

10

A COGNITIVE THEORY OF SUICIDE: BUILDING HOPE IN TREATMENT AND STRENGTHENING THE THERAPEUTIC RELATIONSHIP

M. DAVID RUDD AND GREGORY K. BROWN

Everything that is done in the world is done by hope.

—Martin Luther King, Jr.

The past decade has seen considerable evolution of the application of cognitive therapy and theory to suicidality, with variations across a number of fronts. Of considerable importance has been the emergence of Beck's theory of modes and, more specifically, the suicidal mode (Beck, 1996; Rudd, Joiner, & Rajab, 2000, 2004). The net impact has been movement away from traditional, simple linear cognitive theory models to a transactional, synchronous approach, one with important implications for understanding, assessing, and ultimately treating suicidal behavior. Consistent with the Aeschi approach, more recent cognitive models provide far greater promise for understanding and emphasizing the critical role of the therapeutic relationship.

Both Rudd (2006) and Wenzel, Brown, and Beck (2009) have expanded on the suicidal mode, with Rudd offering fluid vulnerability theory as a way to understand the recurrent nature and course of suicidal behavior over time and Wenzel et al. (2009) offering an empirically supported cognitive therapy specific to the suicidal patient. As cognitive approaches to suicidal behavior have evolved, important implications have emerged for treatment in general, as well as the therapeutic relationship specifically. Both are relevant to the Aeschi approach to suicidality. This is true in terms of a cognitive approach to conceptualizing the relationship, as well as a cognitive perspective on targeting the

therapeutic alliance in treatment. Before offering more detail about implications for the therapeutic relationship, we first provide a few foundational elements of cognitive theory.

UNDERSTANDING THE SUICIDAL MODE

In an effort to establish a solid foundation, a few points of elaboration are needed about the suicidal mode. Beck (1996) conceptualized modes as “specific sub-organizations within the personality organization that incorporate the relevant components of the basic systems of the personality: cognitive (or information processing), affective, behavioral, and motivational” (p. 4). Beck went on to note that the components “form an integrated cognitive-affective-behavioral network” that is activated in response to a range of stimuli. The four systems work in synchrony when triggered either internally (e.g., by a thought, feeling, or image) or externally (e.g., situations, places, people, things). One of the strengths of theory of modes is the possibility of internal activation, providing a mechanism for understanding biological, genetic, and physiological vulnerability.

Once the suicidal mode is activated, the net result is a suicidal state or episode. In accordance with cognitive theory, the suicidal episode is characterized by specific or core cognitive themes (i.e., the suicidal belief system), acute emotional upset and dysphoria, related physiological arousal (i.e., Axis I symptoms such as depression, anxiety, and agitation, among a host of others), and associated suicide-specific behaviors. The *suicidal belief system* (SBS) and core cognitive themes) are discussed in more detail later, but it is important to note here that the SBS is consistent with Beck’s three levels of cognition (core beliefs, underlying assumptions, and automatic thoughts; Alford & Beck, 1997). It is also important to note that the mode is the structural or organizational unit that contains schemas, probably the most commonly recognized construct in cognitive theory and therapy. Accordingly, each subcomponent of the mode incorporates relevant schemas (e.g., affective schema, cognitive schema, behavioral schema, motivational schema).

The *cognitive system* involves all aspects of information processing. This includes the selection of data, related attentional processes (meaning assignment or meaning making), memory, and eventual recall. As is discussed later, suicidal episodes are characterized by considerable bias and distortion in information processing, facilitating retention, and elaboration of the SBS (e.g., core beliefs like “I’m worthless, hopeless, and helpless”). Integrated into the cognitive system is the traditional cognitive therapy notion of the *cognitive triad*, containing beliefs about self, others, and the future. Although three levels of

cognition are assumed, most therapies target more conscious processing (i.e., accessible core beliefs, underlying assumptions, and automatic thoughts). Regardless, though, preconscious and metacognitive processing are important, providing an opportunity to address issues of implicit learning and tacit knowledge (e.g., Dowd & Courchaine, 1996). In other words, cognitive therapy emphasizes the importance of making the implicit explicit, helping patients readily identify and challenge the core content of the SBS.

