INTERNATIONAL JOURNAL OF BEHAVIORAL CONSULTATION AND THERAPY
2014, VOL. 9, NO. 3

ISSN: 1555–7855

Applying the collaborative assessment and management of suicidality (CAMS) to suicidal adolescents

Stephen S. O'Connor[1], Amy Brausch[1], Abby Ridge Anderson[2], and David A. Jobes[2]

1 Western Kentucky University
2 The Catholic University of America

Abstract

Suicide continues to be one of the leading causes of death for adolescents, with limited evidence of empirically-supported treatment approaches for reducing risk of suicide, suicide attempts, and suicidal ideation in this population. The purpose of the current article is to present the Collaborative Assessment and Management of Suicidality (CAMS) therapeutic framework as a potentially useful approach to working with suicidal adolescents given the egalitarian dynamic between therapist and client, as well as the focus on targeting the client's unique drivers of suicide. The published literature was reviewed to determine the current state of science for empirically-supported psychotherapies developed specifically for suicidal adolescents. We conclude that while initial CAMS research and clinical projects are promising, the therapeutic framework requires the development of a rigorous line of research to achieve important benchmarks for establishment as an empirically-supported psychosocial intervention for suicidal adolescents.

Keywords

suicide, adolescents, CAMS, therapy

Case study 1*

Ryan is a 15-year old, African American boy who lives with his biological mother and 18-year old brother in a small apartment. Ryan is described as "socially disconnected" by his mother, who notes that he rarely spends time interacting with his peers. He is known to take long walks on the outskirt of town after school, often returning home well into the evening. Ryan met with a counselor when he was 10-years old after reports surfaced that he was being sexually molested by his biological father. The father was convicted and imprisoned; after 6-months of trauma informed therapy, Ryan no longer met criteria for posttraumatic stress disorder and asked to discontinue counseling. Recently, Ryan was referred to the school counselor by his English teacher who was concerned about morbid themes surfacing in his writing assignments. Ryan's mother was contacted and found hours of audio files of her son talking about death and dying that were recorded during his long walks alone. Instead of returning home that same day, Ryan walked to a local bridge that spans across a major waterway and jumped 80 feet into the water. He was rescued by a local fisherman and was air-lifted to a local trauma center for medical treatment of physical trauma to his spine.

Case study 2*

Janie is a 17-year old, Caucasian girl who is a rising senior at a Catholic High School and the oldest of 3 children. Her parents have an intact marriage, but are not tuned into their three daughters' personal lives due to their own professionally-driven lifestyle. They do, however, place extraordinary pressure on their kids to excel in scholastics and sports. Janie's grades consistently place her near the top of her class, and she has several scholarship offers to prestigious universities based upon her grades and performance in Volleyball. Janie recently discovered that her ex-boyfriend secretly filmed them while having sex and has uploaded the video to a revenge pornography website. Janie completely lost control of her emotions when her girlfriends informed her of the website and she saw the video on-line. She closed her Facebook account with a message about the shame she has brought to her family and how her death is the only way to pay for her mistake. Her youngest sister called her parents, who in turn called 911 to conduct a safety check at their residence, whereupon Janie was found to have ingested 100 Ibuprofen and was taken to the emergency department for a gastric lavage. She was then hospitalized for 5 days before returning to the community and beginning treatment with a Psychologist in private practice.

* Both cases examples are fictional and contain no personally identifiable information

Scope of the problem

Between 2000 and 2010, more than 20,000 adolescents (ages 10-19) in the United States died by suicide (Centers for Disease Control and Prevention, 2014b). Suicide has consistently been the 3rd leading cause of death for this age group, accounting for 15.2% of deaths among young people ages 15-19 in 2010 (Centers for Disease Control and Prevention, 2014b). These alarming numbers represent adolescents who completed suicide, but reveal only a fraction of the numbers of youth who struggle with suicidal thoughts, feelings, and behaviors. Among young adults (ages 15-24), for every completed suicide, an estimated 100-200 suicide attempts are made (Centers for Disease Control and Prevention, 2012). According to the 2013 Youth Risk Behavior Survey (YRBS), 17% of high school students seriously considered suicide, 13.6% made a plan to complete suicide, and 8% made at least one suicide attempt in the year prior to the survey (Centers for Disease Control and Prevention, 2014a). Suicidal thoughts and behaviors differ between boys and girls, with 22.4% of female adolescents reporting suicidal ideation versus 11.6% of male adolescents; conversely, the rate of death by suicide for males age 10-19 is more than three times higher than the rate for females among the same age group (Centers for Disease Control and Prevention, 2014b). Developing, evaluating, and implementing effective assessment and treatment approaches depends on a clear understanding of the scope of the problem, on both an individual and population level.

In order to further describe the nature and prevalence of adolescent suicide risk, Nock and colleagues (2013) analyzed data from 6,483 adolescents, drawn from the National Comorbidity Survey Replication – Adolescent Supplement dataset. Results from this sample (collected between 2001 and 2004) indicate that 12.1% of youth (ages 13-17) reported a lifetime history of suicidal ideation, 4% reported having made a plan, and 4.1% reported at least one suicide attempt; these numbers are lower than the 2011 data from the YRBS sample, which may be due to the difference in data collection procedures (self-report versus clinical interview) (Merikangas, Avenevoli, Costello, Koretz, & Kessler, 2009). Going beyond prevalence rates in the general population, the Nock et al (Nock et al., 2013) analyses provide new insight into the progression from suicidal ideation to planning to attempt behaviors. Specifically, they found that of the adolescents who had ever seriously considered suicide, 33.4% developed a plan, and 33.9% made a suicide attempt. Additionally, the study revealed that most adolescents who go on to develop a suicide plan or make a suicide attempt do so within a year of first experiencing suicidal ideation. Thus, early assessment and treatment of suicidal thoughts and behaviors is particularly important and should be a primary focus of treatment. A discouraging finding was that more than 50% of suicidal adolescents reported receiving some form of treatment for emotional or behavioral issues (including mental health, general medical, and school services) prior to the onset of suicidal ideation; 48.4% of adolescent suicide attempters had received mental health treatment before their first experience of suicidal ideation. One conclusion from this data is that treatments provided to adolescents often do not prevent development of suicidal ideation or prevent a suicide attempt.

