Understanding and Treating Suicidal Risk in Young Children

Abby Ridge Anderson
The Catholic University of America

Grace M. Keyes
Hearts of Hope, Elk City, Oklahoma

David A. Jobes
The Catholic University of America

This article reviews the existing literature on prevalence rates and risk factors for suicidal thoughts and behaviors in children under the age of 12. This review is followed by a discussion of important considerations for assessment and treatment and an overview of 1 potential treatment option (the Collaborative Assessment and Management of Suicidality) and its use in 3 case study examples. Although completed suicides are rare in this population, they do occur. Furthermore, a significant number of children in both clinical and community samples experience suicidal ideation and verbalize thoughts of suicide and death. Risk factors include symptoms of psychopathology (e.g., depression, ADHD, aggression), feelings of worthlessness, parental psychopathology, family conflict, and a history of abuse. There are no evidence-based treatments for suicidality in children under 12; however, there are guidelines for developmentally appropriate assessment. Researchers and clinicians are encouraged to turn their attention and efforts to developing evidence-based treatments for suicidal children.

Keywords: CAMS, children, risk assessment, suicide, treatment

Even though suicide is a leading cause of death in the United States, clinicians in general mental health practice know remarkably little about how to effectively assess and treat suicidal risk (Jobes, Rudd, Overholser, & Joiner, 2008). This is true in general for adults and teenagers, but is remarkably true when we consider general practice knowledge related to clinical work with suicidal young children (under the age of 12). In 1986, Dr. Cynthia Pfeffer published a groundbreaking book, *The Suicidal Child*, blazing an early trail in this area. Since this landmark text, epidemiologists and suicidologists have made efforts to better understand the incidence and nature of suicidal risk among young children. But when we reflect on the larger field of suicidology, it would almost seem that the serious study of suicide and clinical assessment and treatment begins at ages 12 to 14, with an extensive literature on teenage and adult "clinical suicidology" that dwarfs the extant literature on clinical care for suicidal children. Although there have been efforts to amend Pfeffer's approach (e.g., Larzelere, Andersen, Ringle, & Jorgensen, 2004) or develop alternative models (e.g., Orbach, 1988), to date there are virtually no evidence-based treatments for childhood suicidal risk. Indeed, in our extensive review of the literature, we could find only *one* published study describing a treatment targeting suicidal children under age 12 (Perepletchikova et al., 2011). To this end, we will endeavor to describe what is known about suicidal behaviors and suicidal ideation in children younger than age 12, including treatment-related considerations, before describing one potentially promising approach to clinical work with a suicidal child. We close with an exhortation to the field, echoing Westefeld et al. (2010), to move toward the development of effective, developmentally targeted, suicide-specific treatments for children.

Abby Ridge Anderson, Department of Psychology, The Catholic University of America; Grace M. Keyes, Hearts of Hope, Elk City, Oklahoma; David A. Jobes, Department of Psychology, The Catholic University of America.

David A. Jobes is a Chief Executive Officer and Co-owner of CAMs-care, LLC, which is a training and consultation company for the intervention described in this article.

Correspondence concerning this article should be addressed to David A. Jobes, Department of Psychology, The Catholic University of America, Washington, DC 20064. E-mail: jobes@cua.edu

Scope of the Problem

It is possible that the delay in fully addressing the problem of childhood suicidality[1] has been attributable to misconceptions and myths about suicide in preadolescent children. For example, there is a myth that children cannot or will not complete suicide because they do not understand the concept of death (Wise & Spengler, 1997). Nevertheless, young children do in fact take their own lives (Wise & Spengler, 1997). Bridge et al. (2015) conducted an epidemiological study in the United States to investigate the suicide rate in children ages 5 to 11, and found that in a 20-year period, 657 children took their own lives—an average of almost 33 children per year. Nearly 80% of these children died by hanging or suffocation; another 17.7% died by firearms. Rates of suicidal ideation in childhood vary depending on the population studied, ranging from 6% to 14.9% in community samples (Giannetta et al., 2012; Lin, Lin, Hsieh, & Chang, 2014; Mishara, 1999; Viñas, Canals, Gras, Ros, & Domènech-Llaberia, 2002). Importantly, most children who think about suicide do not later attempt or die by suicide. This point does not trivialize the concern of parents, teachers, clinicians, and others who work with distressed children. Suicidal thoughts among kids are a notable marker of intolerable pain and emotional distress (Pfeffer, 1987; Wagner, 2009; Whalen, Dixon-Gordon, Belden, Barch, & Luby, 2015).

Understanding Suicidal Risk in the Context of Child Development

Pertaining to the role of development, Mishara (1999) found, in his sample of 65 school-age children (aged 6–12), that 71% understood that death is final. Although the word 'suicide' was not familiar to most of the children in grades 1 and 2, the idea of 'killing oneself' was found to be understood by 95% of the sample. This study highlighted the difficulties that clinicians may face due to pervasive misconceptions about suicide risk in young children. Interestingly in the Mishara study, age did appear to influence conceptions of death, with 2/3 of 1st graders expressing the belief that dead people can still have experiences (e.g., seeing and hearing). Wagner (2009) pointed out that this phenomenon can be seen even into adolescence, noting that children's abstract cognitive abilities may regress in the face of emotional crises.

Orbach (1988) proposed a four-dimensional model of attitudes toward death that reflects childhood ambivalence about the topic. According to this model, children vary in terms of their attraction to and repulsion by life, as well as their attraction to and repulsion by death. Orbach suggested that how these attitudes are balanced in a given child will determine whether the child is likely to become suicidal. Importantly for clinicians and parents, he noted that children are prone to have a strong attraction to life. So, although they may also have a strong attraction to death (e.g., to escape pain), their attraction to life could mask this aspect of their experience.

Additional developmental considerations include a child's past experience as well as their cognitive ability. The younger a child is the less well developed his or her problem-solving abilities are; this may confer a developmental vulnerability (Weller, Young, Rohrbaugh, & Weller, 2001). Moreover, children's past exposure to death, including loss of family members and pets, has an impact on their understanding of death, and what death means to them (Pfeffer, 1986). The Mishara (1999) study showed that children ages 6 to 12 have typically already had 4 to 5 death-related experiences. Children are also exposed to media representations that can affect their understanding of death; 100% of 3rd grade children may have seen reference to suicide on TV (Mishara, 1999). Regardless of the child's understanding of the finality of death, or of his/her ultimate intent in disclosing suicidal ideation, the fact that suicide has become a part of that child's thought processes is a sign that s/he is in severe distress (Whalen et al., 2015). Talking about suicide with the child demonstrates that the clinician is taking the issue seriously (Pfeffer, 1986). In recognizing the child's pain, the clinician can greatly enhance the therapeutic alliance, which can be a key factor in the child being able to disclose and

---

[1] Throughout this paper, *suicidality* will be used to refer broadly to the full spectrum of suicidal thoughts, feelings, and behaviors, from passive ideation through suicide attempt behavior. Unless otherwise noted, the risk factors described in the following sections refer to suicide ideation, rather than to suicidal behaviors.

discuss his/her suicidal ideation (Pfeffer, 1986). The developmental psychopathology tenets of multifinality and equifinality provide a helpful foundation from which to most accurately conceptualize the many factors that may contribute to childhood suicidality (Wagner, 2009). Multifinality refers to the principle that common experiences can give rise to several different trajectories; equifinality holds that there are many pathways to any given outcome (Cicchetti & Rogosch, 1996). These principles may help to explain the varying and sometimes contradictory child, family, and environmental risk factors that are described in the following sections. Readers familiar with the literature on adolescent suicidality will note that children and adolescents share many of the same risk factors. This review serves to highlight the need to be attuned to these risk factors when working with children of all ages.