The *affective system* provides for affective and emotional experience and expression. Beck (1996) emphasized the role of the affective system in reinforcing adaptive behavior through both positive and negative affect; in particular, negative affective experiences “focus the attention of individuals on circumstances or situational contexts that are not in our best interest or serve to diminish us in some way” (p. 5). The net outcome is a negative valence for the experienced event, situation, or circumstance, along with facilitation of an attentional bias (i.e., selective attention for situations and evidence supporting existing core beliefs that compose the SBS). This increases the sensitivity of the suicidal mode to activation under the same or similar circumstances. This includes *internal activation* through a thought, feeling, or image associated with the original event, situation, or circumstance. It is possible (and likely) that with each successive exposure and negative affective experience sensitivity increases, lowering the individual’s *threshold for activation*. This also provides a mechanism for understanding generalization across similar or comparable circumstances. Consistent with Rudd’s (2006) fluid vulnerability theory, lower thresholds for activation and generalization of triggering events (both external and internal) help explain, in part, the persistence of suicidal behavior over time.

The motivational and behavioral systems provide for autonomic activation (and deactivation), enabling the individual to respond to the situation. Beck (1996) described the motivational and behavioral systems as essentially automatic in nature; he also suggested that they could be consciously controlled under some circumstances. This is essentially consistent with the notion of a modulated response, providing a means for understanding the impact of improved individual understanding, insight, and conscious awareness. The physiological system incorporates the physiological symptoms experienced when the suicidal mode is activated. For the suicidal mode, this includes a broad range of symptoms, depending on the nature of the Axis I disorders (e.g., depression, anxiety, agitation). As is mentioned below, it is particularly important to recognize the impact of physiological symptoms on cognitive processing; that is, they compound further existing attentional and memory biases, both of which serve to exacerbate hopelessness and solidify the SBS.

THE IMPORTANT IDEA OF SYNCHRONOUS ACTIVATION

In contrast to traditional linear cognitive models, the suicidal mode (as with all modes) allows for reciprocal determinism and synchrony of action. Beck (1996) described the mode as “an integrated cognitive-affective-behavioral network that produces a synchronous response to external demands and provides a mechanism for implementing internal dictates” (p. 4). Critical to the suicidal patient, the synchronous and simultaneous interaction of the various subsystems can lead not only to the escalation and expansion of physical symptoms during a suicidal crisis but also to faulty cognitive appraisal, attribution, and interpretation. This helps explain the broad range of empirical findings, noting mental status impairment, poor judgment, hopelessness, helplessness, and poor problem solving during suicidal crises (for a review, see Rudd, Joiner, & Rajab, 2000). The net outcome of synchronous activation is that vulnerability to suicidality extends across all the subsystems mentioned previously:

1. cognitive vulnerability (e.g., impaired problem solving, cognitive rigidity, cognitive distortions about self, others and the future, attentional fixation and bias, poor recall, overgeneral memory),
2. biological vulnerability (e.g., physiological and affective symptoms of Axis I disorders and related genetic vulnerability for those disorders), and
3. behavioral vulnerability (e.g., skill deficits, including impaired emotion regulation ability, limited assertiveness, poor social problem solving).

The idea of synchronous activation also provides a means to understand the rapid onset of suicidal crises. As most clinicians recognize, suicidal crises can emerge with little notice and escalate quickly for some patients. Often the process is an internal one, with the triggering event proving to be a thought, image, or feeling associated with a previous traumatic experience of some sort. The notion of synchronous activation is one that is readily understood by patients, offering a model that helps undermine feelings of being out of control, explaining that there are in fact internal and seldom recognized triggers for suicidal episodes that seemingly “came from nowhere.” The importance and power of such simple explanations are discussed in more detail later.

With respect to the Aeschi approach, the notion of synchronous activation has several important implications. In particular, it emphasizes the need to work on immediate symptom recovery and skill building as mechanisms to strengthen the relationship. Individual vulnerability during an acute suicidal state is pervasive. Targeting symptom recovery through crisis management and

skill building not only improves the patient's ability to more fully participate in care but also results in simultaneous improvements in self-esteem, efficacy, and the overall quality of the interpersonal exchange because the patient sees the therapist as both credible and effective.