It would thus appear that the current system of usual care is failing suicidal adolescents and their families. In this article, we propose that the "Collaborative Assessment and Management of Suicidality" (CAMS) may meaningfully assist and improve clinical care for suicidal adolescents because it incorporates a client-centered assessment of suicidal "drivers" which are client-defined problems and issues that make suicide compelling for the patient. Case examples such as those above illustrate the heterogeneity of suicidality. Both adolescents made suicide attempts, but the underlying contextual and personal factors were quite different. Beyond assessment CAMS emphasizes a pragmatic intervention approach that helps stabilize the client while on-going care targets and treats the suicidal drivers (Jobes, Comtois, Brenner, & Gutierrez, 2011). Again, varied presentations of suicidality demand flexible, client-centered approaches that enable therapists to utilize the strategies that map onto the unique and specific factors that are driving an individual's suicidal ideation. There is a growing empirical-basis within the research literature that supports the use of CAMS in various settings

that provide services to suicidal adults and young adults, including outpatient mental health clinics (Comtois et al., 2011), college counseling centers (Jobes, Kahn-Greene, Greene, & Goeke-Morey, 2009), inpatient psychiatry units (Ellis, Green, Allen, Jobes, & Nadorff, 2012), and military health clinics (Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005). Across all treatment settings and populations of suicidal clients studied, CAMS acceptability has been established, as evidenced by high client satisfaction ratings and therapists typically reaching acceptable levels of fidelity to the intervention manual within the first four sessions with two individual pilot cases. Thus, the intervention is readily trainable, adaptable, and potentially efficacious as a means for reducing suicidal ideation and behaviors. The conclusion of on-going clinical trials with suicidal active duty military personnel and adults in outpatient mental health settings will further inform the efficacy of using CAMS as an evidenced-based approach to treating suicidal individuals.

The current paper endeavors to describe the application of CAMS for suicidal adolescents treated in outpatient mental health settings. We review the state of science for adolescents regarding methods of suicide attempts, motivating factors underlying suicidal ideation and behaviors, and the efficacy of existing psychotherapeutic approaches before presenting the CAMS model in greater detail.

Characteristics and motivations of adolescent suicidal ideation and attempts

Since the ratio of completed suicides to attempted suicides in adolescents is relatively low (1:200), it is likely that adolescents are sometimes engaging in suicide attempts for reasons other than to die. Surprisingly, there are few studies that have specifically investigated the reasons and motivations that adolescents give for their suicide attempts (Jacobson, Batejan, Kleinman, & Gould, 2013). However, as it has been shown in the literature regarding suicide attempts in adults, accessing information about an individual's a motivation for suicidal ideation and attempts can help to facilitate treatment (Jobes et al., 2004). As there remains the absence of empirically-supported treatments for suicidal adolescents (Nock, 2012), being able to identify the characteristics of suicidal ideation, plans, intent, and attempts is an important first step in designing new or modifying existing treatments for use with the adolescent population.

As noted, the lifetime prevalence rate for suicide attempts in adolescents is approximately 6-7%, with girls having significantly higher rates than boys (Jacobson et al., 2013; Lewinsohn, Rohde, & Seeley, 1996). When examining methods of suicide attempts in adolescents, there are also differences seen by gender. Girls most often use ingestion (self-poisoning) or cutting, while boys use these methods to a lesser extent but also use firearms, hanging, and "other" methods like running into traffic or jumping from high places. Most research studies that utilize samples of adolescents who have made a suicide attempt are predominantly female, due to the gender ratio of suicide attempts to completions; therefore, the most common methods studied in the literature is self-poisoning and cutting (Madge et al., 2008).

Hawton and colleagues (Hawton, Cole, O'Grady, & Osborn, 1982) were among the first to assess adolescents' reasons for making suicide attempts and their intent to live or die. In their sample of British adolescent inpatients who were admitted to the hospital following an act of self-poisoning, 34% expressed a wish to die, 42% were ambivalent, and 24% did not want to die. The three reasons endorsed for making an attempt were to obtain relief from a terrible state of mind, to escape, and to make others understand how desperately they were feeling. Similar results were found in a sample of Dutch adolescent inpatients, and this sample also included participants who made attempts other than self-poisoning (Kienhorst, De Wilde, Diekstra, & Wolters, 1995). The most popular reason given for making an attempt in this sample reflected that the adolescent felt they needed to do something about their situation, and did not know what else to do. Other popular reasons endorsed include: to stop feeling pain, a wish to die, wanting to escape, and wanting relief from a terrible state of mind. This study also interviewed adolescents about the 6-month time period prior to their suicide attempt, and results indicated that 40% reported conflict with parents or a significant other in the days before the attempt, and 26% reported having thoughts about problems in their lives and about making a suicide attempt. The majority of adolescents reported feeling depressed during this time period, with some also reporting anger.

Similarly, a study of 120 adolescent inpatients in the United States who presented to the emergency department after a suicide attempt found the same top three reasons for the attempt: to die (56%), to get relief (57%), and to escape (55%) (Boergers, Spirito, & Donaldson, 1998). Death was endorsed as the *primary* reason for the attempt by 28% of the sample; follow up analyses revealed that adolescents who endorsed death as a reason for their attempt also had higher scores on depression, hopelessness, anger expression, and perfectionism (socially prescribed) than adolescents who did not endorse death as a reason. The authors noted that while interpersonal events (i.e., conflicts with parents, friends, and significant others) are reported by adolescents as precipitants of a suicide attempt, the reasons adolescents cite for making a suicide attempt are typically intrapersonal in nature (i.e., dying, escaping, getting relief).