Risk Factors

Child Variables

Many studies have found that depressive symptoms are associated with suicidality, both in clinical and community samples (Giannetta et al., 2012; Greening et al., 2008; Liu et al., 2006; Mayes, Calhoun, Baweja, Feldman, et al., 2015; Viñas et al., 2002; Whalen et al., 2015; Wyman et al., 2009). However, being on alert for suicidality only with depressed children would be a mistake. In a study of Spanish schoolchildren, Viñas et al. (2002) found that one third of the suicidal children in their sample did not exhibit significant symptoms of depression. A surprising number of studies have found significant associations between suicidal ideation and ADHD or other disruptive disorders (Balazs, Miklósi, Keresztény, Dallos, & Gádoros, 2014; Fite, Stoppelbein, Greening, & Preddy, 2011; Giannetta et al., 2012; Gould et al., 1998; Greening et al., 2008; Greening, Stoppelbein, Luebbe, & Fite, 2010; Jackson & Nuttall, 2001; Mayes, Calhoun, Baweja, Feldman, et al., 2015; Mayes, Calhoun, Baweja, & Mahr, 2015; Whalen et al., 2015; Wyman et al., 2009). These patterns of results further reinforce the point that suicidality can arise through many different avenues, and that suicide screening decisions that are driven by diagnoses may not sufficiently capture all at-risk children.

Worthlessness and negative automatic thought processes are strongly related to childhood suicidality (Jackson & Nuttall, 2001; Liu et al., 2006; Nock & Kazdin, 2002). In fact, Liu et al. (2006) found that of all of the specific mood and behavioral features they measured in a study of depressed suicidal children, the only symptom that independently predicted suicidal ideation, suicide planning, and suicide attempts was a feeling of worthlessness. However, the research regarding the role of self-esteem has revealed mixed results, with some studies finding it to be a significant predictor (e.g., Weinstein, Van Meter, Katz, Peters, & West, 2015), and others finding self-esteem to be related to suicidality only in the context of high depressive symptomology (e.g., Viñas et al., 2002).

Hopelessness is significantly correlated with childhood suicidal risk within some clinical samples (Viñas et al., 2002; Weinstein et al., 2015). However, hopelessness may be specific to suicidal ideation, rather than actual suicidal behaviors (Nock & Kazdin, 2002), and it has not proven to be the strongest correlate of suicidal risk (Jackson & Nuttall, 2001). Although gender differences account for some of the equivocal findings regarding the role of hopelessness in adolescent suicidality (Wagner, 2009), gender is unlikely to account for the mixed results on hopelessness in younger children, given that gender differences in suicidal ideation do not appear to emerge until children are 11 to 12 years old (Nock & Kazdin, 2002; Liu et al., 2006). In addition to more pervasive feelings of hopelessness or worthlessness, strong emotional states can also be significant triggers for children to move into a suicidal crisis, including intense feelings of anger or sadness, as well as expectations of an upcoming loss or abandonment (Wyman et al., 2009).

Several studies have found that aggressive behavior may be an important suicide risk factor (Giannetta et al., 2012; Jackson & Nuttall, 2001; Mayes, Calhoun, Baweja, & Mahr, 2015); as with many risk factors, this is not a universal finding (e.g., Crocker & Hakim-Larson, 1997). Researchers have found that the link between aggression and suicidality may be both mediated and moderated by depression (Fite et al., 2011; Greening et al., 2010). Aggression may also mediate the relationship between impulsivity and suicide risk in children (Greening et al., 2008). Pfeffer (1986) sug-

gested that there may be two distinct subtypes of suicidality in young children. Some children who develop suicidal ideation are characterized by the expected depressive symptomology, including strong feelings of hopelessness. Others are more likely to exhibit aggressive behaviors, in the absence of depression. These subtypes may explain why some studies have not found behavioral difficulties to be associated with childhood suicidality (e.g., Crocker & Hakim-Larson, 1997). Viñas et al.'s (2002) sample appears to support these subtypes, with a third of the suicidal children reporting minimal depressive symptoms, as well as average levels of self-esteem, and a supportive family environment. These constellations of features may provide a helpful heuristic to clinicians during intake appointments. Children exhibiting aggressive or disruptive behaviors should be routinely assessed for suicidal ideation, despite a lack of depressive symptoms or expressed hopelessness (Whalen et al., 2015).

Irritability can be a symptom of depression in young children (American Psychiatric Association, 2013); however, it could also be a precursor or correlate of aggressiveness. It is therefore a potentially useful marker of both of the subgroups described above, and has been found to be correlated with suicidal ideation (Jackson & Nuttall, 2001; Liu et al., 2006). Sleep disturbance, bed-wetting, impulsivity, and sensation-seeking may also be signs of child suicide risk (Giannetta et al., 2012; Jackson & Nuttall, 2001; Mayes, Calhoun, Baweja, & Mahr, 2015). Finally, children with frequent somatic complaints should also be assessed for suicide risk (Giannetta et al., 2012).

The variables reviewed here are not necessarily indicative of suicide risk; indeed, this broad range of risk factors can apply to a multitude of clinical presentations and general childhood distress. However, in all but two of the studies referenced here (Fite et al., 2011; Greening et al., 2008), children who reported suicidal ideation or attempts were significantly more likely to display these characteristics or behaviors than comparison groups of nonsuicidal children, even among clinical samples (e.g., Liu et al., 2006).

Family Variables

Wagner, Silverman, and Martin (2003) reviewed a wide range of variables related to family influences on child and adolescent suicidality, and concluded that family cohesion, parent–child relationships, child abuse, and parent psychopathology may each play an important role in understanding the context in which a child's suicidality occurs. Much of the research reviewed in that paper focused on adolescent populations; however, evidence from preadolescent samples suggests that many of these variables are equally important in considering suicide risk in younger children. For example, Sarkar et al. (2010) found that 22% of children with suicidal ideation under 12 had experienced conflict at home prior to hospital admission; this was not significantly different from the rates of family conflict in the adolescents in the sample.

As with many risk factors, the influence of family environment can be dependent on child-specific variables. Depressed children appear to be significantly more vulnerable to the impact of family dynamics (Lin et al., 2014; Viñas et al., 2002). Wagner (2009) hypothesized that difficulties in family communication may lead to a child being more likely to use suicidal ideation or self-harm behaviors as a way of communicating difficult emotional experiences, in the context of an environment in which emotional expression is restricted.

Another possible moderator of the relationship between family functioning and suicidal risk among children may be the presence of parental psychopathology. Sarkar et al. (2010) found that a family history of depression was present in 36.8% of children under 12 who had been admitted to an emergency room for suicidal behaviors. In their study of 3- to 7-year-olds at risk for depression, Whalen et al. (2015) found that maternal psychopathology was a significant predictor of suicidal ideation at baseline (when the children were 5 years old, on average), and that it remained a predictor of suicidal ideation at the follow-up assessment (when children were on average 9.5 years old). A depressed or substance abusing parent may not be as emotionally available to his or her child; this would naturally impact the child's perception of family support, as well as the quality of the parent–child relationship (Wagner, 2009).

The correlational evidence on family risk factors suggests that family discord, parent–child conflict, and attachment difficulties are associated with suicidal ideation (Wagner et al.,

2003). Difficult family environments and relationships may be creating conditions in which children are more vulnerable to suicidal ideation, or it may be that other factors leading to a child's suicidality (e.g., irritability, depression, disruptive behaviors, hopelessness, or low self-esteem) are also leading to difficulties in the family system. As Wagner (2009) notes, the principle of multifinality means that such risk factors are linked to a range of outcomes (not just suicide).

External Variables

Studies of adolescent suicide risk have invested considerable focus on understanding the impact of peer relationships (Wagner, 2009). In studies of younger children, most researchers have focused almost exclusively on parent–child relationships and family functioning when examining the links between social support and suicidality. While evidence is limited, it appears that peer relationships are not as salient for younger children. Whereas preadolescents experience similar levels of intimacy in their friendships as do adolescents, the quality of their friendships appears to be less important to their social and emotional functioning (Buhrmester, 1990). Crocker and Hakim-Larson (1997) found that peer relationships did not significantly predict levels of suicidal ideation in their community sample of children in grades 4 to 6. In turn, Sarkar et al. (2010) found that suicidal children under the age of 12 were more likely to have experienced bullying than were the suicidal adolescents in their sample (15.8% vs. 2.7%).

