

Clinical Assessment and Treatment of Suicidal Risk: A Critique of Contemporary Care and CAMS as a Possible Remedy

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There is a significant need to improve clinical practices related to suicidal patients within contemporary mental health practice. It is argued that there is a general over-reliance on psychotropic medications and the use of inpatient psychiatric hospitalizations for suicidal risk. This reliance is puzzling given the lack of empirical support for these approaches; the evidence supporting the use of psychotropics is mixed and there are recent challenges to the routine use of inpatient care that tends not to be suicide-specific and may increase post-discharge risk. Importantly there are several psychological treatments proven effective in rigorous randomized controlled trials (RCTs). Of the *replicated* RCTs, dialectical behavior therapy (DBT), two forms of suicide-specific cognitive-behavioral therapy—cognitive therapy for suicide prevention (CT-SP) and brief cognitive behavioral therapy (BCBT)—and the collaborative assessment and management of suicidality (CAMS) have shown robust data for effectively treating suicidal risk. But despite the data these treatments are not widely used. Possible reasons for an inadequate professional response to suicidality may include: (a) countertransference, (b) fear of malpractice litigation, (c) lack of knowledge about suicide risk assessment, and (d) lack of knowledge about effective treatment for suicidal risk. CAMS is discussed as a possible remedy for the professional and clinical issues raised in this article.

Clinical Impact Statement

This article critiques current contemporary practices related to suicidal patients with general suggestions for raising the standard of clinical care. Various evidence-based approaches to improving practices with suicidal patients are considered and the Collaborative Assessment and Management of Suicidality (CAMS) is discussed in depth.

Keywords: suicide risk assessment, suicide treatment, malpractice liability, CAMS

Suicide is the fatality of mental health practice and is the 10th leading cause of death in the United States with upward of 44,000 deaths per year (Centers for Disease Control and Prevention, 2015). There are over 1 million suicide attempts and 9.8 million Americans struggle with suicidal thoughts each year (Piscopo, Lipari, Cooney, & Glasheen, 2016). Despite these

appalling data, many mental health professionals (across disciplines) do not receive suicide-specific assessment and treatment training within their professional curriculums (Bongar, 2013). It has been previously argued that the state of affairs pertaining to the assessment and treatment of suicidal patients amounts to a professional—even *ethical*—crisis for the field of

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mental health (Jobes, Rudd, Overholser, & Joiner, 2008). As suicide death rates remain stubbornly static, even rising over the past decade (<http://www.cdc.gov/nchs/products/nvsr.htm>), and with millions of lives being impacted, much more needs to be done to decrease suicide-related suffering to save lives.

Case Example—Tom

“Tom” was a highly decorated multiply deployed Special Operations United States Army Soldier. He served with valor and distinction in various combat operations abroad. After 14 years in the army, Tom decided to leave military service to take a high-paying job with a private security firm. Within months of leaving the Army, Tom began to experience bouts of depression, his drinking became problematic and he was fired for being intoxicated at work. Tom’s depression grew worse and he withdrew from friends and family. His older brother “Jim” became concerned when Tom voiced vague suicidal thoughts and reported having put his handgun in his mouth over a previous weekend. With concern for his brother’s life, Jim convinced Tom to see a clinical psychologist in independent practice who immediately initiated an inpatient hospitalization (secondary to Tom’s depression, alcohol abuse, and acute suicidal risk). Tom was admitted to a psychiatric inpatient unit for 14 days and was discharged on three psychotropic medications—two antidepressants and one for anxiety. Tragically, Tom shot himself in the head on the evening of his discharge. Jim and Tom’s mother sought a family consultation with a clinical psychologist 2 weeks after Tom died, seeking answers for this heart-breaking death. Seen in a handful of “postvention” family sessions, Jim and his mother struggled to process their grief and anger over Tom’s seemingly inexplicable fall from a highly decorated “super-Soldier” to a dysfunctional, depressed, shadow of himself. They were haunted by regrets and the bitter realization of a mental health response that abjectly failed Tom. In session, Jim mused that 2 weeks of inpatient care did nothing to help his brother. His normally quiet mother tearfully blurted out, “. . . that’s because they did nothing for him! He sat in that day-room watching TV, he went to some stupid groups that he hated, and they drugged him up!” Jim angrily confronted the clinician saying, “. . . so this is the best your field can do? That hospital stay made him really

hopeless—no wonder he killed himself!” The psychologist empathically responded, but actually felt ashamed of his field. In their last session Jim and his mother asked for information about finding a good plaintiff attorney to look into suing the psychologist and the hospital for malpractice. The disastrous case of Tom’s inadequate mental health care and subsequent suicide may perhaps be an outlier. Alternatively, it can be argued clinical tragedies such as these happen far too often within contemporary mental health care.

