emotion regulation activity (in this case, walking in a park), calling either the clinic on-call line or the national helpline, and ultimately a visit to the emergency room if the crisis remains unabated after using the CRP. As mentioned previously, the CRP has been effective at both reducing emergency department visits and subsequent hospital readmissions (Diefenbach et al., 2024). As with the treatment log, the CRP can be completed digitally on the phone or in written format. If a phone is not used, the CRP will ideally be written on a 3×5 card or in a similar format that makes it easy to both carry and access. We recommend the clinician write the CRP on a dry erase board to enhance memory and accessibility of information, which can then be captured digitally with a phone.

The issue of emotional salience is important to mention when utilizing the RFL as an intervention, particularly as part of the CRP. Oftentimes, RFLs include a simple list of people or activities such as "my mother," "my kids," "my friends," or "my family." The problem we have encountered with these simple lists is that they are often not emotionally salient or emotionally meaningful when presented in such a sterilized manner. As such, it is important for the clinician to take a few extra minutes and expand the list considerably. For example, if someone identifies their partner as a RFL, it is critical to identify their name in order to personalize the RFL. Emotional salience and RFL can be expanded and enhanced by following up with simple questions like the following:

1. Can you tell me a little about (name)?
2. What kind of things do you like to do together?
3. What do you appreciate/like/love about (name)?
4. What does (name) appreciate/like/love about you?

If someone identifies an activity (e.g., running) as a RFL, the clinician can ask similar questions to enhance emotional salience and expand the RFL list:

1. Where do you like to run? What do you like about that area?
2. How do you feel when you run?
3. What does having the discipline to run say about you as a person?

Each one of the answers to the questions listed above can be included on the RFL list as a separate item, expanding the list considerably. The impact of a dramatically expanded and emotionally salient RFL list cannot be overstated. These are just a few examples of the kinds of Socratic questions that can help expand and enhance the emotional salience and impact of RFL as a strategic intervention. We encourage clinicians to write the RFL on a dry erase board at the same time the CRP is being created. Once completed, a photo can be taken of the list in order to make it accessible across many points in treatment independent of the CRP. The RFL is a living document and can be continuously modified during treatment, even well after an acute suicidal crisis has abated.

Patients are encouraged to review their RFL list on a daily basis for a few minutes prior to each meal. In addition to repeated exposure to the RFL list, patients can also create a tangible survival kit or hope box (both names have been used in RCTs). They are encouraged to include items in the survival kit/hope box that help them feel hopeful and encouraged during periods of acute emotional upset. It is important for the clinician to review items included, as suicidal individuals often identify items that activate the suicidal mode without being consciously aware of the iatrogenic nature of these items (e.g., a picture of a parent that was abusive or a personal loss that provokes unresolved grief). Additional items that are routinely included in the survival kit/hope box are song lyrics, comforting images, and letters or screen captures of text messages from friends or loved ones. On occasion, when a patient has struggled to identify items for the box, we have compiled a list of reasons we feel hopeful about their future and the efficacy of therapy, signed it, and included it in the survival kit/hope box. The survival kit/hope box can be created using digital images on their phone or created manually using a shoe box or a large envelope. It is critical for the clinician to review every item included in the survival kit/hope box to ensure it has the intended positive emotional impact. Another important element is making sure there is ease of access to the material when needed and that the items

included are emotionally salient. Module 2 can be accomplished in a single session.

Module 3

Module 3 includes completing a lethal means counseling (LMC) session with the patient. The primary goal of LMC is to expand the patient's understanding of safety and recognition that, given the frequent fluctuations in suicidal thinking and emotional upset, often only a few additional seconds can provide them with the opportunity to respond more effectively to emotional upset without engaging in suicidal behavior. The clinician should always explore accessibility to lethal means, including firearms, and then collaboratively develop a plan to reduce access. It is important to note that reducing access does not always mean removing access (e.g., trigger locks for firearms, lock boxes for medications). In addition to LMC, Module 3 includes the creation and use of coping cards to address the most common suicide cognitions identified in the narrative assessment. As with all intervention elements, coping cards can be created digitally on the phone or in written format on 3×5 cards. If created digitally, the clinician can write responses to identified suicide cognitions on a dry erase board, allowing the patient to take a picture and use the image as part of their digital survival kit/hope box. See Table 3 for examples of common suicide cognitions and related coping card responses. As mentioned previously, the common themes for suicide cognitions revolve around three core factors, including unlovability (*I am worthless, I am a failure, I am a burden, I am unlovable*), unbearability (*I cannot live with this pain*), and unsolvability (*I cannot solve my problems*; Rudd & Bryan, 2021). Module 3 can be completed in a single session.

