Strategies in Treatment of Suicidality: Identification of Common and Treatment-Specific Interventions in Empirically Supported Treatment Manuals

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Objective: Many reports of treatments for suicidal patients claim effectiveness in reducing suicidal behavior but fail to demonstrate which treatment interventions, or combinations thereof, diminish suicidality. In this study, treatment manuals for empirically supported psychological treatments for suicidal patients were examined to identify which interventions they had in common and which interventions were treatment-specific.

Method: Empirically supported treatments for suicidality were identified through a literature search of PsychLit and MEDLINE for the years 1970–2007, employing the following search strategy: [*suicide* OR *parasuicide*] AND [*therapy* OR *psychotherapy* OR *treatment*] AND [*random* OR *randomized*]. After identifying the reports on randomized controlled studies that tested effectiveness of different treatments, the reference list of each report was searched for further studies. Only reports published in English were included. To ensure that rated manuals actually correspond to the delivered and tested treatments, we included only treatment interventions with explicit adherence rating and scoring and with adequate adherence ratings in the published studies. Five manualized treatments demonstrating efficacy in reducing suicide risk were identified and were independently evaluated by raters using a list of treatment interventions.

Results: The common interventions included a clear treatment framework; a defined strategy for managing suicide crises; close attention to affect; an active, participatory therapist style; and use of exploratory and change-oriented interventions. Some treatments encouraged a multimodal approach and identification of suicidality as an explicit target behavior, and some concentrated on the patient-therapist relationship. Emphasis on interpretation and supportive interventions varied. Not all methods encouraged systematic support for therapists.

Conclusion: This study identified candidate interventions for possible effectiveness in reducing suicidality. These interventions seem to address central characteristics of suicidal patients. Further studies are needed to confirm which interventions and which combinations thereof are most effective.

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Recently, a number of manualized treatments to reduce suicide attempts were developed and empirically supported, including dialectical behavior therapy (DBT),[1] mentalization-based treatment (MBT),[2] transference-focused psychotherapy (TFP),[3] schema-focused therapy (SFT),[4] and cognitive behavior therapy (CBT)[5] (Table 1).

These treatments have many characteristics in common—and quite a few differences, but it is not clear what specific strategies make the treatments effective in reducing suicidality. Identification of the strategies that are effective should help improve existing treatments, point the way for developing new and better treatment strategies, and suggest modifications of existing treatments for other populations in different treatment settings.

Previously published clinical reports strongly suggest that certain interventions are very likely essential in diminishing suicidal behavior. Some of these interventions are patient-centered: help with affect tolerance, validation, psychoeducation, confrontation of distortions, limit setting,[20] and attention to subjective experience of emotional anguish.[21–24] Other interventions are therapist-centered: conveying a caring attitude toward the patient, taking a nonjudgmental stance, collaborative efforts to reach a shared understanding of the patient's suicidality, and engagement in the "real" relationship, not the transference relationship only.[20,23,25]

One intervention—interpretation—has generated some controversy. Some authors discourage the use of interpretation of patients' suicidal behavior,[20] while others advocate it.[26] Some authors encourage the therapist to challenge suicide-driving thoughts, some aim to resolve the immediate crisis, some aim to instill hope, and some aim to build self-regulation skills.[27] Others emphasize the importance of the therapists' availability for telephone crisis interventions, regular "homework," and systematic self-monitoring of suicide-inviting thoughts and feelings.[1]

In this study, we aim to identify aspects of the different treatments associated with a decrease in suicidality, ie, diminished suicidal ideation and behavior. We examined and compared treatment manuals for the presence or absence of a number of treatment interventions that the literature and our experience suggest are probably effective in reducing suicidality.

METHOD

Empirically supported treatments for suicidality (suicidal ideation and behavior) were identified through an exhaustive

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- Empirically supported psychotherapies for suicide attempters, such as DBT, MBT, SFT, TFP, and CBT, converge in terms of treatment strategies.
- Common strategies include clear treatment framework, agreed-upon strategy of suicide management, close attention to affect, active therapist, and emphasis on exploratory and change-oriented interventions.