Contemporary Care of Suicidal Risk

As noted, almost a decade ago Jobes et al. (2008) made the argument that contemporary clinical care of suicidal risk amounted to a professional and ethical crisis for the field of mental health. These authors asserted that there is a pervasive assumption that psychotropic medications are the best treatment for suicidal people and that inpatient psychiatric care is the optimal mental health intervention of choice. But while many argue the primacy of a purely pharmacological approach to suicide, the empirical evidence supporting a medication-only approach to suicidal risk is limited or mixed (O’Connor & Nock, 2014). In turn, evidence supporting the pervasive use of inpatient psychiatric hospitalization for suicidal risk is virtually nonexistent. Indeed, Linehan (2015) has strongly argued that inpatient care is fundamentally *ineffective* for suicidal risk. Even more provocatively, Large, Ryan, Walsh, Stein-Parbury, and Patfield (2014) have argued that inpatient psychiatric care may actually *cause* a subset of suicides—what they call “nosocomial” suicides. Beyond these disquieting viewpoints, there is clear empirical evidence of increased lifetime risk of death by suicide associated with inpatient psychiatric care (Bostwick & Pankratz, 2000) and there is replicated evidence of significantly increased suicide risk within the early weeks and months following discharge from inpatient psychiatric care (Meehan et al., 2006; Qin & Nordentoft, 2005). The present critique is neither meant to be provocative nor to offend. But as reported elsewhere (National Alliance on Mental Illness, 2014) inpatient care has become quite limited and is not sufficiently suicide-specific (The Joint Commission, 2016) and treatments targeting mental disorders (such as depression) have not been shown to reduce sui-

cidal thoughts or behaviors (Cuijpers et al., 2013).

In sharp contrast, there is a growing body of evidence (Brown & Jager-Hyman, 2014) that certain psychological treatments *are* effective for treating suicidal risk based on RCTs. As RCTs, these studies show a *causal* impact on decreasing suicide attempts, self-harm behaviors, suicidal ideation, overall symptom-distress, hopelessness, and other suicide-related markers. For example, psychodynamic interpersonal psychotherapy (Guthrie et al., 2001), Mentalization-based psychotherapy (Bateman & Fonagy, 2009), and the Attempted Suicide Intervention Prevention Program (Gysin-Maillart, Schwab, Soravia, Megert, & Michel, 2016) have all shown significant effects for decreasing suicidal risk, but further replication is needed (especially by independent investigators). There are also a handful of suicide-specific psychological interventions with replicated RCT support (Jobes, Au, & Siegelman, 2015). Among these replicated treatments, the most effective is DBT with data showing an impact on decreasing self-harm behaviors and suicide attempts (Linehan et al., 2015). There are two versions of suicide-specific cognitive-behavioral therapy called CT-SP (Brown, Ten Have, et al., 2005) and BCBT (Rudd et al., 2015). These latter two treatments have been shown to decrease suicide attempt behaviors by 50% and 60%, respectively, in contrast to treatment as usual (TAU) control care. These are impressive data about suicide-related *behavior change* (which is rarely seen within pharmaceutical RCTs).

Yet another proven suicide-specific intervention through replicated RCTs is CAMS developed by the author (Jobes, 2006, 2016) which is a focus in this article further on. There are now eight published non-randomized clinical trials in which CAMS has been associated with rapid decreases in suicidal ideation, overall symptom distress, depression, and changes in suicidal cognitions (Arkov, Rosenbaum, Christiansen, Jønsson, & Münchow, 2008; Ellis, Green, Allen, Jobes, & Nadorff, 2012; Ellis, Rufino, & Allen, 2017; Ellis, Rufino, Allen, Fowler, & Jobes, 2015; Jobes, Jacoby, Cimboric, & Husted, 1997; Jobes, Kahn-Greene, Greene, & Goeke-Morey, 2009; Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005; Nielsen, Alberdi, & Rosenbaum, 2011). There are two published RCTs, comparing CAMS with

usual control care wherein CAMS demonstrated statistically significant decreases suicidal ideation in 6–8 sessions (Comtois et al., 2011; Jobes et al., *in press*). In the Comtois et al. RCT, CAMS significantly reduced overall symptom distress and significantly increased hope, patient satisfaction, and improved clinical retention when compared with TAU.