Whereas Whalen et al. (2015) did not find a significant association between negative life events and suicidality, Wyman et al. (2009) found that 37% of suicidal 1st through 3rd graders noted interpersonal conflict as a trigger for their suicidal feelings. Children who have experienced abuse are at particularly high risk for suicidal ideation (Greening et al., 2008; Taussig, Harpin, & Maguire, 2014).

Assessment

In her book *The Suicidal Child*, Pfeffer (1986) provided detailed descriptions of the important domains of assessment for child suicide risk, as well as the first structured assessment instrument, the Child Suicide Potential Scales (CSPS). Pfeffer (1986) argues that all children (regardless of age) should be asked a question related to suicidal thoughts as part of a standard intake interview. If a child says yes, the next step is to explore what this *means* to the child. For some, suicide might mean an escape from pain or feelings of burdening loved ones, or a punishment that they deserve. Recalling developmental issues (e.g., Mishara, 1999; Wise & Spengler, 1997), the clinician should then work to ascertain the child's understanding of and past experiences with death. Pfeffer (1986) points out that assessing parent or caregiver attitudes toward the child's suicidal thoughts is key to understanding family dynamics that may play a central role in the child's distress and potential for safety planning. She notes that the family may be very reluctant to discuss the issue of suicide as parents may feel guilt related to their child's difficulties and may be unwilling to acknowledge their child's self-harm behaviors as having suicidal intent (Pfeffer, 1986). Clinicians should be attuned to and empathic of this reluctance when engaging parents in assessment and safety planning discussions.

Several structured risk assessments have been developed or adapted specifically for use with younger children (see Larzelere et al., 2004, for a review). As important as the structure of an assessment, the manner in which clinicians conduct an assessment contributes significantly to the quality of the information and the potential relationship between clinician and patient in subsequent therapy. Barrio (2007) provided developmentally targeted recommendations for assessing suicidality in children, including practical suggestions to help clinicians conduct thorough assessments in a child-friendly way. Some of these include taking breaks as needed, using a slower pace, providing reassurance to the child about the purpose of the assessment, and regularly checking the child's understanding of what is being discussed. This last point is in line with Pfeffer's (1986) recommendation that clinicians go over each important domain more than once, asking in different ways to be sure that the child understands what is being asked of them. Both Pfeffer (1986) and Barrio (2007) provide helpful language and ways of asking about suicide and risk factors in child-friendly ways. For example, Barrio (2007) suggests that clinicians

can ask children to draw a picture of a precipitating event (what led to a suicidal crisis), in addition to asking them to describe it verbally. Barrio (2007) addresses the importance of considering family involvement in an assessment interview. She cautions clinicians to be deliberate about the decision regarding when to involve parents or caretakers in the interview, and to be aware of the impact this decision will have on treatment engagement and the therapeutic alliance. With this caveat, she also suggests that parents can be an excellent source of information about family and external risk factors; furthermore, relying on parents for this information serves to alleviate some of the burdensomeness a lengthy assessment interview can have for a child. See Table 1 for a summary of these assessment guidelines.

Treatment

In 2001 Fristad and Shaver stated: "No documented interventions are available for use with

Table 1
Assessment Guidelines

Guideline	Examples	Source
Ask about suicidal ideation	*Do things ever get so bad you think about hurting yourself?* *Have you ever wished you were dead?* *Have you ever tried to kill yourself?* Ask child to draw a picture of what they think about when they are at their most sad, angry or scared.	Barrio (2007); Pfeffer (1986); Wise & Spengler (1997)
Assess child's developmental understanding of death, including past experiences with death and anticipated outcome of suicide plan	*Can someone return to life after they die?* *Have you ever known a person or pet who has died?* *Do you think death is pleasant or unpleasant?* *What do you think will happen when you die?* *If you [describe child's plan, e.g., stab yourself in the stomach], what do you think would happen next?*	Barrio (2007); Pfeffer (1986); Wise & Spengler (1997)
Ask about precipitating event(s)	*What was happening right before you tried to kill yourself? (or, last thought about killing yourself?)* Ask child to draw a picture of what happened.	
Build rapport and incorporate developmentally appropriate interview techniques	Take frequent breaks if needed Use a slow interview pace Check child's understanding of questions Explain purpose of assessment Ask about concepts in several different ways	Barrio (2007); Pfeffer (1986)
Assess parent attitudes	Do parents/caregivers believe the child is at risk? Are they willing to implement safety plans?	Barrio (2007); Pfeffer (1986)
Use a multi-method, multi-informant approach	Observe parent-child interactions; observe child's play behavior; ask parents about relevant history and risk factors, to reduce interview burden on child	Barrio (2007); Pfeffer (1986); Wise & Spengler (1997)
Use structured assessment tools to supplement clinical interview	Suicidal Behavior Questionnaire for Children (SBQ-C; Range & Knott, 1997). Scale for Suicidal Ideation (SSI; Allan, Kashani, Dahlmeier, Taghizadeh, & Reid, 1997) Child Suicide Potential Scales (Pfeffer, 1986) Child-Adolescent Suicidal Potential Index (CASPI; Pfeffer, Jiang, & Kakuma, 2000) Child Suicide Risk Assessment (CSRA; Larzelere, Andersen, & Jorgensen, 2004)	See Larzelere, Andersen, Ringle, & Jorgensen (2004) for a review

suicidal children." (Fristad & Shaver, 2001, p. 193). That same year the American Academy of Child and Adolescent Psychiatry released practice parameters for working with suicidal children and adolescents (Shaffer & Pfeffer, 2001). These parameters noted three possible treatment approaches that had been adapted for adolescent patients: cognitive-behavior therapy, interpersonal therapy, and dialectical behavior therapy. Unfortunately, these practice parameters provided neither an evidence-based approach nor specific guidelines for treating preadolescent suicidal risk.

Some 15 years later, little progress has been made. As Glenn, Franklin, and Nock (2015) have remarked, "there are currently no well-established treatments for suicidal or non-suicidal self-injurious behaviors in youth." (p. 26). Despite this lack of progress with regard to evidence-based treatments for suicidal children, some potentially helpful guidelines have appeared.

For example, Pfeffer (1987) suggested five elements of treatment: (a) being aware of the current literature on risk factors for child suicidal risk; (b) developing self-awareness of one's own responses to one's suicidal child patients; (c) providing treatment with the goal of reducing risk factors; (d) developing a network of supportive people who can help keep the child safe; and (e) maintaining follow-up appointments or contacts. Family members require support and education because they can play a pivotal role in safety planning and help-seeking when needed. Family involvement is also crucial for addressing family dysfunction that may contribute to suicidal risk.

As noted early on, there is one published study of a suicide-relevant treatment for children under the age of 12 (Perepletchikova et al., 2011). This was a community-based feasibility study with no evidence of its actual effectiveness as these authors sought to adapt dialectical behavior therapy (DBT) for use with preadolescent children. Some of the adaptations they made included the use of cartoon characters, large font sizes, and a second-grade reading level in each of their handouts. They added one set of skills to the standard repertoire of DBT coping skills to specifically address the role that impulsivity plays in suicidality in young children. Other skills were combined and simplified to make them more accessible. Finally, sessions included the use of board games, experiential exercises, and role-plays in order to maintain children's engagement. The authors noted that future adaptations may include a caregiver training module, in which parents or caregivers receive training on how they can best support their children, by helping them practice newly learned skills and increasing the likelihood of a validating home environment. But beyond this exploratory work using DBT, there remains little new guidance for treating suicidal risk in children under the age of 12.