IDENTIFYING COGNITIVE THEMES FOR TREATMENT

As readers might guess, the heart of cognitive therapy is identifying and targeting the cognitive content of the SBS. These core beliefs form the foundation for the patient's hopelessness or what Jobes (2006) called "reasons for dying." Rudd (2006) identified four cognitive themes characteristic of the suicidal mode (and the SBS), including unlovability ("I'm worthless"), helplessness ("I can't fix my problems"), poor distress tolerance ("I can't stand the way I feel"), and perceived burdensomeness ("Everyone would be better off if I were dead"), all serving as an expression of the individual's hopelessness. Wenzel et al. (2009) simplified the approach and identified two primary *suicide schema*, including trait hopelessness and unbearability. They argued that all suicide-specific schemas could be categorized under these two domains. Both approaches provide a means to organize the content of the SBS in simple and straightforward fashion, making it easily accessible by patients.

With respect to the therapeutic relationship, it is important to recognize that both themes have implications for the patient's ability to forge and maintain a stable relationship. As unbearability and trait hopelessness increase, the clinician can anticipate a far greater challenge in establishing and maintaining a strong therapeutic bond.

UNDERSTANDING BIASES IN COGNITIVE PROCESSING

In addition to the distortions in cognitive content evident in the SBS, Wenzel et al. (2009) also emphasized the importance of biases in information processing. Simply put, the SBS influences the manner in which someone in a suicidal state attends, processes, remembers, and recalls information. In a general sense, the suicidal individual will focus on negative (or maladaptive) input at the expense of positive (or adaptive) information. The primary biases of concern include attentional biases and memory biases. For the suicidal individual, attentional bias takes the form of attentional fixation, with an almost exclusive focus on the suicidal themes noted earlier, serving as a selective approach to information processing, excluding contradictory information that might well generate a sense of hope. Wenzel et al. described attentional fixation as including "not only cognitive constriction but also a preoccupation

with suicide as a solution to one's problems," noting that it serves to "disrupt conscious and reasoned processing" (p. 65). They also emphasized that state hopelessness serves to increase attentional fixation, essentially working in synergistic fashion.

Memory bias is also important to consider. Williams, Barnhoffer, Crane, and Duggan (2006) described *overgeneral memory* that is typical of suicidal individuals. More specifically, overgeneral memory is vague and nonspecific, depriving suicidal individuals of specific, hopeful memories of previous coping successes and related situational accomplishments. Williams et al. emphasized that overgeneral memory undermines the coping process by preventing suicidal individuals from recalling information that would facilitate effective and efficient problem solving. In short, overgeneral memory robs them of the opportunity to think in specific and optimistic terms about the future—something critical to the emergence and persistence of hope.

Wenzel et al. (2009) cautioned that overgeneral memory may well exacerbate attentional fixation during a suicidal crisis. During such a crisis, the suicidal individual might experience difficulty in recalling specific reasons for being hopeful, previous successes in coping, and related reasons for living. The inability to access previous success experiences makes it difficult to be optimistic during a period of crisis, undermining any opportunity for hope.

Biases in cognitive processing have implications for the therapeutic relationship. Of particular concern, clinicians need to be aware of and sensitive to the tendency on the part of patients to focus on behavioral, visual, and auditory cues that can be construed as rejecting in an interpersonal exchange (e.g., limited eye contact, squirming or discomfort sitting still, watching the clock). In short, suicidal patients are looking for any and all data to support the previously identified cognitive themes, all of which facilitate hopelessness and unbearability.