In a published superiority RCT comparing DBT with CAMS, there were no significant differences between DBT and CAMS for 108 suicide-attempting patients with borderline traits in relation to self-harm and suicide attempts at 28 weeks (Andreasson et al., 2016). These implicitly supportive results for CAMS were surprising considering the well-established effectiveness of DBT for this population. Importantly, CAMS patients did as well as DBT patients being seen 8–10 sessions once/week whereas DBT patients received 16 sessions of DBT twice/week. There are also unpublished RCT data of 62 suicidal college students showing that CAMS significantly reduced suicidal ideation, depression, and anxiety within 8 weeks in comparison to TAU care as part of a larger sequential multiple assignment randomized trial (a “SMART” design; Pistorello et al., *in press*). Finally, unpublished moderator data from a large RCT of 148 suicidal United States soldiers (Huh et al., 2017) has shown CAMS having a significant impact on emergency department admissions and overall symptom distress for subgroups of suicidal soldiers when compared with control care.

Taken together, the relative abundance of empirical support of psychological treatments for suicidal risk is impressive. But what is vexing is why these effective interventions are so rarely used within contemporary care? Moreover, why is it that too many suicidal people are still prescribed medications only and/or psychiatrically hospitalized despite the lack of convincing data? A whole different consideration is that some providers may fail suicidal patients because they feel unqualified to handle the issue or avoid asking about suicide for fear of sparking a suicidal response. But knowing for many years that suicide risk is the most common emergency in mental health care (Shein, 1976) and that providers across disciplines routinely encounter suicidal risk (Feldman & Freedenthal, 2006; Kleespies, Penk, & Forsyth, 1993), one might argue that being unqualified or avoidant is akin to a primary

care provider not knowing about or avoiding the care of heart disease. In direct response to such concerns, state legislatures across the United States are increasingly moving to *requiring* training in clinical suicide prevention to obtain a license (e.g., <https://www.yahoo.com/news/advocates-support-mandatory-suicide-prevention-training-licensed-psychologists-160100694.html>) or maintain a professional license across mental health disciplines (e.g., <https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/SuicidePrevention/TrainingRequirements>).

If points made thus far ring true, how is it that too many providers may be complicit in providing substandard, non-evidence-based clinical care for the single fatality of the profession? To be sure, depending on the clinical setting, there may be systems-level and resource issues that might undermine care for suicidal risk. But within this clinically-focused examination, it is argued that inadequate clinical care for suicidal risk may be explained by the following:

1. Countertransference issues pertaining to suicidal patients
2. Fears about suicide-related malpractice liability
3. Lack of knowledge about effective assessment of suicidal risk
4. Lack of knowledge about effective treatment for suicidal patients

Each of these considerations will be duly explored before examining one possible remedy for many of the issues raised herein.

Countertransference and Suicidal Risk

It has long been known that nothing generates more fear and stress among clinicians than the prospect of losing a patient to suicide (Pope & Tabachnick, 1993). Thus, the classic psychoanalytic notion of countertransference could be a factor that may play a major role in providing ineffective care for the suicidal patient. Namely, the *clinician's* own anxiety, fear, and resentment conjured by a suicidal patient may fundamentally interfere with that clinician's ability to effectively work with such a person. This is not a new notion; indeed, Maltzberger and Buie (1974) forcefully argued four decades ago that clinicians often harbor feelings of "malice and

aversion" toward their suicidal patients as part of their "countertransference hate" of said patients. Some years later Jobes and Maltzberger (1995) argued that many clinicians may experience a sense of "empathic dread" toward suicidal patients which may untherapeutically lead to becoming a "therapist voyeur"—a provider who is not willing to fully engage within the suicidal struggle and may be eager to rid themselves of this kind of patient (perhaps through hospitalization or referral).

What is beyond dispute is that suicidal risk within psychotherapy can create a major power struggle within the therapeutic dynamic centering on the patient's sense of personal autonomy and the clinician's duty to protect them from themselves as per legal statute (Jobes, 2000, 2011; Jobes & O'Connor, 2009). Thus, by its very nature, clinical suicidal risk can potentially pit the patient and clinician against each other, which can naturally cause the provider to feel wary and anxious and may well lead to defensive clinical practices. When this occurs, a clinician may default to hospitalizing even a mildly suicidal person with a "better safe than sorry" sensibility.