The Collaborative Assessment and Management of Suicidality

The "Collaborative Assessment and Management of Suicidality" (CAMS, Jobes, 2006) is an evidence-based, suicide-specific, therapeutic framework that has proven to be effective for working with suicide risk in adult populations (Comtois et al., 2011; Jobes, 2012). Within this framework, CAMS clinicians use intervention techniques that are most appropriate to treat the patient-defined "suicidal drivers," based on the clinician's therapeutic orientation. Central to the use of CAMS is the "Suicide Status Form" (SSF), which functions as a multipurpose assessment, treatment planning, tracking to clinical outcome tool (i.e., the SSF functions as a clinical road map to guide this suicide-specific intervention). Within CAMS-guided care, the patient is always seen as the expert of their idiosyncratic experience of suicide. The patient and clinician collaboratively work together using the SSF to help uncover suicidal drivers which are the issues *identified by the patient* that make them suicidal (Jobes, Comtois, Brenner, Gutierrez, & O'Connor, in press; Tucker, Crowley, Davidson, & Gutierrez, 2015). Critical to CAMS-guided care, patient-defined suicidal drivers are what we target and treat to eliminate suicidal risk over the course of care. CAMS is designed to ideally keep a suicidal patient *out* of inpatient care through the use of the CAMS SSF Stabilization Plan and its suicide-specific driver-oriented treatment. CAMS is further designed to create a strong clinical alliance and to increase patient motivation by engaging the patient as a figurative "co-author" of their own treatment plan.

Within the standard use of CAMS, the SSF is introduced early on in a first session when sui-

cide risk first comes to light. With permission of the patient, the clinician requests to take a seat next to the patient to collaboratively work through "Section A" of the SSF, which consists of various quantitative and qualitative assessments that flush out the phenomenology of the patient's suicidality. With suicidal adult patients, Section A is completed by the patient with the assistance and guidance of the clinician. Still sitting side-by-side the clinician takes over the completion of "Section B" which is a short list of empirically based risk factors and warning signs.

After this extensive assessment the dyad turns to "Section C" of the SSF, which focuses on treatment planning. Standard CAMS treatment planning begins with a discussion about keeping the patient out of the hospital through initial completion of the CAMS Stabilization Plan, which focuses on decreasing access to lethal means, use of coping strategies, decreasing interpersonal isolation, and identifying potential barriers to care (and remedies). Once the Stabilization Plan is completed satisfactorily, the first session ends with a focus on problems (i.e., drivers) that put the patient's life at risk for suicide. The patient routinely receives copies of their SSF or may take pictures of the forms on their smartphone. After the first session, all subsequent CAMS-guided interim sessions begin with the interim version of the SSF that includes a brief assessment; the session then focuses on the use and further crafting of the Stabilization Plan and the focused treatment of patient-defined suicidal drivers. Each CAMS interim session ends with side-by-side treatment plan updating. With three consecutive sessions of managing suicidal thoughts/feelings/behaviors, CAMS comes to an end, which is demarcated by the use of SSF outcome/disposition documentation.

CAMS has not yet been systematically studied with children, although the SSF was used in one inpatient study of suicidal youth (Romanowicz, O'Connor, Schak, Swintak, & Lineberry, 2013). These investigators found that elementary-aged children did not differ significantly from older adolescents in their self-report ratings of key SSF quantitative assessment constructs. Although this was not a psychometric study of the SSF, the investigation did show the potential feasibility of using the SSF with younger suicidal children. Given the dearth of treatments for suicidal youth, it is noteworthy that an article on using CAMS with suicidal adolescents was recently published with recommendations and modifications for using CAMS with this population (O'Connor, Brausch, Ridge Anderson, & Jobes, 2014). Historically the use of CAMS with young children (under the age of 12) was not recommended (Jobes, 2006), but recent developments described in this article have led us to rethink the possible use of CAMS with suicidal children under the age of 12.

Using CAMS With Children

Using CAMS with young children requires some obvious adaptations. For example, depending on the age, some young children may not read or write comfortably enough to complete the SSF, so the clinician may need to complete the SSF for them with the child's direct input. The SSF should thus still be used to guide the assessment in a side-by-side seating arrangement, or sitting on the floor with the child if that is more comfortable for them. It is important to be sure to document the child's responses exactly as verbalized. The CAMS philosophy always places the patient in the role of expert; the child's perspective and voice must thus be heard and fully respected as Sections A and B of the SSF are completed. Beyond the standard SSF assessment, one of us (G.K.) has added two additional assessment questions: (a) How important do you feel? and (b) What makes you feel important or has made you feel important in the past? These questions assist with treatment planning, as they offer the clinician an additional window into the patient's world. Children's answers to these questions are routinely incorporated into the treatment plan or used to guide interventions. For example, if a child feels important when they are helpful with their sibling, the clinician might recommend sibling play time as a possible coping strategy. Clinicians can also use the answers to these questions to guide their approach to rapport building. There is as yet no research to support the psychometric value of using the SSF with children. At the current time, the SSF is best viewed as a tool to help guide the clinician to thoughtfully, sensitively, and systematically delve into the child's experience, thus helping to build the therapeutic alliance in a myriad of ways.

Depending on the case, family involvement in the CAMS assessment can be both a help and/or a hindrance. Our overall bias would be to start with the child's perspective first and double check with family members later in the process. In terms of treatment planning, the child should be fully engaged in Stabilization Planning (again, parents can be later engaged to further support the plan, particularly pertaining to access to lethal means). Beyond stabilization, the child should be fully engaged to articulate their suicidal drivers—what two issues or problems make them want to kill themselves? It is up to the clinician to identify treatment goals and interventions for treating suicidal drivers. Often with young children, supplemental family therapy, cognitive–behavioral interventions, and/or certain kinds of play therapy may be indicated.

As noted repeatedly, the exact role of parental involvement in treatment is the elusive and critical "wild card" when working with suicidal children. Many parents are in abject denial that a child so young could actually mean and understand what suicide is, and in their fear and anger they may accuse the child of lying or being manipulative—which is never therapeutic! There is also a risk that parents may act out, undermine treatment goals, or make things much more complicated for the distressed child. Despite these potential barriers, clinicians can and should work to engage parents in treatment. Depending on the family context, this involvement may be limited to the most basic, yet critical, element of safety planning (i.e., parents may assist with a stabilization plan by agreeing to limit access to lethal means). Alternatively, some children may benefit from a much deeper level of parent involvement. In the best scenarios, the parents can become key treatment allies and may have a directly helpful role in implementing a "Crisis Support Plan" which can be used to further support the suicidal child (see discussion by Bryan, Stone, & Rudd, 2011). Beyond stabilization, parents may benefit from understanding the notion of suicidal drivers and what interventions will be used to treat the patient-defined suicidal problem/drivers. Attachment-Based Family Therapy (ABFT, Ewing, Diamond, & Levy, 2015), developed for use with suicidal teenagers, provides a helpful perspective on how to approach parent involvement. Specifically, ABFT prioritizes building empathy and parent motivation in order to facilitate a repair of the parent–child attachment (Ewing, Diamond, & Levy, 2015). Within a CAMS treatment approach, clinicians can use the SSF and psychoeducation regarding suicidal drivers to help increase parents' empathy for their child's pain. Parental involvement may be directly indicated in the driver-oriented treatment plan. For example, if one of the child's suicidal drivers is their feeling of being unloved by the parents, the corresponding CAMS treatment plan intervention might involve family therapy to directly address and hopefully repair the parent–child attachment. Alternatively, if a driver centers on negative interactions with peers at school, the CAMS treatment plan might include social skills work or group therapy, and the parents constructively engaging school administrators to find ways of reducing negative peer-based interactions and creating a more supportive school environment. It is beyond the scope and focus of this article to fully describe the CAMS model in depth. Those interested in learning more about CAMS should consult the literature (Jobes, 2006, 2012; Jobes et al., in press), as well as two key websites about standard training in the CAMS approach: www.empathosresources.com and www.cams-care.com.