IMPLICATIONS FOR TREATMENT: FACILITATING HOPE AND INVESTMENT IN CARE

The cognitive model of suicidality offered, the suicidal mode, has a number of important implications for treatment of suicidal individuals, many with simple and straightforward application in the clinical context. Rudd, Joiner, Trotter, Williams, and Cordero (2009) recently identified common elements of treatments that work, distilled from a review of available randomized clinical trials that target suicidality. One common element was that effective treatments provide patients with simple and understandable models for their suicidality; something that is done early and often in care. The assumption is that simple and understandable models facilitate hope, with likely positive

implications for motivation, commitment, and overall treatment compliance. Similarly, I would speculate that providing an understandable and straightforward model for suicidality impacts the core beliefs that compose the SBS, likely by helping diffuse shame, guilt, and associated identity-based elements of a patient's hopelessness. To some degree, providing a simple model contextualizes or normalizes the patient's suicidality within the context of their current (and previous) life circumstances and identified diagnosis. Although this is certainly speculative, we do have some empirical efforts underway to test this component of the theory and the related mechanism of action.

The suicidal mode certainly provides a simple and understandable model of suicidality, one that can be translated directly for patients by discussing the following components: (a) triggers (both internal and external), (b) the SBS (across the cognitive themes and core beliefs mentioned above), (c) associated physical symptoms (the most prominent usually include depressive and anxiety symptoms), and (d) suicide-related behaviors (e.g., preparation and rehearsal of suicidal acts, including accessing means). Similarly, the notion of synchronous activation provides a mechanism to help patients understand the rapid or sudden onset of a suicidal crisis. In addition to helping clarify and simplify the nature of a suicidal crisis, the suicidal mode translates to specific treatment targets, that is, the actual work of psychotherapy as well as crisis management and safety planning. The suicidal mode can be diagrammed for patients on a blackboard or piece of paper, providing a sequential (and artificially linear) visual image of treatment targets, along with the nature of their relationships to one another. Such diagrams provide a tangible sequence of events to facilitate a detailed analysis of each suicidal crisis, identifying precipitants or triggers, active core beliefs, associated symptoms, and the eventual behavioral response. Patients will readily recognize feedback loops across the mode domains, for example, that when they "act out of control by rehearsing a suicidal act" it reinforces the belief that they are "out of control and need to die," only facilitating their experienced hopelessness, motivation to die, and overall suicide risk.

The suicidal mode also provides a means to integrate in a seamless fashion a patient's developmental history, allowing for sensitivity to the prominent role of early relationships in understanding individual vulnerability. In particular, patients recognize the importance and impact of early parental relationships, attachments, and modeling on the development of the SBS and associated suicidal acts. They are able to connect these early relationships to beliefs about self and others, particularly the formation and persistence of hopelessness. They are also able to recognize the important role of parental modeling and general social learning, particularly if one or both parents had a history of suicidal behavior. Providing a means to understand individual vulnerability, or what has been referred to as a "low threshold for activation"

of the suicidal mode, is critical to empowering patients and diffusing shame, guilt, related self-loathing, and any additional destructive identity-based cognitions, all of which undermine motivation, compliance, and eventual treatment outcome.

Although often neglected in clinical care, the suicidal mode provides an opportunity to discuss the distortion inherent in the SBS, including distortion that cuts across beliefs about self, others, and the future, as well as the importance of biases in informational processing (including overgeneral memory, attentional fixation, and future fluency). Helping patients identify and understand the role of overgeneral memory, attentional fixation, and future fluency (i.e., the ability to engage in future-oriented thinking) also is likely to have a significant impact on motivation and treatment compliance, not to mention issues of shame and guilt. Once again, providing a model for understanding suicidality helps contextualize and normalize the experience within the individual's unique life circumstances and history.

As is hopefully evident, the cognitive model offered is one that can facilitate and strengthen the therapeutic relationship by reducing the shame, guilt, and related dysphoria all too often associated with suicidality. Shame and guilt, in particular, are often powerful barriers to a strong relationship, driving the patient away from, rather than to, care. A simple, understandable, and efficient model of suicidality can help overcome these invisible barriers to treatment.

Clearly, there is a need for additional empirical research to support many of the speculations offered, but as is evident, the suicidal mode translates to a simple treatment model, one that allows for each critical element of treatment to be identified and discussed in understandable terms with patients. Additionally, issues of individual vulnerability, chronicity of behavior, and other areas of impairment in cognitive processing can be easily integrated into the discussion. As Rudd et al. (2009) noted, the overwhelming majority of empirically supported treatments for suicidality are cognitive behavioral in orientation. It may well be that these treatments facilitate hope in a simple and straightforward fashion by providing patients with models that can be easily grasped and followed in care. The net result is likely improved motivation, better compliance, and more efficacious outcomes, including better management of crises and an improved treatment alliance.

