CAMS-care Framework: CAMS-4Teens Video Training Course
Supplemental Handout 1: General Clinical Strategies

Introduction/Statistics

It is unfortunately common for young people ages 10-24 to struggle with suicidal ideation and behaviors. The Center for Disease Control and Prevention (CDC) and other national surveys have found that:

- **Suicide is the second leading cause of death among teens and young adults** between the ages of 12 and 24.
- Rates of suicide among young people jumped 56% between 2007 and 2016, after declining between 1999 and 2007.
- Suicide rates among 15- to 19-year-old girls doubled between 2007 and 2015, reaching a 40-year high
- Suicide rates among 15-to-19-year-old boys, whose suicide rates have always been troubling, climbed by more than 30 percent between 2007 and 2015.
- 17.7% of high school students admit to thinking about suicide, and almost 9% acknowledge actually making an attempt.

Effectively preventing suicide necessitates awareness of strategies for initiating suicide-focused assessment, knowledge of risk factors and warning signs common to this population, and evidence-based options for intervention. Clinical strategies relevant for each will be provided below.

General Assessment Considerations and Recommendations

One of the questions we most commonly get at our trainings is from clinicians who wonder whether **asking about suicide could be "harmful" or "put ideas" in our clients' heads**. Several studies examining this concern have demonstrated that asking people about suicidal thoughts and behavior does **not** induce or increase such thoughts and experiences. In fact, according to the *American Academy of Child and Adolescent Psychiatry,* asking a child or teen about suicidal thoughts can actually **decrease** some of the anxiety experienced by suicidal youth and convey that someone cares about them and wants to help.

Listen intently and without judgment, and **validate your clients' individual experiences**. Reassure them there are no taboo thoughts and be sensitive to feelings of possible shame. *"Given all you are dealing with right now and given what is happening at school, I would not be surprised if you have thoughts of dying, hurting yourself or suicide. Many people do, and not because they necessarily want to be dead or they "can't deal"; they just cannot figure out how to keep living with the pain they're feeling."*

Never promise perfect/total confidentiality. Though an adolescent may ask you to guarantee confidentiality, healthcare providers are mandated reporters. It is helpful to understand and explicitly convey limits of confidentiality to your clients and her/his caregivers as quickly as possible as you begin a therapeutic relationship (ideally during the informed consent process).

Asking open-ended questions, those that cannot be answered with a simple yes or no, in a way that shows you want to

understand things **from their perspective** Follow their cues: *"Tell me more about that. I'd love to understand more about what that's like for you."*

Don't try to fix it. Be careful not to fall into the trap of jumping in with a solution or by saying, "You should…" or "Why didn't you…" Instead, listen and be supportive. Resist the urge to offer quick fixes or solutions to their challenges, which tends to shut down further dialog. Remember that teens may be hesitant to take advice from an adult. Validate and support their feelings.

Similarly, do not try to argue someone "out of suicide." To the suicidal person, the idea of death can feel like a logical way to solve their problems. And, it's very difficult to help someone who is being irrational understand the flaws in their logic and trying to do so can be invalidating to the person who struggles. Approaching the conversation instead from a "functional" perspective and trying to understand how it "makes sense" given her/his can facilitate a deeper therapeutic relationship. For therapists and clients who are religious, be aware that particular harm can be done by arguing that the youth will go to hell if they kill themselves. This may be viewed as very shaming and does not feel supportive.

Address unsafe behavior of peers: Research suggests that exposure to a peer's suicide can, in fact, have a "modeling effect." *"I've heard that sometimes being around peers making suicide attempts can make other kids think about suicide themselves. Have you had any thoughts about suicide?"*

Trust your judgment. If a young person denies that he or she is having suicidal thoughts, but you doubt their truthfulness, trust your intuition. Take further steps to ensure his or her safety.

Friends don't let friends keep secrets about suicide: Reinforce and praise your client if she/he relays concerns about a friend. Emphasize that no child should ever feel responsible for the safety and well-being of another child, student or friend, and encourage them to share this information with a trusted adult. If a parent/guardian has accompanied her/him to this session, you could guide your client to share this in the room before leaving.