Despite the evidence that medications have limited impact on suicidal ideation and behaviors, there may be an understandable wish or fantasy that a prescription of the right psychotropic medicine is all that is needed to eliminate a patient's painful and complicated suicidal struggle. Within a larger cultural context that is dominated by the medical model and pill-taking, it is perhaps more appealing to believe that medication is the solution obviating the need for patient and clinician to mutually engage in the difficult psychotherapeutic work of directly targeting and treating suicidality (despite the robust evidence of effectiveness).

Fears About Malpractice Liability

It is quite possible that many clinicians are overly paralyzed by fears of being sued for malpractice following a patient suicide (Jobes & Berman, 1993; Jobes et al., 2008). Hence, the abject fear of tort litigation for "wrongful death" may lead to overly defensive practices which may not be in the patient's best interest. Considering the preceding discussion of countertransference, less than therapeutic feelings toward the patient, in combination with abject

fear of liability, may lead to care that is invalidating, shaming, coercive, and controlling which might prompt a needless admission for even a mildly suicidal patient. As an aside, it is important to note that thousands of patients die each year by suicide in United States hospitals (<http://www.psychiatrictimes.com/suicide/inpatient-suicide-identifying-vulnerability-hospital-settingcitations>) and the increased risk of completed suicides associated with inpatient psychiatric care, especially in the weeks and months after discharge, is extremely troubling.

Paradoxically, fears about suicide malpractice can be easily assuaged. As legal experts have noted, suicide-related liability can be considerably reduced by maintaining thorough medical record documentation of suicide-specific practices (Simpson & Stacy, 2004). As argued elsewhere (Jobes & Berman, 1993), enhancing one's suicide-specific assessment, treatment planning, and clinical follow-through with thorough documentation can significantly reduce the risk of tort litigation. While there may always be plaintiff attorneys who are eager to sue mental health professionals for failing to prevent a suicide, the plaintiff and their lawyer are saddled with the burden of proof. Taking such cases on contingency, many plaintiff attorneys are not eager to expend considerable billable hours to litigate a case when they may not recoup their costs unless they settle or win. It follows that most malpractice lawyers are looking for cases they can readily win, which hinges on the quality of the medical record (Simpson & Stacy, 2004).

Effective Assessment of Suicidal Risk

The assessment of suicide risk is too often conceptualized simplistically as a dichotomous black versus white binary notion (Jobes et al., 2008). In other words, a patient is/is not suicidal as reflected in an utterly inadequate chart note as "Patient has SI" or "Patient has no SI" (Jobes, 2006, 2016). An effective assessment of suicidal risk necessarily requires a more complex and nuanced approach. Fortunately, more sophisticated assessment approaches have emerged through various lines of research. For example, Kovacs and Beck's (1977) classic study of the "internal struggle hypothesis" showed that suicidal risk can be reliably divided into three distinct groups based on patient self-reports on 3-point rating scales of

their respective "wish to live" (*none/weak/moderate to strong*) versus "wish to die" (*none/weak/moderate to strong*). Simply subtracting a patient's rating of wish to live from their rating of wish to die renders an interval scale depicting three distinct types of suicidal people: those who primarily wish to live, those who are ambivalent, and those who wish to die. In subsequent research using this simple equation (that was later called a "suicide index score"), Brown, Steer, Henriques, and Beck (2005) found significant odds ratios for suicidal behaviors associated with the wish-to-die subtype based on a one-time index rating of these constructs. Additional research has further replicated reliable subtypes of suicidal states using this cross-sectional trichotomy assessment methodology based on index wish-to-live and wish-to-die patient self-reports (Corona et al., 2013; O'Connor et al., 2012).

In recent years it has become somewhat de rigueur to criticize the use of assessment scales and disparage efforts to talk about relative risk (e.g., Carter et al., 2017). These authors argue that such scales have no predictive validity, therefore we must completely eschew this whole approach altogether. While we have known for many years that we cannot *predict* low base-rate phenomena like suicide (Murphy, 1983), others have argued that thinking about relative suicidal risk and different kinds of *suicidal states* is a compelling endeavor that can directly help inform our clinical treatments for suicidal risk (e.g., Corona et al., 2013).