IMPLICATIONS FOR TREATMENT: CRISIS MANAGEMENT AND SAFETY PLANNING

As an explanatory model, the suicidal mode (and cognitive theory) is uniquely accessible to patients. They can understand it and easily identify the various treatment targets. Of considerable importance is the anticipation and

management of suicidal crises in care. The suicidal mode helps facilitate crisis management, both in terms of planning and practice. Crisis management is facilitated when patients identify the sequential nature of events in their suicidal episodes, recognizing precipitants and intervening events that resulted in a previous suicide attempt or related behavior (e.g., rehearsal or preparation). As articulated by Rudd et al. (2009), a specific crisis management or safety plan is an essential common element of effective treatments for suicidality.

In other words, the suicidal mode provides a mechanism to identify suicide warning signs specific to the patient (Rudd, Berman, et al., 2006) and translates those warning signs to a clear and simple crisis management or safety plan that can be used when another crisis eventually emerges (Rudd, Mandrusiak, & Joiner, 2006; Wenzel et al., 2009). Suicide warning signs include not only suicidal thoughts but also specific symptom clusters (such as sleep disturbance and agitation), as well as suicide-related behaviors like any preparation (e.g., accessing method) or rehearsal.¹

It is recommended that crisis-response and safety plans be put on an accessible, easy-to-store card, one that can be put in a wallet or purse. Rudd, Mandrusiak, and Joiner (2006) also suggested that crisis management plans should have the following characteristics:

1. They should be brief early in the treatment process, with a total of no more than three to four steps in the initial phase of treatment.
2. They should always include a crisis phone number, usually a local number that provides access to the “on call” individual, but it could also be the national 1-800-TALK helpline.
3. They should always include access to a specific emergency room, with the address and phone number.
4. As the patient makes progress in treatment and develops the needed skill set, they can become more involved, with a clear transition in the early steps from self-management to external intervention. Additional self-management steps routinely include skill-building exercises like mindfulness, relaxation, journaling, and exercise. It is important to help patients recognize the implicit beliefs tied to self-management (e.g., “I can manage my own problems,” “Even under great stress I can make it”) versus external intervention (e.g., “I can’t do this on my own,” “I’m incompetent to manage my own life”).

¹An example of a suicide warning signs card produced by the Substance Abuse and Mental Health Services Administration can be found at <http://mentalhealth.samhsa.gov/publications/allpubs/walletcard/engwalletcard.asp>

5. Crisis-response plans need to be practiced. It is recommended that the clinician go through the entire plan with the patient, step by step, identifying any potential problems, self-deficits, or barriers to care. It is also recommended that the clinician and patient role play the use of a crisis-response plan. It is often useful to use guided imagery, accessing the last suicidal crisis as a starting point. Written crisis-response plans offer tangible and accessible hope to patients.

Wenzel et al. (2009) suggested the use of a “hope box” as an initial step in the crisis-response or safety plan. Just as with the card itself, the hope box provides tangible evidence of hope, offering considerable emotional power and salience for the patient. A written crisis-response plan is similar to the simple model offered by the suicidal mode. It translates crisis management into a series of simple, identifiable steps that are all linked to targeted behaviors and associated cognitions.

As is evident, cognitive theory lends itself to practical, concrete interventions all geared toward hopefulness. The very act of demystifying psychotherapy by identifying concrete steps in the treatment process helps reduce patient anxiety, apprehension, and general emotional upset, with the net result an improved therapeutic relationship. As noted previously, the ability to reduce shame and guilt helps make it possible for the patient to more fully participate in treatment.

