CAMS for Difficult Patients
Supplemental Handout: Clinical Tip Summary

Troubleshooting General Assessment Issues

Addressing Patient Concerns about Engaging the Process

- When patients are concerned about discussing suicide, it can be helpful to get a sense of what their fear for doing so is. What is the threat they are expecting? How severe is it? Does their fear reflect a perceived catastrophe (e.g., being hospitalized)? Or perhaps something they worry they can't cope with (e.g., being flooded with emotion)? Answering this question and then normalizing/challenging these fears is a great place to start, even if it means "putting down the form" a bit to do so.
- Honestly and transparently discussing the process of hospitalization and what is *not* severe enough to hospitalize someone can be very useful. In doing so, we also need to relay the fact that, while CAMS explicitly tries to engage people out of the hospital when possible, hospitalization is an option we need to consider when people are in imminent danger. And, not having information about someone's risk level can actually *increase* the likelihood that we'd need to consider that option. For example, if someone notes that she/he has a suicide plan, would we be more or less concerned if they did or didn't reveal it?
- This process often is served by "rolling with resistance" and incorporating broader motivational interviewing (MI_ strategies.

Quickly Discussing Suicide and Maintaining a Suicide-Focus

- Clinicians often ask whether they need to foster a therapeutic relationship with the client before discussing suicide. The answer is definitely no. In fact, the opposite is the case; clients and patients regularly report that their clinicians' willingness to "get in the weeds" and empathize with their suicidal desires facilitates the therapeutic relationship very effectively in in a deep, substantive manner.
- As someone relays painful information, it can be very difficult to ask them to "move on" or engage another topic. However, our goal in completing the Suicide Status Form (SSF) is to get a full picture of this person's risk level so that we can determine whether or not we believe he or she is safe to leave the office. Sacrificing that information in favor of addressing "safer," more superficial topics of conversation can actually leave patients and clinicians at risk.
- It's very possible that topics people would want to prioritize from session one will arise again in later SSF questions. Passing now doesn't mean you lose the opportunity to discuss this topic; you may be able to do so later in this session. If not, you will have many opportunities to do so if the person is alive for your subsequent sessions!

Troubleshooting Common Safety Planning/Treatment Planning Issues

Limited/Counterproductive Internal Coping

- Counterproductive coping strategies, like using substances, binge eating, and cutting, are all functional. It can be very important to label them as such and normalize their development (e.g., "It make sense you'd do this; it's worked for a long time!"). It can also be helpful to explicitly state up front that we don't expect newer coping strategies to feel as effective right away. Such proactive discussions could help lessen the possibility that patients later feel they are "failing" or "doing things wrong."
- Listing strategies at random won't be as effective as listing ones that tap this person's values/reasons for living. You may even find it helpful to refer back to that section of the SSF when identifying coping options.

- Clinicians often feel pressure to have a "perfect" safety plan at a first contact; they want to ensure that their patients are safe and that they're protected from malpractice. But, along with other suicide-focused approaches, CAMS considers this a "living document" that can (and should) be updated as additional information and strategies are uncovered.

Limited Social Support

- If clients have difficulty listing personal options for social support, it can be helpful to explicitly suggest yourself/your agency, general community resources, online support options, and crisis hotlines/ERs. Collaboratively vet these options together, and explicitly identify and challenge barriers to access as necessary.
- Additional helpful options to consider include public places where someone can be less isolated even if not speaking with someone (e.g., parks, department stores, Starbucks). Changing the environmental context such that this person is simply *around* other people (and thus not isolated, alone) can be life-saving.

Access to Lethal Means

- The CAMS framework holds that it's ideal to completely remove access to identified and intended lethal means. But, that's not always possible given logistics or patient willingness. In cases like that, it can be helpful to identify, normalize, and challenge fears they have about doing so.
- If patients are not willing to completely get rid of lethal means, they may be willing to collaborate with you around options for delaying/distracting access, redirecting themselves in crisis, or making their environment safer. For example, consider someone who fantasizes about overdosing by pills but who needs his medication for psychiatric stabilization. If he were to put a picture of his daughter on his medicine cabinet or in his pill bottle to remind himself of his reasons for living, he has taken concrete, positive steps towards making his environment safer.
- Consider involving supportive others in this conversation whenever possible, and ensure they have their own "crisis support plan" if necessary.