The work of Nock and his colleagues is generating important data about psychological attentional biases related to suicide with implications for *prospective* suicidal behaviors. Nock's use of the Implicit Association Test provides compelling data that suicidal people have distinct psychological propensities for future suicidal behaviors (Nock et al., 2010). Goodman's (2012) use of an eyeblink paradigm has also shown a differential impact among highly dysregulated patients who make multiple suicide attempts. In addition, a distinct perseverative response style in written content assessment responses reveals significantly higher level of suicidal ideation at treatment baseline and significantly less responsiveness to an otherwise effective treatment (Hamed, Chalker, & Jobes, 2017). Using another novel assessment methodology—ecological momentary assessment—Kleiman et al. (2017, *in press*) have demon-

strated (and replicated) five distinct profiles of suicidal ideation that naturally evolve. As our research methodologies continue to evolve, we can undoubtedly look forward to more sophisticated approaches to reliably assessing suicidal risk in the future.

The exciting work going on in the assessment of suicidal risk has direct implications for suicide-specific treatment (Pistorello et al., *in press*). From a practical standpoint the Patient Health Questionnaire-9 is a nonproprietary symptom screener available on the Internet that has been shown to provide useful data about suicidal risk within large community-based samples (Simon et al., 2013). Similarly, the Columbia-Suicide Severity Rating Scale is another nonproprietary scale with psychometric support (Posner et al., 2011) that can be routinely used. One can thus become more sophisticated in the assessment of suicidal risk without too much effort, gleaned potentially valuable clinical information that can facilitate proper treatment to possibly help save lives.

Effective Treatment of Suicidal Risk

As previously noted, there are effective treatments for suicidal risk that are not routinely used in clinical practice. But short of full-scale adoption of these interventions, there are compelling and simple suicide-specific interventions that can be readily brought into clinical practice that will enhance care, help decrease one's liability, and may help save lives.

Suicide-specific stabilization planning. The use of a “no-harm” or “no-suicide” contract, or getting a patient to “commit to safety” has been roundly criticized by experts in the field for some years now (e.g., Rudd, Mandrusiak, & Joiner, 2006). These authors have persuasively argued that the “commitment to safety” approach is a coercive and inadequate response that focuses on what the suicidal patient promises that they *will not do* with little to no guidance about what they *will do* instead. A much better alternative is to use some version of a suicide-specific stabilization plan that focuses on what a suicidal patient will do in the midst of suicidal crisis. The most widely known intervention along these lines is the “safety plan intervention” developed by Stanley and Brown (2012). The safety plan is a simple six-step model for helping a suicidal person get through

a suicidal crisis through the identification of various self-help strategies along with pre-planned efforts to gain support from others or professionals if needed.

A variation on this theme is the “crisis response plan” first proposed by Rudd, Joiner, and Rajab (2001). Importantly, this approach has recently been proven to be superior to no-suicide contracting in a rigorous RCT conducted by Bryan et al. (2017) where crisis response planning showed a 76% reduction in suicide attempts compared with the no-harm contracting. A further variation of this approach is the CAMS stabilization plan (CSP) which will be described later.

Lethal means safety. There is overwhelming evidence that reducing access to lethal means (particularly firearms) is one of the most powerful clinical interventions that can be undertaken to avert suicides. Moreover, when lethal means are blocked, there is evidence that there is not “method-substitution” (Miller & Hemenway, 2008). In other words, bridge barriers stop suicides and people do not readily move to alternative lethal methods (i.e., lethal means safety efforts actually help save lives). Accordingly, effective interventions must include candid discussions about access to guns, a stash of pills, or a rope and a site for hanging picked out. There are various ways of doing lethal means safety which are described elsewhere (Jobes, 2016); Bryan, Stone, and Rudd (2011) have proffered additional creative ways of negotiating and verifying the removal of lethal means. Ideally, the involvement of third parties can be a critical aspect of negotiating the management of access to lethal means. Involving loved ones of the patient—with the patient's consent—is also a good clinical practice when dealing with suicidal risk and may significantly reduce the risk of malpractice liability (Simpson & Stacy, 2004).

National Lifeline. As a final consideration there is the National Suicide Prevention Lifeline (1-800-273-TALK). Funded by the Substance Abuse Mental Health Services Administration, the Lifeline is an important resource for supporting suicidal people with convincing evidence of its value to suicidal people (Draper, Murphy, Vega, Covington, & McKeon, 2015). What is common across the evidence-based treatments is specific guidance as to how a suicidal patient in acute crisis may seek out their

professional to provide support. In fact, phone coaching and telephonic crisis support is an inherent ingredient of DBT. While there is support for providing crisis access to one's suicidal patients, many clinicians are still uncomfortable providing access to patients telephonically. In such cases, the National Lifeline number should be routinely provided. For those familiar with the National Lifeline, it is anecdotally known that many mental health professionals may perhaps overly rely on the Lifeline (i.e., abrogating any sense of professional responsibility of after-hours patient care). On the one hand, one can argue that Lifeline volunteers may well have more suicide-specific training than many mental health professionals and they may have a higher degree of comfort talking about suicide through sheer exposure to the topic. On the other hand, however, these crisis line workers are functioning as volunteers—not psychotherapists—and there are distinct limits as to what they can do beyond supportive crisis listening and problem-solving within the crisis line role. This is a thorny issue that makes many mental health professionals uneasy; clinicians need to duly consider what makes sense to them and develop a usual and customary practice accordingly.

