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Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 3, Module 2, Article 4, pp. 61-65, 05-03-07 [copyright by author]

Response to Commentaries on Empirically-Based Outpatient Treatment for a Patient at Risk for Suicide: The Case of "John"

Applying Theory and Science to the Treatment of Suicide Risk

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ABSTRACT

The commentaries by Kalafat (2007) and Henriques (2007) propose new perspectives through which to view the treatment of "John," and highlight several issues related to the application of theory and science to the outpatient treatment of suicidal behaviors. In this response, I briefly address issues of clinical technique and theory, the therapeutic relationship, and misconceptions about transporting efficacious treatments into routine clinical practice. I argue that optimal clinical care uses a scientifically-informed, yet flexible, treatment approach tailored to the needs of the individual patient.

Key words: suicidal behavior; empirically-supported treatment; therapeutic relationship

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I greatly appreciate the commentaries offered by Kalafat (2007) and Henriques (2007), both of whom are respected clinician-researchers in the field of suicide prevention. Their commentaries stimulated my thinking on many more topics than I can reasonably address in this response, so I will focus on a few areas that jumped out as particularly noteworthy for comment or elaboration. First, I will briefly respond to the commentators' observations about technique and theory, then address questions about the therapeutic relationship, and wrap up with a remark on translating research into practice.

ISSUES OF TECHNIQUE AND THEORY

In his commentary on John's treatment, Henriques presents and briefly discusses an intervention technique that might have complemented the treatment package: coping cards.

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Coping cards are a simple yet highly effective intervention for a wide range of presenting problems. In my clinical experience, coping cards are effective because they are highly transportable (e.g., when written on index cards, they can fit into a pocket, wallet, or purse), and use behavioral rehearsal (i.e., reading the card) to simultaneously undermine maladaptive cognitive patterns while reinforcing more adaptive ones. From a more psychodynamic perspective, coping cards also have an added value by serving as a transitional object for the patient. In the case of John, use of coping cards would have been a great supplement to the reasons for living card and the crisis response plan, both of which are based on similar theory and design.

Regarding theoretical bases for clinical work, I must admit that I agree with Kalafat's assertion that Beck's original description of mode theory can be cumbersome (at best) and "esoteric" (at worst). Beck's language can, indeed, be difficult to translate and explain to patients (and potentially even clinicians). It is to Rudd's credit that he applied mode theory to suicidal behaviors in a much more accessible manner, using it as the core feature of fluid vulnerability theory (FVT), which elegantly explains the dynamic *process* of suicide risk over time in a uniquely parsimonious way (see Rudd, 2000). Based on my experience not only as a clinician, but also a trainer of other professionals, Rudd's version of mode theory and his FVT are two concepts that seem to be easily grasped by both patients and clinicians.

In contrast to Kalafat's call for parsimony in theory, Henriques expands on mode theory and FVT by introducing two new theoretical concepts -- the Justification Hypothesis (JH) and the Influence Matrix (IM). Both concepts are more complex than the theories and models upon which I would generally base my clinical work, but they are nonetheless intellectually interesting and may provide useful insights to the therapeutic process. The former of these two concepts (JH), in particular, intrigues me because of its acknowledgment of the important relationship between symbolic language and human suffering. This emphasis on language as a central contributor to the human experience of suffering reminds me of Relational Frame Theory (RFT; Hayes, Barnes-Holmes, and Roche, 2001), which serves as a foundation for Acceptance and Commitment Therapy (ACT; Hayes & Smith, 2005). A primary goal of ACT is to reduce the emotionally distressing aspect of our thoughts by recognizing the symbolic (as opposed to "real") nature of language. As applied to John's case, an important skill for him to develop would be the ability to observe and recognize his self-critical thoughts for what they actually are: ideas in his head, not representations of objective reality or universal truths. In ACT, use of mindfulness skills is one strategy for reducing the distress associated with self-critical thoughts. Because mindfulness has been found to be a promising treatment strategy for reducing suicidal behaviors (Williams, Duggan, Crane, & Fennel, 2006), ACT protocols emphasizing mindfulness skills training might have utility as another treatment approach for reducing suicidal behaviors. However, I am not aware of any current clinical trials investigating ACT as an intervention for suicidal behaviors.