A handful of more recent studies have also examined characteristics of suicide attempts in adolescents, but focused on community samples rather than clinical. Madge et al. (2008) reported results from a very large (30,000+) community sample of adolescents from the Child and Adolescent Self-harm in Europe (CASE) study. Reasons for explaining self-harm that occurred in the previous year included wanting relief from a terrible state of mind (70.9%), wanting to die (59%), and wanting to punish oneself (43.6%). Furthermore, it was rare for adolescents to endorse only one reason for self-harm with most endorsing multiple reasons. The least likely reasons given for suicide attempts were to frighten someone, get attention, or get revenge. The most recent study that examined reasons for attempting suicide also utilized a community sample of adolescents (Jacobson et al., 2013). Jacobson and colleagues interviewed 99 high school students in New York, all of who reported a suicide attempt and one-third of who reported more than one lifetime suicide attempt. The most common precipitant for an attempt was experiencing a problem with a parent (47.5%) or a significant other or friend (35.4%). The method of attempts was mostly equally divided between overdose, cutting, and other methods (jumping, hanging, strangulation). Like the studies before it, the three most common reasons given for attempting suicide were to get relief, to escape, and to die, although the wish to die was the third most common response in this sample.

The study authors also examined relationships between reasons endorsed for the attempt and other factors. Results indicated that adolescents who reported more than one suicide attempt were up to four times more likely to cite death as a reason for their most recent attempt than those who had only one lifetime attempt. Elevated depression scores were also related to citing wanting to die as a reason for the attempt. Similarly, in a study comparing adolescents who made multiple suicide attempts to those who made single attempts or only reported ideation, those with a history of multiple suicide attempts more often reported a wish to die during their attempt than those with a single attempt. Multiple attempters also were found to not plan their attempt with chance of intervention as often, and more often regretted their recovery from the attempt than single attempters (Miranda et al., 2008).

Current approaches for treating suicidal adolescents

Several recent systematic reviews have each concluded that while there are some promising interventions that effectively address adolescent suicide risk, the available research is preliminary, and the state of the field remains in its infancy. Daniel and Goldston (2009) described eleven intervention studies that specifically targeted suicidal adolescents and measured suicidality as an outcome measure. These interventions included brief emergency department-based services, Dialectical Behavior Therapy (DBT) approaches, family-focused therapies, cognitive behavioral therapy (CBT), and a group therapy treatment. Daniel and Goldston (2009) found that several of the interventions yielded positive outcomes with regards to treatment engagement, but few resulted in significantly greater decreases in suicidal ideation or behaviors than the comparison groups. A review by Corcoran, Dattalo, Crowley, Brown, and Grindle (2011) included these eleven studies, as well as six additional interventions, including two CBT studies and one study of Attachment-Based Family Therapy (ABFT). Corcoran et al. (2011) found that overall, the interventions resulted in only a slight improvement in suicidal ideation for the intervention groups as compared with the control groups. For many of the studies, participants in the intervention groups were significantly less likely to have engaged in suicidal or self-harm behavior at the close of treatment, but were slightly worse off than the adolescents in the control groups at 12- or 18-month follow-up assessments. The authors concluded that current research does not provide strong support in favor of suicide-specific interventions for adolescents, over treatment as

usual. De Silva et al. (2013) echo the disappointing conclusion that there is as yet no firmly established evidence-based treatment for suicidal adolescents. However, there are a few developmentally-targeted, suicide-specific treatments that have shown initial promise. These include ABFT (G.S. Diamond et al., 2010), CBT (Brent et al., 2009; Spirito, Esposito-Smythers, Wolff, & Uhl, 2011; Stanley et al., 2009) and DBT (Miller, Rathus, & Linehan, 2007).

Attachment-Based Family Therapy (ABFT) targets the relationship between an adolescent and his or her parents, with the goal of establishing (or re-establishing) a secure attachment that will allow the adolescent to move toward autonomy, a key developmental milestone (G. S. Diamond, Siqueland, & Diamond, 2003). Through a series of five therapeutic tasks, this intervention addresses several interpersonal risk factors for depression, including parental criticism and hostility, parental stress, ineffective parenting, emotion dysregulation, and negative self-concept. Therapy begins with a relational reframing task, which reduces family conflict and blame. This is followed by two to four sessions in which the therapist meets with the adolescent, then the parents, individually; these tasks are referred to as adolescent alliance building and parent alliance building. The family then comes back together for the reattachment task, during which the adolescent expresses his or her concerns about the parent-child relationship, and the parent(s) accept and validate the adolescent's viewpoint. The final task of ABFT is to promote autonomy and competency for the adolescent (G. S. Diamond et al., 2003).

A randomized controlled trial comparing ABFT to an enhanced usual care condition found that ABFT had a large effect size on rate of change in suicidal ideation and led to a significantly greater reduction in suicidal ideation over the course of the study period, which included a 12-week follow-up assessment (G. S. Diamond et al., 2010). An earlier study comparing ABFT to a wait-list control condition (G. S. Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002) found no significant group differences on suicidal ideation post-treatment, however suicidal ideation was not an inclusion criterion for this sample. In a study examining the mechanisms of change in ABFT, using participants drawn from the RCT sample, Shpigel, G. S. Diamond, and Diamond (2012) found that although treatment did lead to significant improvements in parenting behaviors, these changes were not correlated with changes in suicidal ideation. Although the initial RCT for ABFT demonstrated that this intervention can lead to clinically significant improvements in suicidal ideation, further research is needed to establish ABFT as an evidence-based treatment for adolescent suicidality.