CAMS as a Possible Remedy

CAMS is proposed as one potential means for addressing many of the issues raised in this article. CAMS is a suicide-specific therapeutic framework proven to be highly effective with a range of suicidal patients across clinical settings (Jobs, 2012). CAMS is usually initiated in the presence of current suicidal ideation based on the clinician's judgment or by using a clinical screening tool. Central to CAMS is the use of the Suicide Status Form (SSF) which is a multipurpose assessment, treatment-planning, tracking, and clinical outcome tool. As the "roadmap" that guides the entire CAMS treatment process, certain pages of the SSF are used in a first session, other pages are used in all subsequent interim/tracking sessions, and a final set of forms are used in the outcome/disposition session. The SSF Core Assessment is a group of six suicide risk variables (psychological pain, agitation, stress, hopelessness, self-hate, and overall risk) that are assessed repeatedly across the course of CAMS-guided care at the start of every session (Jobs, 2016). The CAMS treatment plan is completed at the end of each CAMS session to

further craft a suicide-specific line of problem-focused treatment that evolves over the course of clinical care. The treatment plan is anchored by the CSP which focuses on the elimination/reduction of lethal means and the use of five coping strategies developed between the clinician and patient that can be used should the patient become acutely suicidal. There is a clear designation of who to contact in case these coping strategies fail to quell a prospective suicidal crisis. One can provide a personal cell number on the CSP (with a pointed discussion about the *privilege* of this access which is to be used in a life-or-death scenario only). But as noted earlier, not all clinicians are comfortable providing this level of personal access. To this end the National Lifeline number (1-800-273-TALK) should always be included on the CSP (even when a clinician provides their number, the Lifeline can still be used as a backup should the clinician be unavailable). The CSP includes the name of key relational supports in the patient's life along with their phone numbers to help decrease isolation. Possible remedies to potential barriers to attending treatment are also noted (e.g., arrangements for child care or anticipating transportation issues should be included as part of the plan). Importantly, the patient is asked to keep a copy of the CSP with them across the duration of care (alternatively, the patient may "carry" their CSP by taking a picture of it for easy access on their smart phone). An overarching goal of CAMS is to do everything possible to keep a suicidal patient *out* of the hospital; within CAMS, inpatient psychiatric hospitalization is seen as a last resort to save a life versus the first response.

A cardinal and defining feature of CAMS is having the patient articulate the two major problems which compel them to consider suicide. In CAMS, these problems are referred to as suicidal "drivers" which are always defined by the patient. Obviously, the clinician has input, but we look to the patient to tell us what puts their life in peril. This kind of treatment planning flies in the face of the traditional medical model where a patient has a mental disorder diagnosed by their provider; suicide is thus relegated to symptom status with the assumption that treating the disorder is the optimal means for reducing this symptom. While this has been a venerable approach within health care and mental health, there are virtually no data to support a mental disorder-focused line of care for suicidal risk. What is very plain through empirical evi-

dence is the primacy of treatment focusing on suicidal ideation and behaviors, *independent* of diagnoses (Jobes et al., 2015). Importantly, patient-defined drivers are usually quite treatable. Our research has shown that relational, vocational, and self-oriented issues are the focus of suicidality (Jobes et al., 2004); suicidogenic issues pertaining to mental disorders and/or symptoms are relatively uncommon. While severe mental disorders such as schizophrenia, bipolar disorder, and substance abuse disorders undoubtedly contribute to suicidal risk, suicidal patients with these serious mental disorders invariably struggle with relational, vocational, and self-esteem issues that are usually central to their suicidal struggle.