Case Studies

The cases described herein provide a glimpse into our early experiences of modifying and using CAMS with suicidal children under the age of 12. In addition to some of the CAMS-based modifications for children just noted, one of us (G.K.) has implemented several other developmentally appropriate, suicide-specific modifications, innovations, and interventions that directly address suicidal drivers within the spirit of the CAMS model of care. Some of these modifications and innovations include: using coping index cards, hope journals, a Virtual Hope Box, and guided imagery (referred to here as Picture Prayers). For additional details regarding these interventions, please see Table 2. The children described in the following case studies all come from strongly religious backgrounds and cultures, where the therapeutic use of prayer is both familiar and comforting. In keeping with the spirit of CAMS, interventions can and should be adapted to best fit the belief systems and values of any given patient. The

Table 2
Child-Friendly Interventions

Intervention	Example	Materials needed/Reference
Coping Cards	In order to give Lillian a tangible and child-friendly reminder of her progress and coping skills, the clinician worked with Lillian to create Coping Index Cards. These cards consisted of pictures that represented how she felt and how she would cope. For example, Lillian chose a picture of an angry SpongeBob SquarePants to represent her direct driver of *self-hate.* Her coping strategies included the use of Picture Prayers, playing with her sister, and deep breathing. Lillian selected images that she felt best represented these strategies. Sarah reported that she liked carrying her Coping Index Cards with her, kept on a binder ring, because they helped to remind her of what to do when she couldn't think and was overwhelmed.	Index cards; loose-leaf binder rings; glue stick; color printer; hole-punch; hole-reinforcements; Sticker Maker or cut-outs of child-friendly images to depict pain and coping strategies (e.g., blowing wind to represent deep breathing)
Hope Journal	The Hope Journal was given to Lillian during the first session and was used to help target and treat the direct driver *hopelessness*. With the clinician seated beside her on the floor, Lillian was asked, "*What is the first thing that comes to your mind when you think of hope?*" Lillian responded with "*It's a bright yellow light and God's angels are inside of it.*" Lillian drew her vision of this concept in her Hope Journal. This and other images from her Hope Journal were incorporated into various aspects of her treatment.	Composition books; markers or crayons; stickers
Virtual Hope Box	The Virtual Hope Box allows a patient to add positive reminders to counter negative thinking. It provides a way to access life saving contacts, positive affirmations, guided relaxation techniques, distractions in times of need, and a way to access coping strategies.	https://msrc.fsu.edu/funded-research/improved-virtual-hope-box Bush et al. (2015)
Picture Prayers (guided imagery)	Picture Prayers is a form of guided imagery in which children are taught to pray using only pictures and emotions. In sessions with Lillian, she was asked to close her eyes and concentrate on her breathing: taking in slow deep breaths and exhaling while she was guided with images to a garden. The clinician incorporated the image of yellow light, and others from Lillian's Hope Journal, in the guided imagery.	Guided imagery script; recorded sounds of nature
Core SSF Worksheet	In order to enhance patient understanding and engagement with the 5 core SSF constructs (psychological pain, stress, agitation, hopelessness, and self-hate), as well as ratings of overall suicide risk, our CAMS clinician developed a child-friendly SSF worksheet. This worksheet includes a range of feeling faces to anchor each number of the 1–5 Likert scale. In addition to the standard open-ended SSF question associated with each construct (e.g., "What I find most painful is. . ."), the worksheet provides space for the child to identify the thought that is associated with each level of the scale (e.g., for hopelessness, a 1 might be "I'm happy" and a 5 might be "I see darkness and no future for me").	Grace M. Keyes, M.S.

CAMS-based interventions used to date have been highly interactive and "hands-on," such that the child and clinician work together in concrete ways during the session. Moreover, these tangible coping interventions provide visual ways for the child and clinician to share newly learned skills with parents or caregivers (who ideally reinforce these coping skills at home). These particular coping interventions also allow the child to take home tangible reminders of the work they have done in session. The common theme across the described coping interventions used in these case studies is that they are meant to address the child-patient's self-described suicidal drivers in a developmentally appropriate way.

Case 1 – Lillian, Age 5

"*I want to die. I think about it all the time. I think about running into traffic, as fast as I can.*

I see myself cutting my throat and blood running all over. I see myself stabbing myself. I know the pain and darkness will leave if I do this. I will be gone forever; I won't have to feel this way anymore." These are the verbatim words used by "Lillian" in her first counseling session. Lillian is a 5-year-old Caucasian girl who lives with her mother, stepfather, and younger sister. Lillian's parents divorced when she was 3 years old. During the course of her initial session, it became abundantly clear that Lillian blamed and hated herself in relation to her parents' divorce, which was central to her suicidal preoccupations. According to her mother, Lillian started talking about killing herself a full year and a half before entering treatment; in the two months before her first session Lillian reportedly had been talking about wanting to die and killing herself on a daily basis. It seems that over time Lillian increasingly found comfort in her thoughts of dying. Given this alarming presentation, a modified version of the CAMS framework was used to assess these thoughts so as to identify and treat her suicidal drivers.

Given Lillian's young age, a number of modifications to the CAMS model were necessary. For example, the clinician needed to complete the initial assessment sections of the SSF for her, with care taken to accurately reflect back her responses to SSF rating scales and qualitative assessment items.

Lillian's five SSF "Reasons for Dying" included: (a) *I hate myself,* (b) *I do not see a future,* (c) *all I see is darkness,* (d) *I cannot stop thinking about death,* and (e) *there's no hope for me.* As the dyad discussed her SSF assessment responses and shifted to treatment planning, Lillian indicated that the two problems that made her want to die were "hating myself" and "feeling hopeless"—these were then her two "suicidal drivers" as defined in the CAMS model which would be targeted and treated within her care. In the course of her CAMS-guided care, these drivers were addressed through a variety of interventions including: a hand-made "Hope Journal," behavioral activation, increasing social support, a Virtual Hope Box, prayer-oriented guided imagery, positive self-talk, breathing exercises, a packet of coping index cards, and other cognitive–behavioral therapy techniques.

The hand-made "Hope Journal" was created by Lillian with her clinician's help during her first session and was used to specifically address her hopelessness driver. Seated on the floor next to Lillian, the clinician asked, "What is the first thing that comes to your mind when you think of hope?" Lillian responded, "it's a bright yellow light and God's angels are inside of it." Using colored markers, crayons, and stickers, Lillian drew and created her vision of this concept in her Hope Journal. In a similar manner, Lillian and her clinician also created Coping Cards (on index cards) as an age-appropriate tangible reminder of different strategies discussed in session. These cards had different pictures that represented how she felt at different points and what she could do to cope. For example, Lillian chose a picture of an angry "Sponge-Bob Square-Pants" (a popular cartoon character on TV) to represent her suicidal driver of self-hate. Her coping strategies included prayer, deep breathing, and playing with her sister. Lillian thus selected images of praying hands and wind blowing from a sticker book, and drew a picture of herself and her sister to represent her various coping strategies. In subsequent sessions Lillian came in with her coping cards in hand, explaining how she had used them in the previous week—even developing more cards on her own—demonstrating her investment in coping.

Early on in the course of care, reflecting the values and cultural references that mattered to Lillian, a spiritually based guided imagery exercise was used that capitalizes on the use of images related to emotions and applying spirituality as a means of coping. In this exercise, Lillian was asked to close her eyes and concentrate on her breathing, taking in slow deep breaths and exhaling while she was guided with images into a garden. The clinician incorporated her image of yellow light (and others from Lillian's Hope Journal) into the guided imagery exercise. Lillian commented at the end of her CAMS treatment that she would "go to the garden" whenever she felt despair, and then did not think of killing herself.

Lillian was seen for 9 sessions over the course of 4 weeks. In Lillian's last CAMS session, she rated key SSF suicide-related constructs at the lowest level; she was no longer experiencing any suicidal ideation and there was no inclination toward suicidal behavior. In

stark contrast to the darkness and hopelessness that had characterized Lillian's experience of life at the start of treatment, she finished this course of treatment expressing hope for the future, including her dream to one day become a cheerleader like her older teenage cousin. Some weeks after her treatment ended, Lillian's mother contacted the therapist to inform her that Lillian had been chosen for the "junior cheerleader" squad at her elementary school.