There is strong evidence that cognitive behavioral approaches can be effective in treating adult suicidality (Brown et al., 2005; Tarrier, Taylor, & Gooding, 2008). Clinicians and researchers have begun to adapt and study cognitive behavioral treatments for adolescents, and the initial results show that CBT for adolescent suicidality warrants further study. Cognitive Behavior Therapy for Suicide Prevention (CBT-SP) (Stanley et al., 2009) begins with a thorough risk assessment, using chain analysis to identify suicide-specific treatment targets. The primary goal of treatment is to increase adolescents' coping skills and decrease the situational stressors than can trigger suicidal behavior. CBT-SP incorporates family sessions and psychoeducation and includes a focus on building hope, as well as on developing distress tolerance, problem-solving, and emotion regulation skills. The Treatment of Adolescent Suicide Attempters Study (TASA) provided initial findings on the effectiveness of CBT-SP for adolescents (Brent et al., 2009). Participants self-selected into one of three treatment groups: CBT-SP, medication, or a combination of the two. Seventy-five percent of the participants chose the combination treatment, and this group did not significantly differ from either the medication-only or the CBT-only group in post-treatment suicidal ideation. All three groups demonstrated significant reductions in suicidal ideation (Vitiello et al., 2009). In a review of CBT treatments for adolescent suicidality, Spirito and colleagues (2011) confirmed that, while studies have shown that CBT treatments for adolescent suicidality are associated with decreased risk of suicidal ideation and behaviors, there is limited evidence demonstrating that CBT is more effective than comparison treatments.

Dialectical Behavior Therapy (DBT) targets persistent suicidality by emphasizing a balance between acceptance and change, using skill-building techniques to enhance clients' ability to tolerate distress, restructure their environments, and cope with negative emotions (Miller et al., 2007). This structured intervention has been adapted for use with suicidal adolescents by adding a family component to the treatment, and including an adolescent-specific module that addresses common themes of family conflict and the adolescents' developmental need for autonomy (Miller et al., 2007). Katz, Cox, Gunasekara, and Miller (2004) conducted a feasibility trial of DBT for suicidal adolescent inpatients and found significant reductions in suicidal ideation both at post-treatment and one-year follow-up. However, there was no significant difference between DBT and the treatment as usual condition. Groves, Backer, van den Bosch, and Miller (2012) reviewed the outcomes for DBT with adolescents, and noted that DBT has been associated with reductions in suicidal ideation and behavior in several studies focusing on suicidal adolescents in a variety of treatment settings and with a range of disorders. However, the authors point out that most of the studies reviewed lacked control groups, and it is therefore difficult to draw firm conclusions about the effectiveness of DBT.

The three manualized treatments for adolescent suicidality reviewed here each have established preliminary evidence that they can effectively reduce suicide risk. However, multiple review articles have reiterated the need for robust RCTs that can demonstrate that suicide-specific treatments for adolescents are more beneficial than the standard of care. Additional research is needed to understand how these and other interventions work, and for whom. As Daniel and Goldston (2009) point out, effective interventions must not only be developmentally appropriate, they must take into account the heterogeneity of adolescents' experience of suicidality.

The collaborative assessment and management of suicidality

As a treatment framework, CAMS provides the structure for clinicians to manage suicide risk while addressing the unique direct and indirect factors underlying an individual's suicidal ideation (Jobes et al., 2011). The organizing documents consist of different versions of the Suicide Status Form (SSF). A detailed version of the SSF is administered in a collaborative fashion during the initial treatment session, with the client and therapist sitting side-by-side while discussing intricate details about the content of suicidal ideation. The therapist gathers information on specific risk factors (e.g., access to lethal means, history of suicide attempts, substance use, shame, perceived burdensomeness, isolation) and then works with the client to create a stabilization plan that addresses barriers to attending treatment, a crisis response plan for suicidal crises, a plan to reduce access to lethal means, and contact information for social supports. The initial session concludes with the dyad creating a suicide-specific treatment plan to address the factors underlying their suicidal ideation.

Subsequent treatment sessions begin with the client completing the SSF tracking form, which consists of the SSF "Core Assessment" which includes six core quantitative ratings scales measuring psychological pain, stress, agitation, hopelessness, self-hate, and self-perceived overall risk of suicide. The dyad then reviews the effectiveness of the strategies reflected on the stabilization plan and updates the plan accordingly. For the next 30-minutes, the therapist works with the client to develop a deeper understanding of what drives and maintains their suicidal ideation, while also employing intervention strategies that are collaboratively determined by the dyad. The dyad is ultimately focused on developing an explanatory model of suicide that identifies how factors indirectly related to suicide (e.g., mental health disorders, poverty, interpersonal conflict, substance use) lead to factors directly associated with a desire for death (i.e., specific thoughts, emotions, behaviors, and themes). The final 10-15 minutes is spent updating the treatment plan and discussing out-of-session work to be completed prior to the next session.

In regards to the fictional cases presented above, a course of CAMS treatment would entail understanding how each adolescent's direct and indirect drivers led to suicidal ideation (Figure 1). It seems that Ryan's direct drivers relate to thwarted belongingness and possibly hopelessness, while his indirect drivers included a history of sexual trauma and potentially residual symptoms of posttraumatic stress. Janie on the other hand experienced direct drivers related to perceived burdensomeness to her family and intense feelings of shame and guilt. Her indirect drivers included a difficult family environment and exceedingly high expectations to succeed from her parents. Notably, it would seem that each adolescent's relationship with suicide was different. Through careful interviewing in ongoing CAMS sessions, the clinician would seek to understand how long each has contemplated suicide and the perceived function of suicidal ideation and behaviors. Ryan's story would reveal a long process of considering the