CAMS-guided care centers on helping a patient learn to stabilize themselves through difficult suicidal moments while the dyad works steadfastly on the treatment of drivers during ongoing interim care. CAMS treatment is concluded when there are three consecutive sessions in which the patient has effectively managed suicidal thoughts/feelings over the previous week (with no suicidal behaviors) and a lowered rating of overall suicide risk. The CAMS provider is looking for the patient to “turn the corner” on suicide; some level of limited ideation is acceptable as long as the patient is managing it with new coping, not turning to suicide as their solution. Within adherent CAMS the clinical dyad also pursues a life with purpose and meaning (a life worth living) toward the end of care. Importantly, SSF pages are always reproduced across the course of care to give to the patient at the end of each session (or, as noted, pictures of the forms can be taken on their phone for direct access and reference as needed).

Having now provided an overview of the CAMS therapeutic model, there is value in reconsidering the four issues raised earlier that can make contemporary care of suicidal patients problematic for many providers with consideration as to how CAMS might allay these concerns.

Countertransference and Suicidal Patients

There is no mystery as to why key portions of CAMS assessment and treatment planning are done with clinician and patient sitting side-by-side (with the patient’s express permission).

The goal of this seating arrangement is designed to meta-communicate something simple and exceedingly important to the suicidal patient: “As your clinician, I am not your adversary; instead I am your collaborator in a joint venture to help save your life and make it worth living.” When a suicidal patient experiences genuine interest in their struggle and that the clinician is not instantly moving to hospitalize them, there is often a positive therapeutic shift in the clinical dynamic.

Talking about empathic fortitude may sound good, even noble, but it does not make actually engaging in the suicidal struggle any easier. But the collaborative use of the SSF within the CAMS assessment and treatment planning process actually can make the engagement on this difficult topic easier as both parties tend to “back into” a shared partnership with a singular focus on saving the patient’s life in a patient-centered way. Importantly, clinical research has shown that suicidal patients like being engaged in this way (Schembri, Jobes, & Horgan, 2016) and these patients are significantly more satisfied with CAMS-guided clinical care when compared with TAU care (Comtois et al., 2011).

Simply creating a collaborative dynamic and a clinical process that patients like does not necessarily eliminate all vestiges of provider countertransference—but it can help. By reducing the adversarial dynamic, clinicians using CAMS usually feel less wary and guarded toward the patient. With repeated use of CAMS, clinicians quickly become more confident with the issue because they can now rely on a proven suicide-specific model. Perhaps the most significant reduction in countertransference and anxiety comes over time through the experience of seeing CAMS work and the unforgettable satisfaction of being part of helping to save a person’s life—there really is nothing that compares with a patient earnestly saying: “. . . thanks, you saved my life!”

Suicide-Related Malpractice Liability

Malpractice cases turn on alleged failures of care that are ultimately deemed to be direct or proximate cause of patient injury or death (Jobes & Berman, 1993). The defendant’s practices are judged retrospectively as to whether they met the “standard of care” (i.e., what a reasonable and prudent practitioner with similar

training and setting would have done). Specific to suicide wrongful death cases, did the clinician-defendant sufficiently identify and assess suicidal risk (foreseeability), was the treatment appropriate, and was there sufficient clinical follow-through? All these aspects of care should be well-documented in the clinical record (Simpson & Stacy, 2004). Given these considerations, there is no way to 100% guarantee the elimination of malpractice liability related to suicide. However, CAMS does provide extensive SSF documentation pertaining to suicide-specific risk assessment and treatment planning; the tracking of suicidal risk to clinical outcomes is a signature feature of the intervention. Plaintiff attorneys may be reluctant to litigate a case against a CAMS provider because the suicide-specific care and documentation tends to far exceed the existing standard of care (Simpson & Stacy, 2004). When CAMS has been adherently provided yet fails to save a patient's life, the plaintiff's attorney must consider: in what ways exactly was the clinical provider negligent?

Effective Assessment of Suicidal Patients

As noted, the CAMS approach emphasizes the importance of a collaborative assessment of suicidal risk exploring the patient's struggle from a *phenomenological* perspective. Through the various SSF quantitative assessments and qualitative prompts, the patient psychologically "unpacks" their experience of how suicide "works" for them within their life-struggles. In a meta-analysis comparing 17 different psychological assessments across mental health problems, the CAMS/SSF assessment experience was seen to function as a "therapeutic assessment" (Poston & Hanson, 2010). Importantly, the psychometric validity and reliability of the SSF Core Assessment is robust (Conrad et al., 2009; Jobes et al., 1997). Previous test construction research has shown that the six SSF variables are quasi-independent and describe unique variance with factor structure reflecting acute and chronic suicidal states. Beyond this dichotomy however there are valuable wish to live versus wish to die ratings that can reliability differentiate distinct suicidal states (Lento, Ellis, Hinnant, & Jobes, 2013). Qualitative SSF prompts may also revelatory information that can inform treatment planning (Jobes & Mann, 1999; Jobes et al., 2004). Most importantly, the

collaborative assessment process of CAMS empathically validates the patient's experience as it illuminates the suicidal struggle. When this happens, the therapeutic alliance is enhanced and patient motivation to fully engage in their care can be fostered.