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THE THERAPEUTIC RELATIONSHIP

Henriques proposes that the disruption in the therapeutic relationship may be a result of John's anger towards me because I took a vacation. From the lens of JH, experiencing this anger would be "unjustifiable" to John, therefore he cognitively turns this anger towards himself and withdraws from the treatment relationship, which only serves to increase his distress. Without a doubt, the tendency to perceive negative emotions and thoughts as unjustifiable is consistent with John's belief patterns, as is the tendency to become self-critical as a result of experiencing what are perfectly natural thoughts and feelings. In this sense, John's behavior and internal dynamics are consistent with JH. If asked to consider whether or not John was truly angry with me at this point in our relationship (consistent with the IM), I cannot say with certainty, though my initial response is to say that this interpretation is not completely on-target. In any event, Henriques' speculation certainly provides a different perspective that I cannot completely rule out.

This perspective does, however, cast new light on later moments in treatment. On more than one occasion, while working on developing distress tolerance and problem solving skills, John would become frustrated with the in-session exercises and lash out verbally, angrily dismissing them as "stupid and pointless." During one particularly difficult and emotionally challenging session, John directly challenged me, accusing me of engaging in "silly" exercises for the purpose of making him look stupid. He explained that he felt inferior to me, and was frustrated by the nagging assumption that I looked down upon him for struggling to achieve such "elementary" concepts. When I attempted to elicit the rationale behind this perception, he immediately backed down and apologized, explaining that he was "just being irrational again." I refused to accept this response, though, and suggested that he had the right to be angry with me about what we were working on together since it was his treatment and his life. Instead of suppressing his anger, I suggested, he could use it to his benefit by improving the quality of his care. This attempt to move John to a position of greater autonomy and power appears to be consistent with Henriques' discussion of the clinical use of the IM, though I am more inclined to use more basic language to describe these similar concepts. Specifically, the need to establish a more equitable balance between his affiliation needs (i.e., *dependency*) and his needs for power (i.e,. *aggressiveness*) is what I would term *assertiveness*.

Kalafat also raises an important question that is commonly taken for granted in treatment contexts (as it was in my own description of this case): the clinician's perceptions of the therapeutic relationship. "On what basis did *he* [Bryan] connect to this client, and what about John initially inspired confidence and positive regard within Bryan?" (p. 8) Kalafat asks.[1] On a certain level, I think all clinicians are drawn towards certain presenting problems or forms of suffering that we prefer to work with -- whether depression, anxiety, marital problems, and so forth -- for any variety of reasons, such as fascination, curiosity, compassion, or empathy. For me, the particular type of suffering that most captures my attention is the intense psychological pain of the suicidal individual. Simply put, suicidal individuals have untold stories of suffering

[1] On a side note, this question is remarkably similar to another one that I am very frequently asked: "What is it about suicidal patients that you like to work with them so much?"

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that I want to hear about and understand. In John's case, his suffering was a result of an inability to put his story into words. I wanted to hear his story, and I wanted *him* to hear it so he could make sense out of his suffering. In order to accomplish this goal, John needed to recognize not only that his suffering was acceptable and reasonable, but also that he was strong enough to face it and integrate it into his identity. Because John was willing to share a piece of his suffering with me (i.e., admitting his suicidal ideation) from the very beginning, despite his fears of what would happen, I felt confident we could work together to develop the skills needed to improve his quality of life.

TRANSLATING RESEARCH INTO PRACTICE

Efficacious treatments developed in academic and research centers have seen a relatively slow dissemination to clinicians in routine clinical settings for a variety of identified reasons (e.g., Ruscio & Holohan, 2006). From the treatment development perspective, Comtois and Linehan (2006) have argued that efficacious treatments for suicidal behaviors are difficult to disseminate due to a relative lack of published treatment manuals and training opportunities for addressing these behaviors, as well as the emphasis in journals on treatment methodology and design instead of descriptions of the treatment itself. From the perspective of the routine clinician, however, Seligman (1995) has argued that efficacy studies are not the ideal method for determining what actually works in clinical settings because the context of treatment in research settings is very different from the context of routine clinical settings.

Many clinicians would echo Seligman's perspective, noting that the research-informing-practice approach to treatment is limited, and must be supplemented by a feedback loop in which practice also informs research. (Such a feedback loop is provided by the case studies in this *PCSP* journal and in related journals.) Indeed, an efficacious treatment for preventing suicide is not very helpful to the routine clinician if it cannot be practically transported to everyday practice. On the other hand, although Seligman's argument is true in many respects, clinicians make a tremendous mistake when they dismiss important scientific advances due to false assumptions about limited generalizability of treatment strategies developed in research settings. Yet in the end, as Kalafat notes, it is not the strict application of any specific, manualized treatment approach that leads to effective clinical intervention, but rather the judicious and flexible application of a range of proven treatment strategies that are matched to the individual needs of the patient in question.

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