literature search. We used PsychLit and MEDLINE for the years 1970–2007, employing the following search strategy: [*suicide* OR *parasuicide*] AND [*therapy* OR *psychotherapy* OR *treatment*] AND [*random* OR *randomized*]. After identifying the reports on randomized controlled studies that tested effectiveness of different treatments, the reference list of each report was searched for further studies. Only reports published in English were included. To ensure that rated manuals actually correspond to the delivered and tested treatments, we included only treatment interventions with explicit adherence rating and scoring and with adequate adherence ratings in the published studies. Five of the treatments identified in this way had treatment manuals. Those 5 were DBT,[1] MBT,[2] TFP,[3] SFT,[4] and CBT.[5]

We further reviewed a variety of psychological treatments for suicidal as well as nonsuicidal patients.[1,3,28,29] We selected 34 relevant interventions and operationalized them using descriptive nonjudgmental language. These were organized into 12 conceptually defined treatment factors. From this organization, the Interventions for Suicidality Rating Scale (ISRS) arose (Table 2).

Each treatment manual was examined by each of the clinicians for the presence or absence of each of the interventions. If a given intervention was contraindicated in a manual, it was scored as −2. If not discussed in the manual, the intervention was scored as 0 (absent). If the intervention was somewhat or passingly (moderately) present, a score of 1 was assigned. If distinctly present, it was scored as 2. When an intervention was emphasized as important, we scored it as 3.

The treatment manuals were evaluated by 6 raters (the authors), all clinicians with 2 to 48 years (median = 25.0 years) of postgraduate clinical experience in treating suicidal patients. All are members of the Boston Suicide Study Group. Four of the raters have completed psychoanalytic training, and 1 is an advanced candidate in training; 5 have DBT training (1 is a DBT trainer); 4 attended a workshop on mentalization, and 1 is conducting mentalization-based group treatment; and 1 has completed CBT training. All the raters are thoroughly familiar with DBT, CBT, MBT, SFT, and TFP.

The study raters independently evaluated the use of these interventions exclusively for the treatment of suicidality (ie, suicidal ideation and behaviors) as outlined in each of the 5 treatment manuals. *Suicidal ideation* refers to thoughts, impulses, or plans to attempt or commit suicide. *Suicidal behavior* refers to an actual attempt to commit suicide and *not* to deliberate self-harm unintended to result in death. No other possible treatment targets were taken into account in our ratings. After independently studying and rating each treatment manual according to the ISRS, the raters met for several hours and compared their scores. Disagreements were addressed and discussed in a careful collective review of each manual. At the end of each discussion, a consensus rating was reached by the group and became the final rating reflected in Table 3. Differences of 2 points or larger between different treatments in final ratings were considered significant.

RESULTS

Ratings of different treatment characteristics presented in the manuals are presented in Table 3.

Similarities

Treatment framework. All 5 treatments emphasize the importance of a clear, thorough, and agreed-upon treatment framework in terms of appointment times, fees, cancellation policy, termination policy, and accepted and prohibited behaviors.

Agreed-upon strategy to manage suicidal crises. All 5 treatments offer explicit plans for addressing suicidal crises. However, they differ with regard to the level of desirable planning detail and the level of involvement by the therapist in dealing with a suicidal crisis. In DBT and SFT, a written crisis plan is advised. Dialectical behavior therapy recommends reviewing and updating this plan over time according to evolving patient needs and level of progress. Both DBT and SFT foster the development of increasing skill at self-regulation outside the treatment sessions. Only these 2 treatments explicitly encourage involvement of the therapist in suicidal crises that arise between sessions. Transference-focused psychotherapy does not prohibit therapist involvement in crises, but if the therapist becomes involved in extrasession crises, detailed exploration of what this means is emphasized. In TFP, treatment may be terminated if the therapist concludes that involvement in management of crises interferes with the position of neutrality.

Attention to affect. All 5 treatments agree that affects are central, and all of the modalities emphasize that therapy must concentrate on affect experience, particularly affect tolerance. Dialectical behavior therapy, for instance, encourages mastering specific skills (*distress tolerance* skills) to cope with painful affect, inside and outside treatment sessions. However, the different treatments advocate different interventions to achieve affect tolerance mastery. Dialectical behavior therapy, MBT, SFT, and TFP, but not CBT, emphasize in-session affect discussion, ie, patients are encouraged to feel and to think about their affect experiences during treatment

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Table 1. Effectiveness Studies of Manualized Psychotherapies for Suicide Attempters