Phase out the phrase "committed suicide." Your words matter, especially when it comes to mental health. The term "committed" is associated with "crimes" and "sins." The better phrases to use are 'thinking about suicide" or "died by suicide."

Using "Risk Factors," "Protective Factors," and "Warning Signs" in Assessment

Risk Factors/Protective Factors

Perhaps unsurprisingly, clinical suiciologists have struggled to identify a series of factors that could help *predict* a future suicide attempt or death. The most consistent attempt to do so has involved studying "risk factors," or variables that *may* increase the likelihood that a person could engage in suicidal behaviors *at some point* in their lives. When risk factors are present, young people may have trouble coping with the stress of being a teen, such as dealing with rejection, failure, breakups, and family turmoil. However, the presence of risk factors **does not necessarily mean** that **a young person** is at increased risk of engaging in suicidal behaviors when she or he leaves the office. It is important to assess these variables collaboratively with the youth and understand these risk factors as they can be important to treatment. .

For many years the field of suicide prevention has proposed—and studied—the notion of "protective factors" that may counteract suicide risk factors. While some of the research is mixed on the matter, there are well-researched "reasons for living" that do seem to make a potential difference to the calculus of the suicidal mind. The following is a table of various risk and protective factors worthy of consideration for teens:

RISK FACTORS	PROTECTIVE FACTORS
A psychiatric disorder, particularly a mood disorder like depression, anxiety and impulse control disorders; these may also include undiagnosed and untreated mental health conditions. Depression and suicide may coincide. Yet not everyone who is depressed attempts suicide — and not everyone who attempts suicide is depressed.	**Support** the young person through ongoing medical and mental health care relationships. **Understand** that treating mental disorders (e.g., clinical depression) has little to no impact on suicide ideation or behaviors. Suicide-focused interventions and clinical treatments that specifically target and treat suicidal ideation and behaviors can be highly effective in decreasing suicide attempts and ideation, independent of psychiatric diagnosis. **Encourage** physical activity ("behavioral activation") as simple as walking or as vigorous as pumping iron can put the brakes on mild to moderate depression by impacted brain physiology and enhancing mood. **Know** the major symptoms of depression: feelings of sadness, hopelessness, or loneliness; declining school performance; loss of interest in social and sports activities; sleeping too little or too much; changes in weight or appetite; nervousness, agitation, or irritability.
Alcohol and substance abuse	**Provide** effective care for substance use disorders. **Ask about** all medications in your client's home, and enlist help from adults in the client's family system when possible to do so. Overdosing using over-the-counter, prescription, and non-prescription medicine is a very common method for both attempting and dying by suicide. The most commonly abused prescription drugs include Vicodin and Xanax. It's also important to be aware that teens may "trade" different prescription medications at school and carry them (or store them) in their locker or backpack.

RISK FACTORS	PROTECTIVE FACTORS
Prior suicide attempts Particularly two or more potentially lethal attempts.	**Learn** the warning signs and risk factors for youth suicide. **Know** the language that youth are using. "KMS," for example, could mean "kill myself."
A recent or serious loss. This might include the death of a family member, a friend or a pet. The separation or divorce of parents, or a breakup with a boyfriend or a girlfriend, can also be felt as a profound loss, along with a parent losing a job, or the family losing their home.	**Facilitate** family support and cohesion, including good communication.
Access to lethal methods - Firearms, pills, knives or illegal drugs.	**Work with the child's family to remove or reduce access to lethal items** from the home, especially firearms, drugs, or sharp objects that could be used for suicide. Lock up pills and alcohol, and be aware of the location of kitchen utensils, as well as ropes, cords, or cleaning products, which can also be used for suicide.
Impulsive or aggressive tendencies	**Help** the teen or child learn skills in problem solving, conflict resolution, and handling problems in a nonviolent way.
Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma)	**Encourage** cultural and religious beliefs that support self-preservation.
Isolation: a feeling of being cut off from other people - lack of a support network, poor relationships with parents or peers, and feelings of social isolation.	**Maintain/promote connections:** Help a struggling child or teen foster, maintain, and deepen connections with friends and loved ones. **Encourage** his/her involvement in positive activities, like clubs, sports, and volunteer work.
Poor coping skills	**Support** adaptive and existing coping and problem-solving skills, including conflict-resolution. **Develop** new coping strategies as appropriate. **Help** your client remain engaged in (or renew engagement in) their usual coping activities, life family activities and sports, by challenging barriers for doing so.