THE RELATIONSHIP IN COGNITIVE THERAPY: AN AESCHI PERSPECTIVE

As is evident, the simplicity and accessibility of cognitive theory and the notion of the suicidal mode have a range of implicit effects on treatment outcomes and process alike. Most important to note, though, simple models are an essential element of effective care, which is something now empirically demonstrated. The likely vehicle is the facilitation of hope, which is something we are currently investigating. Rudd and Joiner (1997) previously discussed a cognitive approach to understanding and targeting the therapeutic relationship, offering a cognitive alternative to the traditional discussion of transference and countertransference.

As the Aeschi approach has emphasized, the therapeutic relationship is the vehicle of change for suicidal patients. Patients need a simple and understandable model for how to think about the therapeutic relationship in treatment. To date, cognitive therapy has fallen short in this area, often defaulting to psychodynamic terminology. The blending of potentially conflicting theo-

retical approaches can result in considerable confusion when translating constructs in direct clinical care.

The notion of countertransference in psychotherapy has been well-defined and thoroughly discussed (e.g., Kernberg, 1965). Maltzberger and Buie (1974) emphasized its importance in the treatment of the suicidal patient, something particularly relevant in the Aeschi approach. Despite their importance, transference and countertransference issues have received little attention in the cognitive literature, although Linehan (1993) has long emphasized the importance of the therapeutic relationship as a vehicle for therapeutic change (see also Chapter 14, this volume). Rudd and Joiner (1997) offered the *therapeutic belief system* (TBS) as an alternative to traditional transference-countertransference models. As with the suicidal mode, the simplicity of the TBS makes it accessible to the patient.

The core elements of the TBS include beliefs about the three critical elements of treatment: the patient's role in treatment (self), the clinician's role, and the treatment process itself. What is important for practicing clinicians to keep in mind is the importance of translating tacit beliefs to active ones, helping the patient recognize how beliefs across these three domains can either facilitate recovery or undermine care. For example, if the patient believes he or she should have a passive role in care, it is likely this belief will emerge in limited use of the crisis-response plan and related self-management efforts. It is also likely that such a belief would be related to a range of fantasy-based beliefs about the role of the therapist (e.g., "You can read my mind," "You're supposed to just know what's going on with me," "If you really cared, you would know"). The net outcome would be difficulty not only in treatment progress but also in the relationship itself. Clearly, there will be a relationship across the three domains. That relationship is most evident in beliefs about treatment itself (e.g., "Treatment is hopeless," "Treatment is going nowhere fast"). There is also a clear relationship between the patient's SBS, compensatory strategies, and the TBS.

The TBS offers a simple and straightforward approach to monitoring the therapeutic relationship in cognitive therapy. I recommend that it become a routine part of the treatment agenda. At the beginning of care, it is important to dedicate time to discussing the patient's beliefs about his or her role in treatment, the therapist's role, as well as the treatment process in general. This can include questions about expectations regarding care, as well as a discussion of previous treatment experiences, including successes and, most important, perceived failures. It is particularly important to dedicate time to discussing previous treatment withdrawal. Why did the patient withdraw from care? Why does the patient believe treatment did not work? What did he or she like about treatment? What did the patient not like? With what kind of therapist does the patient work best? If a clinician would like a more formal approach, Rudd and Joiner (1997) offered a TBS scale to measure beliefs across each domain.

Ultimately, the TBS dovetails nicely with the suicidal mode, making it possible for the clinician to explore how the various themes identified in the SBS permeate beliefs about treatment, as well as the compensatory strategies (e.g., passivity, withdrawal, self-sabotage) the patient uses in treatment. Taken together, the TBS and the suicidal mode offer a relatively simple guide to treatment, one the patient can understand and one that facilitates hope. Effective treatment for suicidality is all about the development, facilitation, and maintenance of hope. In addition, the facilitation of hope starts with an approach that helps set the foundation for a strong therapeutic relationship.