Study	Treatment Cells (n)	Proportion of Female Patients, %	Age Range, y	Treatment Length, mo	Adherence Rating	Included Primary Diagnoses	Length of Follow-Up, mo	Results
Dialectical behavior therapy (DBT)[a]								
Linehan et al[6,7,b]	DBT (24) vs treatment in community (22)	100	18–45	12	None	BPD	12	DBT decreased parasuicidal acts and proportion of patients engaging in parasuicide. These changes were maintained during follow-up
Turner[8,b,c]	DBT-like (12) vs client-centered therapy (12)	79	18–27	12	None	BPD	None	DBT decreased parasuicidal acts and proportion of patients engaging in parasuicidal acts
Koons et al[9,b,c]	DBT-like (14) vs outpatient services (14)	100	21–46	6	Yes	BPD	None	DBT decreased frequency of parasuicidal acts
Verheul et al,[10,b–d] van den Bosch et al[11,b–d]	DBT (25) vs drug abuse or psychiatric treatment (27)	100	18–70	12	Yes	BPD	6	DBT did not decrease suicide attempt frequency
Linehan et al[12,b–d]	DBT (52) vs "experts" (49)	100	18–45	12	Yes	BPD	12	Both approaches decreased suicide attempts, DBT more than "experts." The changes were maintained during follow-up
Mentalization-based treatment (MBT)[e]								
Bateman and Fonagy[13–15,c,d]	MBT (22) vs treatment in community (19)	58	16–65	18–60	Yes	BPD	36–78	MBT decreased frequency of suicide attempts and number of patients engaging in suicide attempts. These effects were maintained and further improved during follow-up
Cognitive behavior therapy (CBT)[f]								
Brown et al[16,c]	CBT + treatment in community (60) vs treatment in community (60)	61	18–66	6 (average)	Yes	MDD, substance use	12 (average)	Suicide attempters in CBT had a 50% significantly lower reattempt rate, which was maintained during follow-up
Davidson et al[17,b,c]	CBT + treatment in community (54) vs treatment in community (52)	84	18–65	12	None	BPD	12	Suicide attempts decreased in the CBT group. The difference continued to be present at follow-up
Schema-focused therapy (SFT)[g]								
Giesen-Bloo et al[18,b,d]	TFP (42) vs SFT (44)	93	18–60	36	Yes	BPD	Not reported	Parasuicide decreased in both treatments, more in SFT than in TFP
Transference-focused psychotherapy (TFP)[h]								
Clarkin et al[19,b,d]	TFP (30) vs DBT (30) vs supportive therapy (30)	92	18–50	12	Yes	BPD	None	All 3 approaches decreased parasuicidaliy, TFP and DBT more than supportive therapy

[a]Dialectical behavior therapy, developed for patients with BPD, focuses on teaching skills in 4 areas: distress tolerance, emotional regulation, interpersonal effectiveness, and mindfulness to overcome difficulties with impulsivity, emotional dysregulation, and interpersonal instability, thus decreasing suicide risk. It includes once-per-week individual therapy and 2.5 hours per week in a skills-training group.
[b]Blind assessments.
[c]Suicidal behaviors were measured separately from parasuicidal behaviors.
[d]Uniform medication use.
[e]Mentalization-based treatment, developed for patients with BPD, focuses on helping the client to develop better ability to think about intentions of self and others, thereby promoting better handling of interpersonal relationships, distress, and impulsive behaviors, including suicidal acts. It includes an individual therapy, expressive therapy, group therapy, and a community meeting.
[f]Tested cognitive behavior therapy for suicide attempters, developed for BPD and non-BPD patients, focuses on challenging negative, distorted thoughts, thus decreasing helplessness, as well as encouraging behaviors that increase pleasure and mastery and counteract the "giving-up" attitude. Thus, these interventions diminish suicidality. In tested approaches, CBT was provided weekly or in as-needed individual sessions.
[g]Schema-focused therapy, developed for patients with personality disorders, focuses on challenging negative beliefs and thoughts about self through cognitive techniques and behavioral experiments and uses treatment relationship to help the client develop better experience of attachment to others. Suicide risk is expected to diminish as a result of these changes. This treatment includes 1-hour sessions twice per week.
[h]Transference-focused psychotherapy, developed for patients with personality disorders, focuses on helping the client achieve a better integration of perceptions of self and others and of positive and negative feelings. As a result, affect tolerance and impulse control improve, and suicide risk diminishes. This treatment includes 1-hour sessions twice per week.
Abbreviations: BPD = borderline personality disorder, MDD = major depressive disorder.