Effective Treatment of Suicidal Patients

Of the proven effective treatments for suicidal risk, CAMS is the most flexible, easiest to learn, and it does not require the clinician to use a potentially unfamiliar theoretical model to provide the care. Indeed, as a therapeutic framework, CAMS facilitates the clinician's usual approach to treatment (as long as suicidal drivers are the target of the care). Many CAMS clinicians feel reassured by having a structured—yet flexible—clinical pathway for treating a suicidal patient. There can also be comfort in knowing that CAMS is proven to be effective through clinical research and SSF documentation should significantly reduce the risk of liability.

Case Example—Melinda

As a 15-year-old high school freshman, "Melinda" is heartbroken by her parent's bitter divorce. She is a mixed race Asian-American who struggles with her cultural identity. Like many teens Melinda struggles to find a close friend group; she is very active on social media. Over the course of her freshman year, she finally settled into a group of friends in the drama club. Melinda then fell in love "Matt" a popular junior who was often the lead in school plays, but her interest in Matt was unrequited. However, at a party where peers were drinking, Melinda got drunk and had sex with Matt. Melinda subsequently announced through social media that she and Matt were a couple. In turn, Matt posted that there was no relationship and openly criticized her lack of sexual prowess. A series of Instagrams and Snapchats ensued among the drama students who teased and taunted Melinda. It follows that Melinda posted a Snap-story that alluded to "ending it all" prior to overdosing on all the prescription medications in her mother's medicine cabinet. Fortunately, a concerned peer told her mother who called Melinda's mother and she consequently found Melinda seizing on the floor of her bedroom in a pool of vomit. Melinda was rushed the emergency department where her stomach was la-

vaged. She spent 2 days in the intensive care unit before being transferred to an inpatient psychiatric unit for 3 days. The school principal visited with Melinda's mother prior to discharge and offered a referral to "Dr. Smith," a counseling psychologist in independent practice. Dr. Smith had an initial meeting with Melinda and her estranged parents and proposed using CAMS to treat Melinda's ongoing suicidal thoughts—her abjectly terrified parents enthusiastically agreed.

Melinda was seen for nine sessions of CAMS. She was initially wary but quickly settled in when she experienced Dr. Smith's genuine interest in her suicidal struggles and her willingness to have candid discussions about her suicidal thinking, particularly about what made her suicidal. Melinda's two suicidal drivers were: "being bullied by classmates" and "my parent's divorce." Melinda's near-lethal suicide attempt prompted a truce between her parents—they agreed to do whatever was needed to support her which led to a genuinely productive course of family therapy. In her sixth session of CAMS Melinda announced that she is gay and ". . . I've known it all my life." Her parents proved to be remarkably supportive in relation to this revelation and her suicidal risk as per CAMS criteria rapidly resolved by her ninth session. A final joint session with her parents was convened and Dr. Smith reviewed with Melinda and her parents the CAMS SSFs, her CSP, and the evolving driver-focused treatment plan. Everyone agreed that Melinda was doing much better and a break from therapy could be okay (because she wanted to focus on the upcoming school play in which she got a small supporting role). Melinda never returned to therapy; she became a successful member of the drama club and an excellent student. A relationship with her classmate Michelle proved to be a relatively stable and loving experience. In her senior year, Melinda was the lead in her final high school play and she graduated as an honors student after being admitted to her first-choice college.

Conclusion

For the fatalities of the mental health field, there is a great need for clinical practice innovations to *help save lives*. It is argued that given the extant evidence, there is a need to shift practice behaviors from an over-reliance on medicines that may not change suicidal ideation

or behaviors and hospitalizations that are too often insufficiently suicide-focused. Suffering patients tragically die when existing effective psychological treatments are not used. It is argued that too often countertransference and malpractice fears may impact clinical care of suicidal risk; lack of knowledge about evidence-based assessments and treatments can mean that suicidal risk gets missed or not treated, totally missing the proper treatment bullseye, which is suicidality. Given these considerations, CAMS is tendered as just one of the evidence-based approaches that can potentially make a meaningful difference but only if a provider embraces such a treatment within their practice to help clinically save the life of their patient.

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