A FEW PARTING THOUGHTS

It is argued that the one of the primary benefits of cognitive theory, the suicidal mode, and the TBS is their relative simplicity. It is believed that simplicity translates into enhanced insight, understanding, and general individual awareness about the nature of suicidality, with subsequent improvement in motivation, treatment compliance, and eventual outcomes (e.g., suicide attempts and associated symptoms). Although speculative, active empirical study is underway. In contrast to labor-intensive, expensive, and time-consuming randomized clinical trials, many of the hypotheses offered about simple cognitive interventions can be tested with simple designs and accomplished in a relatively short time frame. The treatment outcome literature in suicidality is extremely limited (e.g., Rudd et al., 2009), in part because of costs, including financial, time, and resources. The investigation of simple but common interventions used across different treatments and theoretical orientations would provide the clinician with much-needed resources that are simple to apply, regardless of context or setting.

At the heart of the issue is the need to develop, facilitate, and maintain hope with patients who are suicidal. Critical to doing so is recognizing the importance of the treatment relationship as a vehicle of change, perhaps the primary one. This is what the Aeschi approach is all about. The suicidal mode and the TBS offer the practicing clinician a mechanism to do just that.

REFERENCES

- Alford, B. A., & Beck, A. T. (1997). *The integrative power of cognitive therapy*. New York, NY: Guilford Press.
- Beck, A. T. (1996). Beyond belief: A theory of modes, personality and psychopathology. In P. Salkovkis (Ed.), *Frontiers of cognitive therapy* (pp. 1–25). New York, NY: Guilford Press.

- Dowd, E. T., & Courchaine, K. E. (1996). Implicit learning, tacit knowledge, and implications for stasis and change in cognitive psychotherapy. *Journal of Cognitive Psychotherapy*, 10, 163–180.
- Jobes, D. A. (2006). *Managing suicidal risk: A collaborative approach*. New York, NY: Guilford Press.
- Kernberg, O. F. (1965). Notes on countertransference. *Journal of the American Psychoanalytic Association*, 13, 38–56. doi:10.1177/000306516501300102
- Linehan, M. M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.
- Maltsberger, J. T., & Buie, D. H. (1974). Countertransference hate in the treatment of suicidal patients. *Archives of General Psychiatry*, 30, 625–633.
- Rudd, M. D. (2006). Fluid vulnerability theory: A cognitive approach to understanding the acute and chronic nature of suicide risk. In T. Ellis (Ed.), *Cognition and suicide: Theory, research and therapy* (pp. 355–368). Washington, DC: American Psychological Association. doi:10.1037/11377-016
- Rudd, M. D., Berman, L., Joiner, T. E., Nock, M. K., Silverman, M., Mandrusiak, M., . . . Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical application. *Suicide and Life-Threatening Behavior*, 36, 255–262. doi:10.1521/suli.2006.36.3.255
- Rudd, M. D., & Joiner, T. E. (1997). Countertransference and the therapeutic relationship: A cognitive perspective. *The Journal of Cognitive Psychotherapy*, 11, 231–251.
- Rudd, M. D., Joiner, T. E., & Rajab, H. (2000). *Treating suicidal behavior*. New York, NY: Guilford Press.
- Rudd, M. D., Joiner, T. E., & Rajab, H. (2004). *Treating suicidal behavior* (2nd ed.). New York, NY: Guilford Press.
- Rudd, M. D., Joiner, T. E., Trotter, D., Williams, B., & Cordero, L. (2009). The psychosocial treatment of suicidal behavior: A critique of what we know and don't know. In P. Kleespies (Ed.), *Behavioral emergencies: An evidenced-based resource for evaluating and managing risk of suicide, violence, and victimization* (pp. 339–350). Washington, DC: American Psychological Association. doi:10.1037/11865-015
- Rudd, M. D., Mandrusiak, M., & Joiner, T. E. (2006). The case against no-suicide contracts: The commitment to treatment statement as an alternative for clinical practice. *Journal of Clinical Psychology*, 62, 243–251.
- Wenzel, A., Brown, G., & Beck, A. T. (2009). *Cognitive therapy for suicidal patients: Scientific and clinical applications*. Washington, DC: American Psychological Association. doi:10.1037/11862-000
- Williams, J. M. G., Barnhoffer, T., Crane, C., & Duggan, D. S. (2006). The role of over-general memory in suicidality. In T. Ellis (Ed.), *Cognition and suicide: Theory, research and therapy* (pp. 173–192). Washington, DC: American Psychological Association. doi:10.1037/11377-008