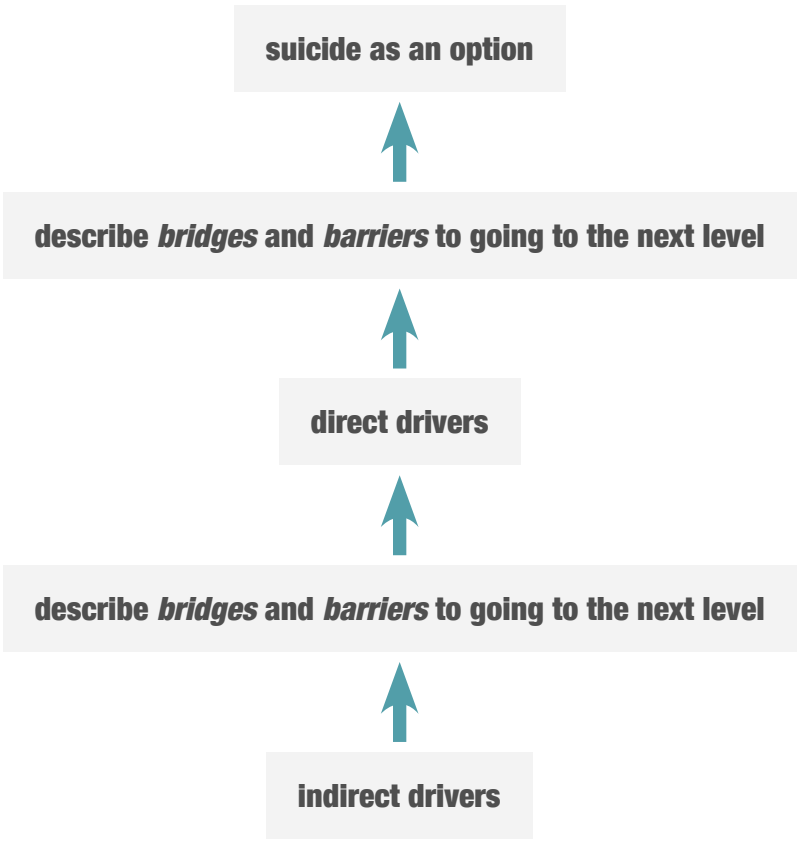

Figure 1. Collaborative assessment and management of suicidality explanatory model that informs the development of an accurate representation of the unique factors directly and indirectly related to a client's suicidal ideation. This information informs the development of appropriate intervention strategies reflected in the suicide-specific treatment plan on the suicide status form.

pros and cons of suicide as he took those long walks by himself. It was not an impulsive decision even though it coincided with his teacher's and mother's expression of concern for his well-being. In contrast to Ryan's slow-paced decision making process, Janie appears to have acted on impulse when she attempted suicide. Her extreme emotion dysregulation led to a quick decision and an almost tragic end. Thus, each adolescent had a different relationship with suicidality and this would be explored throughout the course of CAMS treatment.

Resolution of treatment is ultimately at the discretion of the clinician, but is generally informed by week-to-week scores reported on the SSF Tracking Form. The recommended algorithm for ending treatment consists of three consecutive weeks where the client reports an overall risk of suicide score of 2 or less, no suicidal behaviors, and a consistent ability to manage suicidal thoughts and urges they may infrequently experience. Quickly assessing the suicide index score, which is the combined rating of a person's wish to live and wish to die can also be informative in determining whether the client has greater attachment to living than dying (O'Connor, Jobes, Comtois, et al., 2012; O'Connor, Jobes, Yeargin, et al., 2012).

■ Applying CAMS to suicidal adolescents

We believe that the philosophy of CAMS, which is overtly egalitarian and client-focused, meaningfully helps the client by developing a model that reflects how each client experiences suicidal ideation matches the unique characteristics posed by suicidal adolescents. The therapist overtly communicates that the adolescent is the expert on their own experience and is expected to partner on a plan to address the issues that engender suicidal coping. In many ways the course of treatment for adolescents does not differ greatly from that described above for adults; however, greater flexibility regarding completion of forms may be warranted. The therapist should prioritize a suicide focus during the treatment process, while also recognizing that adolescents' cognitive and emotional maturity will vary greatly. Slowing down as needed in order to maintain a collaborative relationship is encouraged when the client signals that they are overwhelmed or is feeling that their voice is not being heard. We would never advise clinicians to place a greater emphasis on completing the forms in a timely manner than establishing and maintaining a therapeutic relationship with the suicidal adolescent.

Managing dynamics with parents

As covered in previous writings by Jobes (e.g., Jobes, 2006), thoughtfully managing the informed consent process can increase the likelihood of building a collaborative relationship with a suicidal client. This topic takes on even greater importance when considering the dynamic of entering into a therapeutic relationship with a suicidal adolescent, where anxious and over-bearing parents may undermine the very treatment meant to save their child's life. We recommend clinicians have an initial meeting with the parents and child where sensitive topics related to ethical considerations (e.g., when the therapist is required to report concerns regarding suicide) and privilege (e.g., how much information actually needs to be reported to parents in order to maintain a confidential and trusting relationship between the client and therapist). It is essential that the client understand that the therapist is not simply a conduit for the parents' preferences regarding the direction and content of treatment.

Still, certain ground rules should be communicated early. For example, a clinician cannot support the use of CAMS in an outpatient setting if the adolescent and their family are unwilling to reduce access to lethal means. It simply undermines the goal of treatment, which is to prevent suicide. CAMS fundamentally relies on the client implementing a suicide-specific treatment plan to address the factors that make then suicidal. Thus, they are likely to continue experiencing suicidal thoughts and urges for at least the first month of treatment. It is therefore in the best interest of the adolescent to minimize the likelihood that a moment of desperation prevents potential treatment gains. Second, a stabilization plan for managing acute suicidal crises must be completed in the first session. With adolescents, we recommend discussing the need to remove access to lethal means and reviewing the crisis response plan with the parents at the end of the initial session so that everyone is on board with a critical component of care.

Parental concern is often the impetus for treatment, which places the adolescent in the unenviable position of having problems that need to be "addressed." This is a difficult way to begin treatment and actually runs counter to the CAMS principle of expressing empathy for the suicidal wish. Thus, the therapist seeks to reduce shame, embarrassment, or resentment by engaging the adolescent in an honest discussion about their relationship to suicide. When did they first begin having suicidal thoughts? Was there a time in their life when they did not consider suicide an option? If so, what changed and why? This approach communicates that suicidal thoughts are not something to be "fixed," rather they are to be understood and acknowledged as something only the client has the ability to retain or discard moving forward.

Once engaged in CAMS, the clinician needs to thoughtfully consider how the child's parents relate to their suicidal ideation. This will help inform the degree to which the dyad engages the parents in treatment. For example, if the parents are seen as allies, it may be helpful to let the adolescent present them with the explanatory framework of the unique factors that relate to his/her own suicidal ideation. Parents may also be able to provide more effective support if

they are privy to the intervention strategies included on the treatment plan. At the same time, it may be that parents contribute to the adolescent's suicidal ideation through their dysfunctional behaviors and therefore would not be expected to contribute as much during the course of treatment. Regardless of how parents are engaged, it is essential that the client be engaged in a collaborative discussion about the topic and empowered to work with the therapist to determine what is in their best interest.