Table 2. Interventions for Suicidality Rating Scale

Intervention Factor	Definition
Factor 1: Multimodal treatment	
Multimodal treatment	Combination of individual, group, medication, art, or other treatments
Team approach	Members of the team collaborate, communicate, and meet on a regular basis and think flexibly about the patient in an attempt to maximize effects of the treatment on the basis of all available clinical information. The treatment team has a designated leader, and the team implements the developed treatment plan in a consistent manner
Factor 2: Clear treatment framework	
Clear treatment framework	Treatment framework is established (appointment time, fees, vacations, cancellation policy, termination policy, confidentiality, accepted and prohibited behaviors)
Factor 3: Suicidality is an explicit target behavior	
Target behavior	Therapy identifies target behaviors and systematically addresses them; suicidal behavior is one of the explicit target behaviors
Between-session self-monitoring	Patient keeps track of (1) problematic behaviors, thoughts, and feelings, including suicidality, and (2) use of coping skills between sessions
In-session monitoring of suicidality	Therapist keeps track of levels of suicidality during session and addresses these shifts
Factor 4: Agreed-upon strategy to manage suicidal crises	
Management of intersession crises-I	There is a detailed plan for management of intersession suicidal crises
Management of intersession crises-II	Therapist plays an active role in management of intersession suicidal crises
Factor 5: Attention to affect	
Attention to affect	Treatment emphasizes focus on emotional experiences of the patient, especially those experiences that contribute to suicide risk. Particular affects: anguish, aloneness, hopelessness, rage, self-hate, and loss of internal control
Attention to in-session affect	The explicit focus of therapy is the focus on affective shifts in session
Experiencing affect	Facilitating experience of affect
Informal exposure to affect	Exposure to affect that does not use directed guidelines but happens as a by-product of other interventions
Formal exposure to affect	Use of explicit guidelines to help the patient with exposure to affect
Tolerance of internal states encouraged	Facilitation of tolerance of feelings, thoughts, opposing feelings/thoughts, and ambiguity
Factor 6: Focus on treatment relationship	
Attention to relationship between the therapist and the patient	Thoughts, feelings, and behaviors associated with the relationship with the therapist are one of the explicit foci of the treatment
Attention to feelings of patient toward therapist is explicit focus	Feelings of the patient toward the therapist are systematically examined; every feeling is examined as bearing upon the patient-therapist relationship
Attention to reactions to the patient	Therapist pays attention to his or her emotional reactions to the patient; therapist makes use of these reactions in treatment
Personal disclosure	Disclosure regarding personal life or personal experiences of the therapist that are not related to feelings toward the patient
Factor 7: Active therapist	
Active therapist	Therapist (1) is able to show his or her emotional involvement through action, disclosure, or change in affect and (2) brings up thoughts, feelings, and behaviors related to the patient's difficulties
Problem-solving	Teaching and applying problem-solving skills regarding real-life problems
Advice	Direct or indirect suggestions are given regarding possible action steps
Factor 8: Interpretations	
Interpretations	Making the dynamic unconscious (in the psychoanalytic sense) conscious
Factor 9: Exploratory interventions	
Clarification	Making passively avoided thoughts or feelings conscious; recognizing patterns; connecting thoughts, feelings, and behaviors
Confrontation	Bringing actively avoided thoughts or feelings to awareness
Exploration	Chain analysis and behavior analysis
Insight	Active facilitation of awareness of problem thought patterns, feelings, and behaviors and their interrelationships
Factor 10: Supportive interventions	
Validation	Affirmation of existing thoughts, feelings, or behaviors of the patient
Education	Provision of knowledge regarding treatment or patient's condition
Support	Active and intentional instillation of hope
Factor 11: Change-oriented interventions	
Manipulation	Planned use of external or internal contingencies to reinforce or suppress target behavior
Homework	The patient receives formal assignments that are expected to be done outside of the treatment sessions
Behavior change	Active facilitation of behavioral changes
Challenging self-defeating behaviors	Self-defeating and treatment-interfering behaviors are taken up as they manifest themselves inside or outside treatment
Factor 12: Support for therapists	
Support for therapists	Therapists get support and validation through regular group or individual (peer) supervision

Table 3. Ratings of the Presence of Interventions Within 5 Different Therapies for Suicide Attempters[a]