Module 4

Module 4 has been conceptualized as a relapse prevention task, providing the clinician an opportunity to review with the patient all the emotional self-management skills practiced and identify specific ways in which these skills could be integrated into the patient's life moving forward following resolution of the acute suicidal crisis. This session also provides an opportunity for discussion about the issue of enduring vulnerability, often captured by identified suicide cognitions, and how this relates to any ongoing therapy independent of the suicidal crisis. The primary relapse prevention task is reviewing the suicidal crisis that precipitated the need for intervention and how the newly developed skills might be used to manage the upset. Module 4 can be completed in a single session.

Tracking Treatment Fidelity

Maintaining treatment fidelity for BCBT+ is straightforward given the specific nature of each of the intervention modules. Table 4 includes the specific fidelity checklists for the four modules. As detailed in Module 1, it is important for the narrative suicide risk assessment to create a timeline or sequence of events that precipitated and led up to the suicide attempt or suicidal crisis. As the patient describes each step, the clinician can clarify identifiable predispositions (i.e., earlier life events and experiences such as loss of a loved one, parent's divorce, etc.), activating events, associated suicide cognitions, emotional

Table 3
Identified Suicide Cognitions and Coping Card Responses

Suicide cognition	Coping card response
Unlovability: "I'm worthless and a failure"	"I've made some mistakes, but everyone does and I can work on forgiving myself. My kids (names) told me they love me and need me in their lives."
Unbearability: "I can't live with this emotional pain"	"I'm working on more helpful ways to manage my upset. I can practice the following strategies: deep breathing, taking a walk, going for a fun, meditation."
Unsolvability: "I can't solve my problems"	"There's likely a solution I can't see right now because I'm so upset. I'm going to continue to practice my emotional self-management skills and continue in therapy to find better solutions."

Table 4
Fidelity Checklist for Brief Cognitive–Behavioral Therapy+ Modules

Module 1: Narrative assessment and conceptualization
a. Facilitated narrative description of events leading up to the index suicidal episode
b. Elicited information about contributory/associated domains, including predispositions, activating events, cognitions, emotions, and related coping behaviors
c. Identified consistencies across suicidal crises or suicide attempts (where appropriate) that can be useful in understanding what self-management skills are needed and can be applied to any ongoing therapy after the crisis abates
Module 2: Reasons for living list and crisis response plan
a. Written on a card (or completed digitally) that can be easily carried by the patient
b. Explained rationale for CRP
c. Identified and listed self-management skills to be used
d. Identified and listed professional sources of help (where to call)
e. 911 and identified emergency department to visit if crisis persists
f. Verbally reviewed all steps and practiced (role play)
g. Gauged patient's understanding and commitment to use of CRP
Module 3: Explained rationale for means safety
a. Discussed impulsivity, cognitive confusion, and poor problem solving when highly upset and the importance of time
b. Identified potential methods for means safety (e.g., trigger lock for firearms)
c. Asked about access to firearms
d. Collaboratively engaged the patient in discussions about means safety steps that can be taken
e. Elicited feedback and input from the patient regarding preferred options for securing means
f. Explored commitment to means safety steps
Module 4: Relapse prevention
a. Collaboratively identified likely triggers for future suicidal episodes
b. Encouraged the patient to recount prior suicidal episodes
c. Strategically prompted the patient to increase memory vividness, focused on beliefs, emotions, behaviors, and circumstances directly related to the crisis
d. Facilitated problem solving by introducing new challenges/barriers to skills use
e. Encouraged the patient to imagine use of learned skills
f. Debriefed the patient about how to integrate skills moving forward and how they might be useful in therapy in general

Note. CRP = crisis response plan.

and physiological symptoms (e.g., sleep disturbance, worry, anxiety, sadness, depression), and ultimately coping behaviors that are not working well in efforts to manage severe emotional upset (e.g., substance use, self-harm, suicide attempts). Identifying consistencies across suicidal crises or suicide attempts if the individual has experienced previous suicidal crises can be useful in understanding which self-management skills are needed, when, and how they can be applied to any ongoing therapy after the current crisis abates.

The previous description and detail offered regarding the CRP is reasonably extensive. Two issues of particular importance are emotional salience and identifying useful emotional self-management strategies, although only one is included on the documented CRP (see Table 2). Similarly, it is critical to gauge the patient's commitment to using the CRP. We routinely ask the question, "Can you rate on a scale of 1 to 10 how likely it is that you'll use the CRP, with one being never and 10 being always when needed?" This question allows the clinician to anticipate potential barriers to use, identify them, and proactively problem-solve. We believe this is one of the reasons the CRP has been demonstrated to be efficacious in RCTs. The same strategy can be applied in gauging commitment to using the coping cards targeting identified suicide cognitions. From an anecdotal perspective, this simple question on probability of use allows patients to express ambivalence, hesitation, or help negation in a proactive fashion that encourages critical front-end problem solving.