Case 2 – Jeremy, Age 9

"Jeremy" is a 9-year-old Caucasian male who was brought to therapy by his biological mother. He was experiencing difficulty in school, had trouble getting along with his peers, and was not obeying school rules. For approximately 3 months he had been treated for depression through a combination of medication and counseling. After a violent altercation with peers at school, Jeremy was admitted to a child treatment facility where he remained for 30 days, receiving treatment for depression and oppositional defiant disorder. After discharge Jeremy returned to his primary psychotherapist to continue counseling. Approximately 2 months later his primary therapist moved and he was subsequently referred to our CAMS clinician.

During the initial assessment Jeremy was asked if he had thoughts of harming himself. Jeremy broke down in tears, explaining that he indeed did have thoughts of killing himself, and that he had made two previous attempts which he kept secret. He stated, "nobody listens to me anyway and nobody would care if I was dead." Given these disclosures, the clinician explained to Jeremy and his mother how the CAMS model is used and was then authorized by the mother to proceed with CAMS-guided care. In the first session Jeremy and the therapist sat side-by-side to complete the initial CAMS assessment using the SSF, as well as an SSF Stabilization Plan and driver-oriented treatment plan. As in the previous case of Lillian, Jeremy identified hopelessness and self-hatred as his two problem drivers. Jeremy's mother was brought into the session to help in the development of his Stabilization Plan, as it required the securing of various available guns in the home. Although his mother was understandably upset about the issue of Jeremy's suicidal risk, she did find

some comfort in knowing that the therapist and Jeremy were addressing this problem.

During his second CAMS session the clinician introduced the "CAMS Therapeutic Worksheet" (CTW; refer to Jobes et al., in press) to further explore and understand the nature of Jeremy's suicidal drivers. This led to fruitful discussion about his anger, low self-esteem, and loneliness. This exploration was used to "connect the dots" related to how his drivers of hating himself led to subsequent feelings of hopelessness that things would never change.

Over a 13-week period, at the beginning of every session, the therapist and Jeremy collaboratively filled out the interim SSF document which tracked Jeremy's ongoing suicidal risk; the focus of each session was then on suicidal drivers. In CAMS we talk about "sharpening" the drivers over the course of care. For Jeremy, this meant evolving an understanding about hating himself to seeing the issue more in terms of self-esteem and self-worth. In turn, the discussion of hopelessness increasingly focused on identifying things he could aspire to and believe. At the end of each session the therapist and Jeremy updated his CAMS treatment plan together, making sure to explore what had worked (and not worked) from his perspective. The therapist routinely met with Jeremy and his mother at the close of each session, providing updates on his treatment progress and reviewing his updated treatment plan. A key piece of treatment for Jeremy was to ensure that his mother felt empowered and supported as she learned how to better support him in his recovery. His mother's struggles with the stress of parenting Jeremy, in addition to her own psychological issues and conflictual relationships, ultimately led to a referral for her to receive individual treatment (much to the delight of Jeremy who often noted that she needed more help than he did).

Jeremy's SSF scores steadily improved as he learned how to handle his intense feelings of anger more constructively. In addition, Jeremy developed skills that allowed him to deal with other people differently (and better) and he improved his ability to ask for help. As this progress was made, his thoughts about suicide dissipated. In the course of Jeremy's care his suicidal ideation had been revealed, treated, and he no longer showed symptoms related to the diagnoses of Major Depression or Oppositional

Defiant Disorder. Jeremy is now a healthy 9-year-old, attending school, doing well and enjoying his life. His mother is currently in remission from an active substance use disorder and her relational life—including her relationship with her son Jeremy—has become more stable.

Case 3 – Sarah, Age 8

"Sarah" is an 8-year-old Caucasian girl who lives with her maternal grandparents. Sarah's mother passed away a few months before she first came in for counseling. She helped care for her mother during her mother's protracted illness with terminal cancer and was with her mother when she passed away. Sarah's grandparents brought her in for treatment after she asked her grandmother to help her write a note, which simply read, "I love you, bye."

At the start of her CAMS treatment, Sarah's SSF "Core Assessment" ratings of psychological pain, stress, agitation, hopelessness, and self-hate were all rated at the highest level; reassuringly, despite the severity of her distress, she rated her overall risk of suicide a "2" on a five-point scale. In terms of her SSF Reasons for Living, Sarah only had two responses: (a) "My mom would want me to live," and (b) "My cat." In turn, Sarah had four Reasons for Dying: (a) "I want to be with my mom," (b) "I don't want to be alone," (c) "I hurt," and (d) "I hate where I live." For the SSF "One Thing" response of what would help Sarah no longer feel suicidal, she answered: "If I wasn't alone."

The CAMS Stabilization and driver-oriented treatment plan was also completed at the end of the first session. Through this process it became clear that Sarah's grandparents had to be directly involved in reducing her access to lethal means. These stabilization steps included: (a) to stay close to her and supervise her, (b) to hold her hand when walking across the street and/or close to the curb, and (c) to keep child safety locks on the car engaged at all times. Moreover, any available drugs, rope, and firearms were to be secured in the home. In terms of her own crisis coping, Sarah chose five things that she would try to do if she were in a suicidal crisis: (a) pet her cat, (b) play with friends, (c) talk with her grandparents, (d) use her Hope Journal, and (e) use modified DBT-based relaxation strategies. Sarah identified three people whom

she could reach out to if she felt too lonely and the phone numbers of these people were programmed into her phone during the session. In terms of the CAMS treatment plan, Sarah's two problem-drivers were (a) "missing my mom" and (b) "hopelessness." Treatment interventions for these drivers included: Coping Cards, grief work, actively increasing social support, a Hope Journal, DBT relaxation skills, a Virtual Hope Box, and the use of guided imagery. The processing of Sarah's grief related to losing her beloved mother included talking about her mom, writing her a letter, using a modified Gestalt "two-chair" technique, and cognitive therapy related to her distorted thinking. Sarah liked carrying her Coping Cards with her, kept on a binder ring, because they helped to remind her of what to do when she was overwhelmed.

Over a 7-week period, Sarah's SSF assessment scores slowly improved. In her final CAMS session, Sarah stated that she had learned how to say goodbye to her mother and to deal with her sadness without wanting to die. Sarah further noted that she had learned better how to ask for help when she needed it, and commented, "now it's okay for me to live."

Discussion

As noted, there is no established evidence-based treatment for suicidal children under the age of 12. Yet epidemiologically and as illustrated in our case study examples, such children *do* exist and they are clearly in need of effective mental health care. That so little about this topic exists in the professional literature is baffling. Does it perhaps reflect a collective level of denial that children are simply incapable of such thoughts? How can a 5-year-old possibly know what it means to die and take their life? Where could they have learned such a thing? How can it really be true? And yet, it is. To this end, this article has endeavored to grapple with this uncomfortable and thorny topic as a means to further press the field to seriously engage on the topic of suicidal risk in young children leading to a better understanding of the phenomenon and ultimately to clinical care that may help save the youngest of lives from suicide.

In presenting the CAMS model and our three case studies, we are not yet suggesting that we have the answers. We are nevertheless determined to responsibly ask the key questions in

pursuit of crucial answers that may one day lead to rigorous empirical investigations. But at this early juncture in our own work, there are some observations that we feel compelled to share that might further shape the discussion and pursuit of evidence-based care for suicidal children.

First, across our case studies we see very young children who readily verbalize a desire to die when they are directly asked. They are freely saying they want to kill themselves, and in fact they seem quite captivated by the idea of it. In our experiences to date, it has not been unusual to observe adults responding to such verbalizations in dismissive, angry, and even punitive ways, perhaps out of their own fear, anxiety, frustration, or the abject horror of such a notion. What seems pivotal in our clinical case study examples is having an adult clinician take such words seriously and pursuing these words so as to understand them as *the child* understands and means them. Beyond taking such verbalizations seriously and endeavoring to understand their meaning, it also seems plain that a clinician can play a strategic role in the interface between child and custodial adults related to this topic. Issues of *control* are central within child suicidal risk. Children quickly learn that adults react quite strongly to the word "suicide," thereby behaviorally reinforcing suicide-related verbalizations and behaviors and increasing the likelihood of further suicide-related behaviors in the future. In this regard, we would underscore the obvious *instrumental* utility within a child's nascent "coping" repertoire, as "suicide" usually does get the attention of others including parents, teachers, and peers. On reflection, one gets the distinct sense from our case study examples that the children we describe do not so much crave the termination of their biological existence as much as a desire for control, empathy, acceptance, recognition, validation, and the prompt interpersonal responsiveness of key people in the child's life.