Intervention	DBT	MBT	CBT	SFT	TFP
Multimodal treatment	3	3	2	0	0
Clear treatment framework	3	3	2	2	3
Suicidality is an explicit target behavior	3	1	3	2	uncertain
Agreed-upon strategy to manage suicidal crises	3	3	3	3	2
Attention to affect	3	3	3	3	3
Focus on treatment relationship	3	3	1	3	3
Active therapist	3	3	3	3	3
Interpretations	−2	−2	0	0	3
Exploratory interventions	3	3	3	3	3
Supportive interventions	3	2	3	3	1
Change-oriented interventions	3	2	3	3	3
Support for therapists	3	3	1	0	0

[a]If an intervention was contraindicated in the manual, it was scored as −2; if not discussed in the manual, it was scored as 0 (absent); if only somewhat or passingly (moderately) present, it was scored as 1; if distinctly present, it was scored as 2; if emphasized as important, it was scored as 3.

Abbreviations: CBT = cognitive behavior therapy, DBT = dialectical behavior therapy, MBT = mentalization-based treatment, SFT = schema-focused therapy, and TFP = transference-focused psychotherapy.

sessions. In behavioral terms, this appears to amount to "informal exposure" to painful affect. In line with its strong behavioral roots, DBT is the only modality that encourages formal affect exposure. Whether CBT deliberately encourages affect exposure is unclear in its manual.

Active therapist. All 5 treatments emphasize active engagement and participation by the therapist, mentally and emotionally. Therapists communicate their involvement with the patient in many ways: through what they say, through how they disclose about their own emotional responses (verbal and nonverbal) to the patient and the treatment, and through self-disclosure, emotional sharing, and confrontation. In addition, DBT, CBT, and SFT also suggest active advice-giving and problem-solving. However, advice-giving and problem-solving were only moderately identifiable in the MBT manual and were absent from that for TFP.

Exploratory interventions. All 5 treatments make strong use of exploratory interventions such as clarification, confrontation, exploration, or behavioral analysis to identify contributing contextual and individual events that stimulate and drive suicidality in every form—fantasy, impulse, and behavior. Using different language (eg, exploration in TFP and chain analysis in DBT), all treatments indeed agree that suicidal thoughts, plans, and acts must be investigated and understood. Insight or awareness of suicide-inviting as well as suicide-protecting patterns is promoted in all 5 treatments.

Change-oriented interventions. All 5 treatments explicitly encourage change in thinking and behavior. They overlap in how they use planned external or internal contingencies to reinforce or suppress target behaviors, especially suicidal ones. Dialectical behavior therapy uses the treatment relationship to motivate and reinforce change. In SFT and CBT, praise and other forms of reinforcement are present. Mentalization-based treatment only moderately emphasizes behavioral change per se, holding that behavioral change follows change in thinking and feeling. Other treatments promote behavior change through limit-setting (DBT, CBT, SFT, and TFP), skills training (DBT, CBT, and SFT), or behavioral experiments (SFT). Dialectical behavior therapy, CBT, and SFT, but not TFP or MBT, assign patients homework to build change and to generalize outside the therapy context. Dialectical behavior therapy, CBT, SFT, and TFP actively and systematically challenge self-defeating thoughts and behavior. This intervention is only moderately present in MBT.

Differences

Multimodal and team collaborative treatment. Dialectical behavior therapy, MBT, and CBT call for a multimodal treatment approach. Mentalization-based treatment explicitly includes all clinicians in contact with the patients in the treatment team, while DBT includes only the DBT-oriented individual and group therapists. Cognitive behavior therapy is less explicit about the kinds of treatments involved but still allows for a multimodal approach. Schema-focused therapy and TFP do not require multimodal treatment, yet they do not explicitly discourage such treatment either.

Suicidality as an explicit target. Dialectical behavior therapy, CBT, and SFT identify suicidality as an explicit treatment target and systematically focus on it. Such focus is only moderately present in MBT and is uncertain in TFP. Dialectical behavior therapy, CBT, and SFT recommend monitoring suicidality *between sessions*. In addition, DBT, SFT, and, to a moderate degree, TFP monitor suicidality *during sessions*.