Treatment Planning

- Clinicians often feel an unfair pressure to perfectly understand this person's drivers at the end of the initial assessment. Patients often voice drivers that are "indirect" (e.g., "I'm suicidal because I'm depressed"), and we can sharpen and understand their pain further over the course of treatment. You may be able to drive down further in this session, but you may not for a variety of reasons.
- If you find you can't "dig deeper" right now that's okay! In fact, accepting what someone is contributing as their understanding without prolonged challenging reinforces CAMS' collaborative focus.
- Similarly, clinicians often feel pressure to have the entire course of treatment planned or to perfectly select interventions at the end of the first session. We don't put that pressure on ourselves with any other clinical presentation; we allow "room for breathe" and further assessment. In the absence of imminent risk concerns (which you're assessing with the SSF), you similarly have time to assess and refine your conceptualization.

Troubleshooting Issues in Ongoing Sessions

What if patients come in and say they're fine or they don't want to discuss suicide?

- Sometimes, patients are concerned that CAMS' suicide-focused approach means that we're going to *exclusively* focus on re-hashing suicide attempts or discussing ways to apply distress tolerance skills. But that's not necessarily the case; maintaining suicide-focus simply means that we'll continue to prioritize the pain putting their life on the line.
- If clients are unwilling to discuss suicide or say they don't need to, it's helpful to start by curiously assessing why they feel this way. Are there changes that would justify this different perspective? If not, does this unwillingness reflect avoidance of a feared outcome that we can de-catastrophize?

- Another option when clients deny concerns about suicidality is to "flip the script" and discuss resilience. What do they make of the fact that they experienced X stress *without* becoming suicidal? What skills/strengths are they tapping that they might want to call on in the future? In this way, we're maintaining a suicide focus without "being so down."

What if someone does not use/attempt a stabilization plan or complete an assignment?

- Marsha Linehan once noted that the "patient does not fail the treatment, the treatment fails the patient." If we can adopt this perspective when approaching potential setbacks like this, it can allow us move forward in a way that gauges new data while potentially facilitating a corrective experience. Why does it make sense this was harder than expected? What does this tell us about the plan and your relationship to it? What got in the way of your homework/action plan? What can we learn about how to improve the process for you?
- This conversation can be powerfully aided by MI/ rolling with resistance.
- If barriers include practical logistics, problem-solving strategies could be considered. For example, if someone struggles to locate her/his safety plan, it might be helpful to suggest taking a screenshot and keeping it as a phone background.

What if someone is still thinking about suicide after 12 sessions?

- That's not a problem! CAMS is *not* intended to make suicidal thoughts go away; it is intended to help someone change their relationship with suicide such that it no longer feels like the *only* option for addressing pain. If someone has suicidal thoughts but chooses other options for managing pain, that's an unqualified treatment success! It's equivalent to a patient with OCD having an intrusive thought and trusting their ability to manage distress without engaging in compulsions.

What if people can't do a full 12 sessions because of logistical or financial constraints?

- You can definitely do successful CAMS care in less than 12 sessions. Many clinicians will pace differently if clinically appropriate (e.g., meeting other week) or consider brief, unbilled phone check ins (5 minutes) outside of session. Or, you can revise goals accordingly; perhaps we may not be able to fully alleviate drivers, but we can offer a new conceptualization of your distress that you can immediately apply and use with your next provider.

What do you do if patients "no show"?

- It is helpful to be aware of your organizational policy around follow-ups and to convey it to people ahead of time as part of the informed consent process. Then, you can move forward with your organization's follow-up policy as noted.
- If someone fully disengages from care and you have a working address/phone number, consider following up with non-demand caring contact via mail or text.