The issue of relapse prevention in Module 4 helps clarify and consolidate BCBT + self-awareness and related self-management strategies. It provides a unique opportunity for the clinician to use identified consistencies in suicidal crises over time in a proactive fashion to anticipate future periods of significant emotional upset, strategize, and role-play how best to respond and effectively manage the upset. Module 4 is critical to the integration and consolidation of the BCBT+ intervention.

Clinical Application in Day-to-Day Practice

As detailed above, BCBT+ can be utilized at any point during treatment when elevated suicide risk is identified or emerges and is not specific to an intake evaluation or related suicide risk assessment. Once elevated suicide risk is identified, it is recommended that the clinician discuss with the patient the importance of fully understanding how and why suicidality emerged as an issue, the importance of specifically targeting the identified elements of risk (e.g., suicide cognitions, related emotional self-management skills), and how these emotional self-management skills relate to the therapy model to date and moving forward.

Module 1 (the narrative assessment and case conceptualization) and the transdiagnostic nature of BCBT+ allow a unique opportunity for the clinician to develop a conceptual model that integrates therapeutic work completed to date and establish clear ties to ongoing therapy, particularly with respect to identifying predispositions (i.e., significant life events and/or experiences to date) that have helped establish vulnerability to suicidal crises and likely fueled suicide cognitions. Similarly, Module 4 provides an opportunity to consolidate what has been learned throughout the targeted intervention and discuss how some of these clinical strategies and emotional self-management skills relate to ongoing therapy. We have found the use of the treatment log to be particularly useful for ongoing therapy, a tool that can easily be expanded and utilized as a way to capture, synthesize, and consolidate the psychotherapy process in general.

The abbreviated format and narrow focus of BCBT+ allow both clinician and patient to address elevated suicidality in a specific and practical manner. Specifically, BCBT+ allows for a conceptual model to enhance a personal understanding of suicidality and motivation to die, coupled with targeted skills to reduce emotional suffering and improve emotional self-management critical to the resolution of discrete episodes of elevated suicidality. Patient engagement across the RCTs reviewed in Table 1 has been consistently high, likely secondary to the easily accessible and personal model developed, coupled with practical self-management skills integrated with conceptual simplicity, clarity, and purpose. For those actively engaged in psychotherapy addressing other clinical issues outside of elevated suicidality, the compact nature of the treatment add-on complements, rather than disrupts, ongoing psychotherapy. Similarly, there are identifiable benefits for clinicians using BCBT+. The abbreviated nature of the BCBT+ protocol and clarity of fidelity checklists simplify both the delivery of module content for the clinician and maintenance of fidelity, something consistently demonstrated across the BCBT+ RCTs.

It is important to mention that BCBT+, along with the full BCBT-SP protocol, has similarities to other empirically informed approaches, such as the Collaborative Assessment and Management of Suicidality (Jobes, 2023) and Cognitive Behavior Therapy for Suicide Prevention (Stanley et al., 2009), with conceptual overlap around the critical role of emotion regulation and clinical strategies targeting individual management of suicidal crisis and related emotional suffering. However, several elements differentiate BCBT+, including reliance on the use of narrative assessment, development of a personalized conceptual model within the broader psychotherapy framework, and the integration of distinctive elements in crisis response planning (e.g., emotional salience in RFL and LMC). Although the precise mechanisms of action for BCBT+ are not clearly identified, BCBT has consistently demonstrated efficacy in reducing posttreatment suicide attempts, with arguably the most consistent findings to date with respect to posttreatment behavior change. Other empirically informed approaches like the Collaborative Assessment and Management of Suicidality and Cognitive Behavior Therapy for Suicide Prevention have been effective in reducing suicidal thinking but not suicidal behaviors.

The abbreviated BCBT+ protocol does have identifiable limitations relative to the full BCBT-SP protocol. In particular, the abbreviated protocol does not allow time for (a) an expanded focus on developing a range of emotion regulation skills, (b) addressing cognitive distortions and related identity and agency beliefs common to elevated suicidality (i.e., unlovability, unbearability, and unsolvability; Rudd et al., 2025),

and (c) the integration of targeted relapse prevention exercises, all components of the full BCBT-SP protocol. Despite these shortcomings, the abbreviated protocol results in similar reductions in post-treatment suicide attempt rates. In short, BCBT+ is a unique and EBT add-on that can be utilized across the full spectrum of clinical settings to help clinicians manage one of the most difficult and anxiety-provoking scenarios, elevated suicide risk.

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Received December 3, 2025
Revision received January 21, 2026
Accepted February 14, 2026 ■