Focus on treatment relationship. All the treatments strongly focus on the therapeutic relationship except for CBT, which only concentrates on it somewhat. Dialectical behavior therapy, MBT, SFT, and TFP agree in paying strong attention to the quality of the therapy relationship, ie, the patient's feelings toward the therapist and the therapist's feelings toward the patient. The therapist's engagement is that of a real, whole person, but how this is to be accomplished is conceived in different ways. The DBT therapist uses self-disclosure, in which he or she will tell the patient if his or her own personal tolerance and emotional limits are being exceeded or excessively stressed. The therapist will point out all behavior that interferes with the treatment. In DBT and MBT, the relationship of the therapist and patient is an interaction between 2 collaborators, not only as stemming from the past, or dedicated just to sorting out distorted processing—the relationship is not studied in transference terms. While TFP and SFT teach observation of the treatment relationship to identify interpersonal patterns, the therapist's immediate emotional presence is underscored through active emotional involvement (TFP) or through self-disclosures (SFT). Only TFP strongly emphasizes interpretation of patients' behaviors, including those that are suicide-related. Transference-focused psychotherapy is also the only treatment approach that explicitly makes use of the therapist's feelings toward the patient (countertransference) to formulate hypotheses about the personal experience of the patient. Unlike TFP, MBT and DBT explicitly discourage

interpretation of the treatment relationship in terms of the past (ie, *transference interpretations*).

Interpretation. Interpretations in the strict psychoanalytic sense (ie, an intervention to make unconscious material conscious) are strongly advocated by TFP but discouraged by DBT and MBT. However, TFP therapists vary in the way they make interpretations. In fact, most of them conduct TFP primarily using exploratory interventions instead, making maximal use of clarification (a maneuver that makes preconscious material conscious; F. E. Yeomans, personal communication, March 2008).

Supportive interventions. Supportive interventions such as problem-solving and advice-giving are recommended in DBT, CBT, and SFT. These activities are moderately present in MBT but absent in TFP. All treatments except TFP use explicit interventions to instill hope, yet TFP appears to encourage hope indirectly. Transference-focused psychotherapy workers argue that although direct reassurance and support are to be discouraged, there is a strong secondary supportive influence when correct treatment interventions are employed; an effective clarification can be experienced as supportive and encouraging.[3] Validation is present in all treatments except TFP, in which it is only moderately present.

Support for therapists. Dialectical behavior therapy and MBT acknowledge the challenging nature of work with suicidal patients and explicitly incorporate supportive group activities for therapists.

DISCUSSION

The implication in each of the 5 treatments is that their specific interventions account for the decrease in suicidal behavior. The effectiveness of several of the identified common treatment components and interventions has been demonstrated in psychotherapy studies, ie, the therapeutic alliance,[30] insight,[31] interpretation,[32] experiencing of avoided negative emotions,[33] and exposure.[34] Convergence between psychodynamic and cognitive-behavioral approaches is reflected in the fact that treatments arising from both theoretical bases employ many common interventions. This convergence has been noted[35,36] and empirically supported[37,38] by others.

Our findings support those reported in studies of psychodynamic treatment of patients with borderline personality disorder (BPD), many of whom are suicidal. Those treatments have much in common with the manualized therapies we have examined here, namely stability of treatment framework, increased activity of the therapist, addressing self-destructive behaviors by making them ungratifying, increasing awareness of therapists' feelings toward patients, and developing awareness of the connection between actions and feelings.[39] Our results show that most of these characteristics (ie, active therapist, addressing self-defeating behaviors, regular framework for treatment) were present not only in treatments developed for patients with BPD (DBT, SFT, TFP, and MBT) but also in the CBT treatment of suicide attempters at large, suggesting that these elements might be effective for patients other than those with BPD. Similarly, our results are consistent with 10 reported mistakes in intervention with suicidal patients (ie, superficial reassurance, avoidance of strong feelings, professionalism, inadequate suicide assessment, failure to identify the precipitating event, passivity, insufficient directiveness, advice-giving, defensiveness, and stereotypic responses) reported by others.[40]

The common interventions shared by these 5 treatments lock into well-known mental characteristics of suicidal patients. *Increased activity of the therapist* can be particularly important when suicidal patients are hopeless.[41] Similarly, suicidal patients who have passive and avoidant problem-solving styles[42] may respond best to an active therapist. An active therapist will engender hope, model proactive attitudes and behavior, set limits to patients' impulsivity, and keep the treatment focused on the patient's suicidality. *Attention to affect* is essential—mental pain and anguish, rising to the level of desperation, drive suicidal behavior.[43–46] Suicidal patients report elevated levels of depression, desperation, rage, anxiety, abandonment, hopelessness, self-hatred, guilt, loneliness, and humiliation[47]—and of "mental pain" at large.[48,49] Desperation (the state of no longer being able to endure mental suffering and requiring urgent relief) is specific to suicidal states.[50]