CAMS adolescent research

Several projects support the use of the CAMS therapeutic framework to assess and treat suicidal adolescents. Romanowicz and colleagues (Romanowicz, O'Connor, Schak, Swintak, & Lineberry, 2013) investigated sex differences in suicidal ideation using the SSF and demonstrated the acceptability and feasibility of using the SSF with an adolescent clinical population. The study included 1,153 adolescents who were treated in the inpatient psychiatric unit at the Mayo Clinic, which has all psychiatric patients complete a self-administered SSF within 24 hours of admission. Girls reported greater psychological pain, stress, hopelessness, and self-hate, but not significantly higher ratings of agitation and self-perceived overall risk of suicide than boys. The findings indicate that boys and girls are equally likely to endorse suicidal thoughts on the SSF, which addresses possible concerns about differential validity in assessing suicidality between sexes, given evidence that girls are more likely to seek help from adults for suicidal ideation (Kalafat & Elias, 1992).

There is an especially intriguing example of a large scale use of the CAMS framework within a juvenile offender population where the majority of youth indicate that they are suicidal sometime in the course of their incarceration. As described in exploratory studies (Holmes, Saghafi, Monahan, Cardell, & Jobes, 2014; Monahan, Saghafi, Holmes, Cardell, & Jobes, 2014; Ridge Anderson et al., 2014; Saghafi, Monahan, Holmes, Cardeli, & Jobes, 2014), a modified use of CAMS was used within the Department of Juvenile Justice in the state of Georgia. Across 28 different forensic facilities, clinicians used CAMS to guide assessment and treatment of suicidal youth. This initial application of CAMS was not without its challenges. For example, clinicians rather than clients completed the SSF because offenders were not allowed to have any access to pens or pencils which could become weapons. Moreover, for many youth being "suicidal" was highly instrumental and their actual "suicidal" behaviors were often in the Non-Suicidal Self-Injury (NSSI) realm of acting out (e.g., head banging, biting, and scratching). Yet such a population is still at very high risk for completing suicides (Sanislow, Grilo, Fehon, Axelrod, & McGlashan, 2003) and clinicians using modified CAMS in this setting reported finding the approach highly effective in clarifying suicidal thinking while providing valuable structure to managing genuine suicidal risk and self-harm behaviors. Additional CAMS research with this extraordinarily high risk and under-studied population is now underway.

The next phase of CAMS research for suicidal adolescents will involve a psychometric evaluation of the SSF that mirrors the approach previously used with an adult sample (Conrad et al., 2009). Two of the authors (SO and AB) have partnered with an adolescent inpatient psychiatric hospital in Kentucky to recruit 150 adolescents, who will complete the SSF along with a large battery of assessments in order to demonstrate convergent and divergent validity. Our team has discussed possibly renaming certain items on the SSF, such as psychological pain and self-hate, to make them more appropriate for a younger population. We will reach a final decision prior to launching the psychometric evaluation. Once this study is completed, the focus will shift towards a Phase I intervention development study, where we will develop a treatment manual and adherence measures necessary to later conduct a formalized pilot study with our partners in community mental health in Kentucky.

Several resources are currently available for those interested in learning more about CAMS. David Jobes has published a book, titled, *Managing Suicidal Risk: A Collaborative Approach* (Jobes, 2006), which provides a foundation in the CAMS framework approach to working with suicidal clients in outpatient settings. The book includes copy-ready versions of the SSF to be used in the initial session, as well as all subsequent and termination sessions. Implementation efforts in healthcare systems in the United States and Canada have led to a stepped training model consisting of 1 day of foundation training, 1.5 days of live demonstration and role-playing, and 12 weeks of consultation calls. An innovative approach to delivering the foundation training is being developed by Empathos (Pazur, 2014), which created a 3-hour eLearning module that provides video demonstration, voice-over by Dr, Jobes, and self-evaluation tools. Additionally, the published chapter by Jobes and colleagues (2011) and article by Jobes, Moore, and O'Connor (2007) provide helpful overviews of the CAMS framework. ■

References

Boergers, J., Spirito, A., & Donaldson, D. (1998). Reasons for adolescent suicide attempts: associations with psychological functioning. Journal of the American Academy of Child and Adolescent Psychiatry, 37, 1287-1293. doi: 10.1097/00004583-199812000-00012

Brent, D. A., Greenhill, L. L., Compton, S., Emslie, G., Wells, K., Walkup, J. T., … Turner, J. B. (2009). The Treatment of Adolescent Suicide Attempters study (TASA): predictors of suicidal events in an open treatment trial. Journal of the American Academy of Child and Adolescent Psychiatry, 48, 987-996. doi: 10.1097/CHI.0b013e3181b5dbe4

Brown, G. K., Ten Have, T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts: a randomized controlled trial. Journal of the American Medical Association, 294, 563-570.

Centers for Disease Control and Prevention. (2012). Suicide: Facts at a glance. Accessed June 1, 2014.

Centers for Disease Control and Prevention. (2014a). High school youth risk behavior survey data. Accessed June 1, 2014.

Centers for Disease Control and Prevention. (2014b). Web-based injury statistics query and reporting system (WISQARS). Accessed June 24, 2014.