In our early exploration of using one evidence-based suicide-specific clinical practice developed for adults with suicidal children we have noted the potential power and possible effectiveness of this adaptation thus far. The case studies presented here are limited in terms of ethnic and religious diversity, which limits generalizability. This raises important questions about the potential application of CAMS to more diverse patients, underscoring the need for additional research. This research is clearly necessary, and we do aspire to rigorous randomized controlled trials of such care to prove treatment effectiveness in a causal manner. But there are some striking early clinical impressions of what might work. At this early stage in our work with children, it seems that core elements of the CAMS philosophy pertaining to being suicide-focused, empathic, honest, and collaborative works across the age spectrum (Jobes et al., in press). Although obvious adaptations are needed to make CAMS assessment and treatment "child-friendly," we find this can be readily done if we take development and the *child's* perspective fully into account. The CAMS framework can readily guide the process, but stabilization and driver-related interventions must be concrete, "hand-made," and understandable through the eyes of the child. An elusive but crucial aspect to working with suicidal children is a better understanding of the role of parents both as contributors to suicidal risk and as key allies in treatment. Finally, while we have seen the use of CAMS for children in some half dozen cases to date, we would note remarkably rapid response to the intervention.

We believe the time has come for the field to turn its talent and resources toward the suicidal child so that contemporary work can go far beyond the early trail-blazing work of Dr. Pfeffer some *thirty* years ago. Suicidal children are among us. We must therefore endeavor to find them, engage them, hear them, and treat them if we aspire to address the tragedy of a child at a tender age terminating their life seemingly before they have even begun to really live it. Such is the challenge, and the promise, of understanding and effectively treating suicidal children.

References

Allan, W. D., Kashani, J. H., Dahlmeier, J., Taghizadeh, P., & Reid, J. C. (1997). Psychometric properties and clinical utility of the scale for suicide ideation with inpatient children. *Journal of Abnormal Child Psychology, 25,* 465–473. http://dx.doi.org/10.1023/A:1022633714888

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Balazs, J., Miklósi, M., Keresztény, A., Dallos, G., & Gádoros, J. (2014). Attention-deficit hyperactivity

disorder and suicidality in a treatment naïve sample of children and adolescents. *Journal of Affective Disorders, 152–154,* 282–287. http://dx.doi.org/10.1016/j.jad.2013.09.026

Barrio, C. A. (2007). Assessing suicide risk in children: Guidelines for developmentally appropriate interviewing. *Journal of Mental Health Counseling, 29,* 50–66. http://dx.doi.org/10.17744/mehc.29.1.1x8qu2axd1v6rv3q

Bridge, J. A., Asti, L., Horowitz, L. M., Greenhouse, J. B., Fontanella, C. A., Sheftall, A. H., . . . Campo, J. V. (2015). Suicide trends among elementary school-aged children in the United States from 1993 to 2012. *Journal of the American Medical Association Pediatrics, 169,* 673–677. http://dx.doi.org/10.1001/jamapediatrics.2015.0465

Bryan, C. J., Stone, S. L., & Rudd, M. D. (2011). A practical, evidence-based approach for means-restriction counseling with suicidal patients. *Professional Psychology: Research and Practice, 42,* 339–346. http://dx.doi.org/10.1037/a0025051

Buhrmester, D. (1990). Intimacy of friendship, interpersonal competence, and adjustment during preadolescence and adolescence. *Child Development, 61,* 1101–1111. http://dx.doi.org/10.2307/1130878

Bush, N. E., Dobscha, S. K., Crumpton, R., Denneson, L. M., Hoffman, J. E., Crain, A., . . . Kinn, J. T. (2015). A Virtual Hope Box smartphone app as an accessory to therapy: Proof-of-concept in a clinical sample of veterans. *Suicide and Life-Threatening Behavior, 45,* 1–9. http://dx.doi.org/10.1111/sltb.12103

Cicchetti, D., & Rogosch, F. A. (1996). Equifinality and multifinality in developmental psychopathology. *Development and Psychopathology, 8,* 597–600. http://dx.doi.org/10.1017/S0954579400007318

Comtois, K. A., Jobes, D. A., S O'Connor, S., Atkins, D. C., Janis, K. E., Chessen, 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. http://dx.doi.org/10.1002/da.20895

Crocker, A. D., & Hakim-Larson, J. (1997). Predictors of pre-adolescent depression and suicidal ideation. *Canadian Journal of Behavioral Science/Revue Canadienne Des Sciences Du Comportement, 29,* 76–82. http://dx.doi.org/10.1037/0008-400X.29.2.76

Ewing, E. S. K., Diamond, G., & Levy, S. (2015). Attachment-based family therapy for depressed and suicidal adolescents: Theory, clinical model and empirical support. *Attachment & Human Development, 17,* 136–156. http://dx.doi.org/10.1080/14616734.2015.1006384

Fite, P. J., Stoppelbein, L., Greening, L., & Preddy, T. M. (2011). Associations between relational aggression, depression, and suicidal ideation in a child psychiatric inpatient sample. *Child Psychiatry and Human Development, 42,* 666–678. http://dx.doi.org/10.1007/s10578-011-0243-4

Fristad, M. A., & Shaver, A. E. (2001). Psychosocial interventions for suicidal children and adolescents. *Depression and Anxiety, 14,* 192–197. http://dx.doi.org/10.1002/da.1066

Giannetta, M. M., Betancourt, L. M., Brodsky, N. L., Wintersteen, M. B., Romer, D., Giannetta, J. M., & Hurt, H. (2012). Suicidal ideation and self-harm behavior in a community sample of preadolescent youth: A case-control study. *Journal of Adolescent Health, 50,* 524–526. http://dx.doi.org/10.1016/j.jadohealth.2011.09.013

Glenn, C. R., Franklin, J. C., & Nock, M. K. (2015). Evidence-based psychosocial treatments for self-injurious thoughts and behaviors in youth. *Journal of Clinical Child and Adolescent Psychology, 44,* 1–29. http://dx.doi.org/10.1080/15374416.2014.945211

Gould, M. S., King, R., Greenwald, S., Fisher, P., Schwab-Stone, M., Kramer, R., . . . Shaffer, D. (1998). Psychopathology associated with suicidal ideation and attempts among children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 37,* 915–923. http://dx.doi.org/10.1097/00004583-199809000-00011

Greening, L., Stoppelbein, L., Fite, P., Dhossche, D., Erath, S., Brown, J., . . . Young, L. (2008). Pathways to suicidal behaviors in childhood. *Suicide and Life-Threatening Behavior, 38,* 35–45. http://dx.doi.org/10.1521/suli.2008.38.1.35

Greening, L., Stoppelbein, L., Luebbe, A., & Fite, P. J. (2010). Aggression and the risk for suicidal behaviors among children. *Suicide and Life-Threatening Behavior, 40,* 337–345. http://dx.doi.org/10.1521/suli.2010.40.4.337

Jackson, H., & Nuttall, R. L. (2001). Risk for preadolescent suicidal behavior: An ecological model. *Child & Adolescent Social Work Journal, 18,* 189–203. http://dx.doi.org/10.1023/A:1011058419113

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

Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): An evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior, 42,* 640–653. http://dx.doi.org/10.1111/j.1943-278X.2012.00119.x

Jobes, D. A., Comtois, K. A., Brenner, L. A., Gutierrez, P. M., & O'Connor, S. S. (in press). Lessons learned from clinical trials of the Collaborative Assessment and Management of Suicidality (CAMS). In R. C. O'Connor & J. Pirkis (Eds.), *International handbook of suicide prevention: Research, policy, and practice* (2nd ed.). West Sussex, UK: Wiley-Blackwell.