Active interventions provide relief of urgency to act, encourage problem-solving, help to gain a new perspective, and give support. *Clarification, confrontation, and exploration* help identify events, thoughts, and feelings that stir up suicidal behavior. These interventions increase inner reflectiveness (mentalization) and expectably address such characteristics of suicidal patients as dissociation[51] and low self-awareness.[44] *Identification of affect and encouragement to tolerate internal states* target impulsivity[52–55] and emotional dysregulation.[56,57] *Management of intersession crises* through agreed-upon coping plans teaches patients how to better deal with suicidal states, conveys a caring attitude, and encourages practice of alternative solutions other than suicide. Finally, *regular framework for treatment* provides structure and stability that reduces impulsive potential,[52–55] while at the same time affording a consistent and positive relationship to decrease hopelessness of suicidal patients.[41]

Differences between these treatments partly arise from the affinity of different approaches to particular therapeutic schools of thought. For instance, the behavioral roots of DBT, CBT, and SFT are implicit in such interventions as homework, between-session self-monitoring, and self-disclosure. In contrast, TFP and MBT, like psychoanalysis from which they arise, make only minimal use of problem solving, advice giving, or personal disclosure. The kinship of TFP to ego-psychology and object relations theory may account for the tenet that interpretations are essential for change. Interpretations—in the sense of making unconscious material conscious—are contraindicated in DBT. This fact reflects behavioral psychology's focus on observable behavioral patterns rather than implied intentions or meanings of behavior.[1] Mentalization-based treatment discourages interpretation also—but for a different reason. According

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to the theoretical (psychoanalytic) matrix underlying the MBT technique, patients with BPD are deficient in the mentalization capacity and therefore cannot profit from interpretations, which require intact mentalization capacity.[2]

All but 1 of the treatment manuals examined here (CBT) were specifically tested for patients with BPD. Egregious BPD phenomena such as intense unstable interpersonal relationships and emotional lability may account for the strong emphasis on the therapist's feelings toward the patient, the patient's feelings toward the therapist, and in-session affect in some of the manuals.

Treatments differ regarding provision of support for therapists. This fact suggests that such support is feasible and is likely to be helpful for therapists to cope with their emotional responses and think about the treatments in a meaningful way.

Still, other differences probably stem from variant formulations of suicidality. The relatively modest attention to affect in the CBT manual as compared to the other 4 manuals most likely reflects CBT formulation of suicidality in terms of distorted cognitions.[5] Formulation of suicidality in terms of distorted representations of self and others[3] may in part account for the emphasis on interpretation in TFP.

Limitations of the Study

The conclusions of this study are tentative. We relied on manuals from interventional studies, but only a minority of interventional studies for suicide attempters provided manuals and adherence monitoring. Therefore, our conclusions may not generalize to other treatment approaches. Second, the study group members both constructed the rating scale and rated the manuals. Our conclusions may be distorted by a priori biases regarding effective treatment strategies. Third, 4 of our 5 chosen treatments were developed for patients with personality disorders and are empirically supported for patients with BPD. Further studies are required to examine whether the same strategies can effectively decrease suicidality in non-BPD suicidal patients. Fourth, most of the studies reviewed in Table 1 excluded patients with alcohol or substance abuse disorders, and all of them excluded patients suffering from psychosis or bipolar disorder. Therefore, generalization of our results to patients suffering from these disorders is limited. Finally, given our methodology (ie, comparative analysis), we cannot conclude with certainty that the treatment characteristics discussed here are responsible for effectiveness in the reduction of suicidal behavior and ideations.

Our findings warrant further dismantling studies to replicate our results. Independent judges using study methodologies with more direct measurement (eg, comparison of blind rating of videotaped treatment sessions of successfully treated suicide attempters vs repeaters) would further clarify these important issues.

Disclosure of off-label usage: The authors have determined that, to the best of their knowledge, no investigational information about pharmaceutical agents that is outside US Food and Drug Administration–approved labeling has been presented in this article.

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