Comtois, K. A., Jobes, D. A., O'Connor S, S., Atkins, D. C., Janis, K., E., C. C., … Yuodelis-Flores, C. (2011). Collaborative assessment and management of suicidality (CAMS): feasibility trial for next-day appointment services. Depression and Anxiety, 28, 963-972. doi: 10.1002/da.20895

Conrad, A. K., Jacoby, A. M., Jobes, D. A., Lineberry, T. W., Shea, C. E., Arnold Ewing, T. D., … Kung, S. (2009). A psychometric investigation of the Suicide Status Form II with a psychiatric inpatient sample. Suicide & Life Threatening Behavior, 39, 307-320. doi: 10.1521/suli.2009.39.3.307

Corcoran, J., Dattalo, P., Crowley, M., Brown, E., & Grindle, L. (2011). A systematic review of psychosocial interventions for suicidal adolescents. Children and Youth Services Review, 33, 2112-2118. doi: http://dx.doi.org/10.1016/j.childyouth.2011.06.017

Daniel, S. S., & Goldston, D. B. (2009). Interventions for suicidal youth: a review of the literature and developmental considerations. Suicide & Life Threatening Behavior, 39, 252-268. doi: 10.1521/suli.2009.39.3.252

De Silva, S., Parker, A., Purcell, R., Callahan, P., Liu, P., & Hetrick, S. (2013). Mapping the evidence of prevention and intervention studies for suicidal and self-harming behaviors in young people. Crisis, 34, 223-232. doi: 10.1027/0227-5910/a000190

Diamond, G., Siqueland, L., & Diamond, G. M. (2003). Attachment-based family therapy for depressed adolescents: programmatic treatment development. Clinical Child and Family Psychological Review, 6, 107-127.

Diamond, G. S., Reis, B. F., Diamond, G. M., Siqueland, L., & Isaacs, L. (2002). Attachment-based family therapy for depressed adolescents: a treatment development study. Journal of the American Academy of Child and Adolescent Psychiatry, 41, 1190-1196. doi: 10.1097/00004583-200210000-00008

Diamond, G. S., Wintersteen, M. B., Brown, G. K., Diamond, G. M., Gallop, R., Shelef, K., & Levy, S. (2010). Attachment-based family therapy for adolescents with suicidal ideation: a randomized controlled trial. Journal of the American Academy of Child and Adolescent Psychiatry, 49, 122-131.

Ellis, T. E., Green, K. L., Allen, J. G., Jobes, D. A., & Nadorff, M. R. (2012). Collaborative Assessment and Management of Suicidality in an inpatient setting: Results of a pilot study. Psychotherapy, 49, 72-80. doi: 10.1037/a0026746Groves, S., Backer, H. S., van den Bosch, W., & Miller, A. (2012). Dialectical behaviour therapy with adolescents. Child and Adolescent Mental Health, 17, 65-75. doi: 10.1111/j.1475-3588.2011.00611.x

Hawton, K., Cole, D., O'Grady, J., & Osborn, M. (1982). Motivational aspects of deliberate self-poisoning in adolescents. British Journal of Psychiatry, 141, 286-291.

Holmes, J., Saghafi, S., Monahan, M., Cardeli, E., & Jobes, D. (2014, April). Self hate and suicide: An analysis of incarcerated youth.. Paper presented at the 47th Annual Conference of the American Association of Suicidology, Los Angeles, CA.

Jacobson, C., Batejan, K., Kleinman, M., & Gould, M. (2013). Reasons for attempting suicide among a community sample of adolescents. Suicide & Life Threatening Behavior, 43, 646-662. doi: 10.1111/sltb.12047

Jobes, D. A. (2006). Managing suicidal risk: A collaborative approach. New York, NY US: Guilford Press.

Jobes, D. A., Comtois, K. A., Brenner, L., & Gutierrez, P. M. (2011). Clinical trial feasibility studies of the collaborative assessment and management of suicidality (CAMS). In R. C. O'Connor, S. Platt & J. Gordon (Eds.), International handbook of suicide prevention: Research, policy, & practice (pp. 383-400). West Sussex, UK: Wiley-Blackwell.

Jobes, D. A., Kahn-Greene, E., Greene, J. A., & Goeke-Morey, M. (2009). Clinical improvements of suicidal outpatients: Examining suicide status form responses as predictors and moderators. Archives of Suicide Research, 13, 147-159. doi: 10.1080/13811110902835080

Jobes, D. A., Moore, M. M., & O'Connor, S. S. (2007). Working with suicidal clients using the Collaborative Assessment and Management of Suicidality (CAMS) approach. Journal of Mental Health Counseling, 29, 283-300. http://www.amhca.org/news/journal.aspx

Jobes, D. A., Nelson, K. N., Peterson, E. M., Pentiuc, D., Downing, V., Francini, K., & Kiernan, A. (2004). Describing suicidality: an investigation of qualitative SSF responses. Suicide & Life Threatening Behavior, 34, 99-112. doi: 10.1521/suli.34.2.99.32788

Jobes, D. A., Wong, S. A., Conrad, A. K., Drozd, J. F., & Neal-Walden, T. (2005). The collaborative assessment and management of suicidality versus treatment as usual: a retrospective study with suicidal outpatients. Suicide & Life Threatening Behavior, 35, 483-497. doi: 10.1521/suli.2005.35.5.483

Kalafat, J., & Elias, M. (1992). Adolescents' experience with and response to suicidal peers. Suicide & Life Threatening Behavior, 22, 315-321.

Katz, L. Y., Cox, B. J., Gunasekara, S., & Miller, A. L. (2004). Feasibility of dialectical behavior therapy for suicidal adolescent inpatients. Journal of the American Academy of Child and Adolescent Psychiatry, 43, 276-282. doi: 10.1097/00004583-200403000-00008

Kienhorst, I. C., De Wilde, E. J., Diekstra, R. F., & Wolters, W. H. (1995). Adolescents' image of their suicide attempt. Journal of the American Academy of Child and Adolescent Psychiatry, 34, 623-628. doi: 10.1097/00004583-199505000-00014

Lewinsohn, P. M., Rohde, P., & Seeley, J. R. (1996). Adolescent Suicidal Ideation and Attempts: Prevalence, Risk Factors, and Clinical Implications. Clinical Psychology: Science and Practice, 3, 25-46. doi: 10.1111/j.1468-2850.1996.tb00056.x

Madge, N., Hewitt, A., Hawton, K., de Wilde, E. J., Corcoran, P., Fekete, S., … Ystgaard, M. (2008). Deliberate self-harm within an international community sample of young people: comparative findings from the Child & Adolescent Self-harm in Europe (CASE) Study. Journal of Child Psychology and Psychiatry, 49, 667-677. doi: 10.1111/j.1469-7610.2008.01879.x

Merikangas, K., Avenevoli, S., Costello, J., Koretz, D., & Kessler, R. C. (2009). National comorbidity survey replication adolescent supplement (NCS-A): I. Background and measures. Journal of the American Academy of Child and Adolescent Psychiatry, 48, 367-369. doi: 10.1097/CHI.0b013e31819996f1

Miller, A. L., Rathus, J. H., & Linehan, M. M. (2007). Dialectical behavior therapy with suicidal adolescents. New York, NY: The Guilford Press.