Jobes, D. A., Rudd, M. D., Overholser, J. C., & Joiner, T. E., Jr. (2008). Ethical and competent care of suicidal patients: Contemporary challenges, new developments, and considerations for clinical practice. *Professional Psychology: Research and Practice, 39,* 405–413. http://dx.doi.org/10.1037/a0012896

Larzelere, R. E., Andersen, J. J., Ringle, J. L., & Jorgensen, D. D. (2004). The child suicide risk assessment: A screening measure of suicide risk in pre-adolescents. *Death Studies, 28,* 809–827. http://dx.doi.org/10.1080/07481180490490861

Lin, F. G., Lin, J. D., Hsieh, Y. H., & Chang, C. Y. (2014). Quarrelsome family environment as an enhanced factor on child suicidal ideation. *Research in Developmental Disabilities, 35,* 3245–3253. http://dx.doi.org/10.1016/j.ridd.2014.08.007

Liu, X., Gentzler, A. L., Tepper, P., Kiss, E., Kothencné, V. O., Tamás, Z., . . . Kovacs, M. (2006). Clinical features of depressed children and adolescents with various forms of suicidality. *Journal of Clinical Psychiatry, 67,* 1442–1450. http://dx.doi.org/10.4088/JCP.v67n0917

Mayes, S. D., Calhoun, S. L., Baweja, R., Feldman, L., Syed, E., Gorman, A. A., . . . Siddiqui, F. (2015). Suicide ideation and attempts are associated with co-occurring oppositional defiant disorder and sadness in children and adolescents with ADHD. *Journal of Psychopathology and Behavioral Assessment, 37,* 274–282. http://dx.doi.org/10.1007/s10862-014-9451-0

Mayes, S. D., Calhoun, S. L., Baweja, R., & Mahr, F. (2015). Suicide ideation and attempts in children with psychiatric disorders and typical development. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 36,* 55–60. http://dx.doi.org/10.1027/0227-5910/a000284

Mishara, B. L. (1999). Conceptions of death and suicide in children ages 6–12 and their implications for suicide prevention. *Suicide and Life-Threatening Behavior, 29,* 105–118.

Nock, M. K., & Kazdin, A. E. (2002). Examination of affective, cognitive, and behavioral factors and suicide-related outcomes in children and young adolescents. *Journal of Clinical Child and Adolescent Psychology, 31,* 48–58. http://dx.doi.org/10.1207/S15374424JCCP3101_07

O'Connor, S. S., Brausch, A., Ridge Anderson, A., & Jobes, D. A. (2014). Applying the Collaborative Assessment and Management of Suicidality (CAMS) to suicidal adolescents. *International Journal of Behavioral and Consultation Therapy, 9,* 53–58.

Orbach, I. (1988). *Children who don't want to live: Understanding and treating the suicidal child.* San Francisco, CA: Jossey-Bass.

Perepletchikova, F., Axelrod, S. R., Kaufman, J., Rounsaville, B. J., Douglas-Palumberi, H., &

Miller, A. L. (2011). Adapting dialectical behaviour therapy for children: Towards a new research agenda for paediatric suicidal and non-suicidal self-injurious behaviours. *Child and Adolescent Mental Health, 16,* 116–121. http://dx.doi.org/10.1111/j.1475-3588.2010.00583.x

Pfeffer, C. R. (1986). *The suicidal child.* New York, NY: Guilford Press.

Pfeffer, C. R. (1987). Elements of treatment for suicidal preadolescents. *American Journal of Psychotherapy, 41,* 172–184.

Pfeffer, C. R., Jiang, H., & Kakuma, T. (2000). Child-Adolescent Suicidal Potential Index (CASPI): A screen for risk for early onset suicidal behavior. *Psychological Assessment, 12,* 304–318. http://dx.doi.org/10.1037/1040-3590.12.3.304

Range, L. M., & Knott, E. C. (1997). Twenty suicide assessment instruments: Evaluation and recommendations. *Death Studies, 21,* 25–58. http://dx.doi.org/10.1080/074811897202128

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. http://dx.doi.org/10.1016/j.jad.2013.06.026

Sarkar, M., Byrne, P., Power, L., Fitzpatrick, C., Anglim, M., Boylan, C., & Morgan, S. (2010). Are suicidal phenomena in children different to suicidal phenomena in adolescents? A six-year review. *Child and Adolescent Mental Health, 15,* 197–203. http://dx.doi.org/10.1111/j.1475-3588.2010.00567.x

Shaffer, D., & Pfeffer, C. R., & the American Academy of Child and Adolescent Psychiatry. (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of the American Academy of Child & Adolescent Psychiatry, 40,* 24S–51S. http://dx.doi.org/10.1097/00004583-200107001-00003

Taussig, H. N., Harpin, S. B., & Maguire, S. A. (2014). Suicidality among preadolescent maltreated children in foster care. *Child Maltreatment, 19,* 17–26. http://dx.doi.org/10.1177/1077559514525503

Tucker, R. P., Crowley, K. J., Davidson, C. L., & Gutierrez, P. M. (2015). Risk factors, warning signs, and drivers of suicide: What are they, how do they differ, and why does it matter? *Suicide and Life-Threatening Behavior, 45,* 679–689. http://dx.doi.org/10.1111/sltb.12161

Viñas, F., Canals, J., Gras, M. E., Ros, C., & Domènech-Llaberia, E. (2002). Psychological and family factors associated with suicidal ideation in pre-adolescents. *The Spanish Journal of Psychology, 5,* 20–28. http://dx.doi.org/10.1017/S1138741600005795

Wagner, B. M. (2009). *Suicidal behavior in children and adolescents*. New Haven, CT: Yale University Press. http://dx.doi.org/10.12987/yale/9780300112504.001.0001

Wagner, B. M., Silverman, M. A. C., & Martin, C. E. (2003). Family factors in youth suicidal behaviors. *American Behavioral Scientist, 46,* 1171–1191. http://dx.doi.org/10.1177/0002764202250661

Weinstein, S. M., Van Meter, A., Katz, A. C., Peters, A. T., & West, A. E. (2015). Cognitive and family correlates of current suicidal ideation in children with bipolar disorder. *Journal of Affective Disorders, 173,* 15–21. http://dx.doi.org/10.1016/j.jad.2014.10.058

Weller, E. B., Young, K. M., Rohrbaugh, A. H., & Weller, R. A. (2001). Overview and assessment of the suicidal child. *Depression and Anxiety, 14,* 157–163. http://dx.doi.org/10.1002/da.1061

Westefeld, J. S., Bell, A., Bermingham, C., Button, C., Shaw, K., Skow, C., . . . Woods, T. (2010). Suicide among preadolescents: A call to action. *Journal of Loss and Trauma, 15,* 381–407. http://dx.doi.org/10.1080/15325024.2010.507655

Whalen, D. J., Dixon-Gordon, K., Belden, A. C., Barch, D., & Luby, J. L. (2015). Correlates and consequences of suicidal cognitions and behaviors in children ages 3 to 7 years. *Journal of the American Academy of Child & Adolescent Psychiatry, 54,* 926–37.e2. http://dx.doi.org/10.1016/j.jaac.2015.08.009

Wise, A. J., & Spengler, P. M. (1997). Suicide in children younger than age fourteen: Clinical judgment and assessment issues. *Journal of Mental Health Counseling, 19,* 318–335.

Wyman, P. A., Gaudieri, P. A., Schmeelk-Cone, K., Cross, W., Brown, C. H., Sworts, L., . . . Nathan, J. (2009). Emotional triggers and psychopathology associated with suicidal ideation in urban children with elevated aggressive-disruptive behavior. *Journal of Abnormal Child Psychology, 37,* 917–928. http://dx.doi.org/10.1007/s10802-009-9330-4