Considerations with Common, Difficult Presentations

Applying CAMS in the context of Borderline Personality Disorder

- The label of "borderline personality disorder" (BPD) encompasses a range of presentations, and emerging research suggests that the CAMS as a therapeutic approach may not be appropriate for all of them. For example, results from one of our studies suggests that patients who have been diagnosed with BPD and who have made four or more suicide attempts may be better served by a DBT referral than engaging multiple CAMS sessions. We do know that there are several BPD presentations that can be successfully treated using the CAMS framework, and more research is forthcoming that can help us better inform when/how to choose interventions with this population.
- However, in all cases, the SSF remains an effective first line assessment for gathering data and approaching risk determination.

- In cases where CAMS is appropriate, the philosophical CAMS approach matches nicely with BPD's biopsychosocial model. Both emphasize the reality that suicide is functional and logical in the context of an individuals' experience but that there may be more effective coping options available.
- Approaching these initial conversations and subsequent sessions in a way that emphasizes radical genuineness/empathy, transparency around goal setting, collaboration, and the usefulness of corrective experiences can be life-altering.

Approaching CAMS in the Context of Substance Abuse

- As with many psychosocial approaches, CAMS sessions should not be conducted when someone is *acutely* intoxicated. But, a substance use disorder is not a rule out for CAMS. CAMS can be conducted quite effectively with comorbid suicide and substance use concerns, particularly when addressed in the context of a multidisciplinary team.
- An important question when addressing substance abuse involves seeing the function this behavior is serving and how it does or does not relate to suicide for *this person*. For some patients, suicide may be a driver; they may be suicidal because they are hopeless about their ability to maintain sobriety. For others, it may function as their primary emotion regulation strategy. For still others, it may be a "bridge" to increased risk; they may be most at risk when drinking too much.
- Depending on the function(s) substance abuse is serving for this person, we may want to target it in the context of suicide-focused care. If it's not directly related to suicide, though, we might suggest holding off on addressing it until the relationship with suicidality has been changed.

Approaching CAMS in the Context of "Unchangeable" Drivers

- Clinicians often see ways that the CAMS approach can be helpful in the context of "changeable" drivers. For example, if someone says that she is suicidal because she is hopeless about her ability manage her panic attacks, we know there are effective medical and psychosocial approaches she may benefit from. However, it can be much harder to proceed when people voice "unchangeable" drivers, saying, for example, that they are suicidal because they will be incarcerated following a trial, or they lost their jobs, or because they are now paralyzed. CAMS is effective, but it can't make people walk again!
- In cases like this, it's helpful to "sharpen" drivers further. All of these examples are stressful and life altering. But, not everyone who would "check" these boxes is suicidal. So, can we work with this person to understand what it is about these things that suicide is intended to solve? Are they interpreting these stressors catastrophically and/or in a way that drives hopelessness and helplessness? If so, we might be able to intervene on that level.
- For example, if someone who was recently paralyzed is feeling suicidal because of the extent to which he feels hopeless and like a burden on his family, CAMS sessions could potentially alleviate his distress by challenging these assumptions and helping him identify other ways he can meaningful contribute for them and others.

Approaching CAMS in the Context of Psychosis

- As with many psychosocial approaches, CAMS sessions should not be conducted when someone is *acutely* psychotic. But, like previously mentioned for substance use disorders, psychotic spectrum disorders are not a rule out for CAMS. CAMS can be conducted quite effectively with comorbid suicide and psychotic spectrum concerns, particularly when addressed in the context of a multidisciplinary team.
- When patients link their suicidality and psychotic experiences, it can be helpful to discuss them in a similar manner to what we do with other "unchangeable drivers." Many people experience psychotic symptoms and are *not* suicidal. What is it about these symptoms that the person feels they need suicide to manage? Or, why are they "buying into" sensations, like auditory hallucinations saying "kill yourself"?

For more information about the CAMS framework or additional training opportunities in it, please contact Kevin Crowley at camscare.crowley@gmail.com.

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