Miranda, R., Scott, M., Hicks, R., Wilcox, H. C., Harris Munfakh, J. L., & Shaffer, D. (2008). Suicide attempt characteristics, diagnoses, and future attempts: comparing multiple attempters to single attempters and ideators. Journal of the American Academy of Child and Adolescent Psychiatry, 47, 32-40. doi: 10.1097/chi.0b013e31815a56cb

Monahan, M., Saghafi, S., Holmes, J., Cardeli, E., & Jobes, D. (2014, April). "Manipulative" Vs. "Genuine" Suicidal Risk: An Examination of Juvenile Offenders. Paper presented at the 47th Annual Conference of the American Association of Suicidology, Los Angeles, CA.

Nock, M. K. (2012). Future directions for the study of suicide and self-injury. Journal of Clinical Child & Adolescent Psychology, 41, 255-259. doi: 10.1080/15374416.2012.652001

Nock, M. K., Green, J. G., Hwang, I., McLaughlin, K. A., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2013). Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: results from the National Comorbidity Survey Replication Adolescent Supplement. JAMA Psychiatry, 70, 300-310. doi: 10.1001/2013.jamapsychiatry.55

O'Connor, S. S., Jobes, D. A., Comtois, K. A., Atkins, D. C., Janis, K., C, E. C., & S, J. L. (2012). Identifying Outpatients with Entrenched Suicidal Ideation Following Hospitalization. Suicide & Life Threatening Behavior, 42, 173-184 . doi: 10.1111/j.1943-278X.2012.0080.x

O'Connor, S. S., Jobes, D. A., Yeargin, M. K., Fitzgerald, M. E., Rodriguez, V. M., Conrad, A. K., & Lineberry, T. W. (2012). A cross-sectional investigation of the suicidal spectrum: typologies of suicidality based on ambivalence about living and dying. Comprehensive Psychiatry, 53, 461-467. doi: 10.1016/j.comppsych.2011.09.007

Pazur, D. (2014). Empathos: Empowering suicide prevention through education. Retrieved from www.empathosresources.com

Ridge Anderson, A., Bowers, M., Willard, C., Casey, T., Caulfield, N., Cardeli, E., & Jobes, D. A. (2014). Isolation and adolescent suicide risk: The moderating role of self vs. relational orientation. Paper presented at the American Association of Suicidology Annual Conference, Los Angeles, CA.

Romanowicz, M., O'Connor, S. S., Schak, K. M., Swintak, C. C., & Lineberry, T. W. (2013). Use of the Suicide Status Form-II to investigate correlates of suicide risk factors in psychiatrically hospitalized children and adolescents. Journal of Affective Disorders, 151, 467-473. doi: 10.1016/j.jad.2013.06.026

Saghafi, S., Monahan, M. F., Holmes, J., Cardeli, E., & Jobes, D. A. (2014, April). The subjective experience of suicide among youth: A comparison between suicidal college students and incarcerated juvenile offenders. Paper presented at the 47th Annual Conference of the American Association of Suicidology, Los Angeles, CA.

Sanislow, C. A., Grilo, C. M., Fehon, D. C., Axelrod, S. R., & McGlashan, T. H. (2003). Correlates of suicide risk in juvenile detainees and adolescent inpatients. Journal of the Amreican Academy of Child and Adolescent Psychiatry, 42, 234-240. doi: 10.1097/00004583-200302000-00018

Shpigel, M. S., Diamond, G. M., & Diamond, G. S. (2012). Changes in parenting behaviors, attachment, depressive symptoms, and suicidal ideation in attachment-based family therapy for depressive and suicidal adolescents. Journal of Marital & Family Therapy, 38 Suppl 1, 271-283. doi: 10.1111/j.1752-0606.2012.00295.x

Spirito, A., Esposito-Smythers, C., Wolff, J., & Uhl, K. (2011). Cognitive-Behavioral Therapy for Adolescent Depression and Suicidality. Child and Adolescent Psychiatric Clinics of North America, 20, 191-204. doi: http://dx.doi.org/10.1016/j.chc.2011.01.012

Stanley, B., Brown, G., Brent, D. A., Wells, K., Poling, K., Curry, J., … Hughes, J. (2009). Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. Journal of the American Academy of Child and Adolescent Psychiatry, 48, 1005-1013. doi: 10.1097/CHI.0b013e3181b5dbfe

Tarrier, N., Taylor, K., & Gooding, P. (2008). Cognitive-behavioral interventions to reduce suicide behavior: a systematic review and meta-analysis. Behavior Modification, 32, 77-108. doi: 10.1177/0145445507304728

Vitiello, B., Brent, D. A., Greenhill, L. L., Emslie, G., Wells, K., Walkup, J. T., … Zelazny, J. (2009). Depressive symptoms and clinical status during the Treatment of Adolescent Suicide Attempters (TASA) Study. Journal of the American Academy of Child and Adolescent Psychiatry, 48, 997-1004. doi: 10.1097/CHI.0b013e3181b5db66

Author contact information

Stephen O'Connor, Ph.D.

Assistant Professor of Psychological Sciences
Western Kentucky University
1906 College Heights Blvd
Gary Ransdell Hall 3042
Bowling Green, KY
Phone: 270-745-4328
Fax: 270-745-6934