RISK FACTORS	PROTECTIVE FACTORS
Exposure to the suicidal behavior of others, such as from family or peers, in the news, or in fiction stories	**Talk** to the child or teen directly about suicide.
No positive role model in one's life	**Seek out** programs and resources to provide access for the young person to positive role models.
Physical or medical issues, for example, severe chronic pain, chronic medical condition, becoming pregnant or having a sexually transmitted infection.	**Express empathy for her/his suicidal ideation.** **Encourage** a healthy lifestyle**,** and problem solve around barriers for doing so.
Struggling with sexual orientation or gender identity in an environment that is not respectful or accepting of that orientation/identity. The issue is not whether a child is gay or lesbian or transgender, but whether he or she is struggling to come out in an unsupportive environment.	**Express empathy for her/his suicidal ideation, and repeatedly covey nonjudgment and acceptance in the context of your clinical work.** **Connect** LGBTQ youth with supportive resources such as local support groups or the Trevor project website and textline.
High risk behaviors (drinking and driving, poor decision-making).	**Pay attention.** Listen what your client is saying and watch how he or she is acting. Never shrug off threats of suicide as melodrama.
Bullying. Being a victim of bullying is a risk factor, but there's also some evidence that kids who are bullies may be at increased risk for suicidal behavior.	**Appropriately discuss** your client's whereabouts and communications (texting, Facebook, Twitter) with the goal of promoting safety, and encourage adults in the family system to do the same. **Encourage adults in the family system to be aware** of their young person's social environment (friends, teammates, coaches) and communicate regularly with other parents and teachers in the community.
Public humiliation	**Be sensitive to youth who may be embarrassed-** always take their concerns about embarrassment or shame in relation to peers seriously.

It is important to understand that there are no magic numbers in suicide prevention. Ten risk factors and one protective factor does not equal a suicide attempt. One risk factor and ten protective factors does not guarantee a young person won't kill themselves. These factors help you and the young person understand why suicide may be possible, why it seems to be an option for the young person, and potential things that you can target in your therapy.

Most people who attempt suicide both want to die and want to live; they have risk factors and protective factors. Thus, a simple calculation of these is not going to give you the "right answer" but assessing them can help you understand the young person and their risk better.

Warning Signs

Because risk factors don't seem to predict who will kill themselves in the coming hours or days, the American Association of Suicidology convened a panel of experts to try to develop a model of understanding near-term suicide risk that could be more accurate. This panel suggested the concept of "warning signs," and they based this idea off of constructs that are commonly used in cardiology to understand the risk of heart disease. In this metaphor, many people live long lives with various risk factors for heart disease (e.g., high cholesterol, smoking, hypertension, etc.), and merely having these risk variables does not mean a heart attack is at hand. However, warning signs such as acute chest pains, shortness of breath, and pain in the arm may be indicators of an imminent heart attack.

The team of suicidologists thus attempted to make a short list of suicide warning signs to complement or help us further understand near term risk of possible suicidal behaviors vs. more general or long-term risk associated with suicide. The list of warning signs created by this panel includes **recent changes** for your client compared to her/his average in areas like:

- Suicidal Ideation, threatening to hurt or kill self, actively looking for ways to die
- Increased or excessive substance use (alcohol or drugs)
- Having no sense of purpose, no reason for living
- Extreme anxiety, agitation, and unable to sleep (insomnia)
- Feeling trapped, like there's no way out, and resistant to help
- Hopelessness about the future
- Withdrawing from friends, family and society, isolating
- Anger and rage, seeking revenge
- Acting recklessly or engaging in risky activities, seemingly without thinking
- Significant mood changes

Changes in the following may be especially important to track when working with teenagers and young adults:

1. **Suicide Ideation**: talking about suicide or preoccupation with death; for example, recurring themes of death or self-destruction in artwork or written assignments, writing songs, poems, or letters about death, separation, and loss; making suicidal threats, even jokingly, in the form of direct ("I am going to kill myself") and indirect ("I wish I could fall asleep and never wake up again"); verbal hints, such as:
    - *"I won't be a problem much longer,"*
    - *"If anything happens to me, I want you to know ...."*
    - *"No one will miss me" ,*
    - *"Nothing matters."*
    - *"I wonder how many people would come to my funeral?"*
    - *"Everyone would be better off without me."*
    - *"You won't have to worry about me much longer"*

2. **Suicide behaviors:** making final arrangements (e.g., making funeral arrangements, writing a will, giving away (or throwing away) favorite possessions); researching suicide methods; seeking access to firearms, available pills, or other lethal means (the most frequent methods used by teenagers are hanging, jumping from high places, and overdosing on pills or other poisons); writing suicide notes and plans, these notes may be in the form of letters, emails, social media posts or text messages.

Threats of suicide and other suicide-related communication can be a potential cry for help. Always take such statements, thoughts, behaviors, or plans seriously. Make safety and stability a top priority by removing all dangerous implements or substances from the immediate physical environment, make sure the young person is not left alone during the crisis and find a mental health provider who has experience with youth suicide trained in CAMS or similar evidence-based suicide-focused treatment.

3. **Feeling hopeless:** feeling trapped - like there's no way out, seeing no reason for living or having no sense of purpose in life.

4. **Sleep Disturbance**: insomnia, nightmares, excessive sleeping, - beyond usual teenage fatigue (which could indicate depression or substance abuse);

5. **Loss of interest in usual activities** - losing interest in hobbies or events; loss of interest in school or schoolwork; not caring about activities that used to matter.

6. **Withdrawal from people or activities**: withdrawal from friends and family members; withdrawal from people or activities they typically take pleasure in and enjoy; deterioration in social relationships and school and/or work performance, reduced involvement in positive activities.

7. **Risky, reckless or self-destructive behaviors:** harmful behaviors such as cutting, sexual promiscuity, reckless driving, truancy, and vandalism; running away; unexplained or unusually severe, violent, or rebellious behavior.

8. **Mood swings** – changes in mood and personality can be normal for teens, but they don't generally last for more than a few days. These rapid changes in mood can include seeming down or sad as well as angry, overly irritated, or generally lashing out.

   If your teenage or child client's sleep, energy, appetite, motivation, substance use, and frustration aren't bouncing back to normal after a few days, encourage them see their pediatrician or a mental health practitioner. It can often be helpful as part of your differential diagnostic process to "rule out" comorbid medical concerns.

When considering these warning signs, like risk and protective factors, it is again important to understand that there are no guarantees about youth suicide. Research shows that most youth will demonstrate one or more warning signs before a suicide attempt, but the **vast** majority of youth with one or more warning signs **do not** kill themselves.

One or more warning signs does not necessarily mean that suicide is coming tomorrow or the next day or that a youth needs to be so closely guarded that they cannot live their lives. It means that suicide is simply more likely. In some cases, it may mean parents need to be informed about this risk. Warning signs absolutely mean that treatment is needed and some sort of safety or coping plan for the youth should be made.

Sources of the information included in this documentation include:

Dr. David Jobes
Dr. Amy Brausch
Dr. Raymond Tucker
Ms. Colleen Kelly
Dr. Kevin Crowley
Centers for Disease Control and Prevention
Suicide Prevention Resource Center
American Foundation for Suicide Prevention
American Association of Suicidology
The Mayo Clinic
The American Academy of Pediatrics
National Institutes of Mental Health
American Psychological Association
National Suicide Prevention Lifeline
Dr. Anthony, Children's Hospital Colorado
Healthchildren.org
Children's Hospital of Orange County
Society for the Prevention of Teen Suicide
Suicide Awareness Voices of Education
Stanford Children's Heath
University of Rochester Medical Center
Boston Children's Hospital

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

CAMS-care, LLC
5712 Kingswood Road
Bethesda, MD 20814
www.cams-care.com