Kevin Crowley's
CAMS Clinical Corner

Hi everyone! It's wonderful to connect with you again.

Thanks so much for taking the time to check out this resource. I always appreciate your doing so, but I know that this is a particularly busy time of year with many demands on your time.

After our initial post in September, I got several wonderful ideas from people for topics to consider. The most frequent ones, perhaps unsurprisingly, mirrored the subject I get questioned about more than any other: **Drivers**.

I'd like to offer guidance on clarifying drivers in my **Clinical Musings** section. Then, please note how I've codified these thoughts into a **New Supplemental/Optional Form** you're welcome to take if desired!

Clinical Musings (December 2025)

What are Drivers?

Why do **YOU** want to die?

What is the problem suicide is trying to solve for **YOU**?

These explicitly asked questions are fundamental to CAMS, regardless of whether clinicians ask them in a single session assessment (CAMS-BI); a brief, discharge-focused episode of care; or a full course of treatment. If suicide is always an option, as CAMS holds, we need to understand what *drives* it to the top of someone's coping list.

Hence, **DRIVERS**.

Broadly defined, "drivers" in CAMS are person-specific answers to those questions. When patients tell us why they want to die or what suicide is trying to solve for them, we believe them. They answered the question! And that answer is ultimately what we need to address in our treatment plan for work to go beyond preventing behaviors into crafting a post-suicidal life.

This broad, quick overview typically lands well for and feels very appealing to most clinicians who attend our trainings. They understand the value of connecting with patients around why they want to die **in their patients' own words**.

But then what?

How do we transition from someone's initial words to an effective treatment plan?

I can't without their narrative.

The Importance of Understanding YOUR Narrative

A few years ago, I had two young women present for suicide-focused care within three weeks of each other. They, strikingly, both told me that they wanted to die because of PTSD following sexual assaults.

In both cases, these clients gave me a “driver.” They each told me why they wanted to die in their own words. But even though they answered this question, I could not explain **why** PTSD was deadly for either.

We certainly know that PTSD is a profoundly painful experience! But having PTSD is not a “one way ticket” to wanting to die by suicide. There’s more to that story I want to understand.

I need to clarify their narratives.

- What it is about X you feel you can’t live with/cope with?
- What it is about X you feel you’d rather die than manage?
- What is it about X that takes this problem from feeling painful to being deadly for you?

These specific questions are almost always where I choose to start clarifying the narrative of someone’s drivers. And they can quickly and directly help us set our whole treatment trajectory.

Consider these cases. When asked what was it about PTSD that Client A felt she couldn’t live/cope with, she referenced hyperarousal. She acknowledged how physically painful it was to leave her apartment for any reason, even if around safe people. When she sharing this, she tearfully looked into her hands and said, “If this is what I’m going to have to feel every time I go outside for the rest of my life, I’d rather be dead.”

Client B’s relationship with suicide reflected a different narrative. She blamed herself for her assault, and couldn’t get “unstuck” from the idea that it was “her fault” that she was “unlovable.” She very sadly and directly acknowledged feeling that: “if it's my fault that no one will want me and I can't be a wife and mom, I should just kill myself now.”

Treatment Planning Implications

It can be very tempting to begin charting a course for treatment the minute someone gives us some an to the question of why they want to die. And charting a course that quickly can seem in line with fundamental CAMS philosophy! After all, isn't targeting "PTSD" once I hear that answer in the cases above doing exactly what CAMS suggests: going after the pain this person says suicide is trying to solve for them?

It is and it isn't.

Had I immediately hopped into a treatment broadly targeting PTSD without narrative context, I could have set us on a trajectory that missed the specific aspect of my clients' experience that was too painful to live with. I could, for example, have offered a wonderful course of treatment that allowed Client B to better manage physiological PTSD symptoms.

But would she have been satisfied with that, or *could her relationship with suicide have changed*, if she still felt unlovable when we were done?

When we take the time to sit in someone's pain and clarify their narrative around it, we start **changing the language** they use to describe their drivers. We "sharpen" the way they describe these problems by using language that is more specific and reflective of their internal experiences.

This leads to more effective treatment planning.

Seeing changes in problem/driver language towards something that catches individual ways of thinking/feeling/filtering is a wonderful sign that you've gotten more "direct" in your conceptualization. And it is a concrete, notable sign of insight! But changing that language does so much more.

It's often the key to a plan we both feel good about.

It certainly clarifies what I want to try first in treatment.

As a reminder, when I'm setting suicide-focused treatment plans in CAMS, my first goal is for us to facilitate safety and stability. But then, as quickly as possible, I want to "sell" you on a path we can walk that gets you to a "post-suicidal" life, or a life where you don't feel you need suicide at the top of your options list.

A trajectory like that is much easier to "gamble on" for clients when they see *exactly* how this treatment targets the aspects of their problems that make them want to die.

Demonstrating that we have a plan that can address PTSD is wonderful; showing you *specifically* that this plan will directly target "hyperarousal" and or feeling "unlovable" hits a "bullseye."

A connection and understanding like that is the start of a treatment worth staying alive for.

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New Resource:

Concrete Strategies for Troubleshooting Difficult Drivers

I really love the CAMS Therapeutic Worksheet (CTW), a wonderful, optional form developed by Dr. Stephen O'Connor. As you may remember, we recommend using it early in treatment to clarify someone's "relationship history" with suicide and visually map a conceptualization of their drivers.

But questions often come up around its implementation, including:

- What do I do if someone's stuck on their narrative and "doesn't know" how to answer certain questions?
- Are there specific questions you recommend for getting "sharper" drivers?

- What are specific things I can think about when planning treatment?
- What do I take from the form and put in the treatment planning boxes?

Given these questions, I thought it might be helpful to put together a supplemental tool that codifies my approach to sharpening driver narratives and shows how I use new language to update treatment plans. You're welcome to use it on its own or pair it with the CTW.

Please feel free to access that form here:

- Troubleshooting Difficult Drivers: Lined Form (In Person)
- Troubleshooting Difficult Drivers: Fillable Form (Telehealth)

When you look at this form, you'll notice that it spans two pages. Here's what I intended to do with each.

Page 1*: *Clarifying the Narrative
I set this form up to cover one driver/problem description, though you could easily write or type in answers for both "problems" someone offered on their Treatment Plan.

The first page is bookend-ed in "language" questions. As clients and I look at this form together, I want to start with the language they currently use to describe their driver(s). Remember, it's a "right answer" already!

Most likely, the answer for this question will be taken directly from their most recently completed "treatment plan" (the language we used for their "Problem Description").

Then, *after* we clarify the narrative of their drivers, I want to explicitly and directly highlight the extent to which their language changed to something more direct, internal, and specific in the span of just a few minutes (see the last question on Page 1).

That change is facilitated by the narrative questions I ask in the middle of that “language sandwich.” These are specific questions I have personally found very helpful for sharpening drivers.

I don’t ask every one of the questions I’ve listed to every CAMS client every time. In fact, this list is more comprehensive than you may need. But I wanted to offer several options I’ve found most helpful so that you have semantic choices to consider together.

Page 2: Treatment Planning Implications

The second page allows us to specifically consider what to do in our treatment plan now that we have this new sharper understanding.

For the **goals/objectives**, there are several options that might be relevant! In all cases, goals/objectives reflect the overarching things we want to accomplish that will change our client's relationship with suicide. But with our new understanding, what’s the course that makes the most sense now?

Can we **change** something directly, or do we need to **challenge** perceptions?

Can we **solve** the problem, or would it be more fruitful to help you **live with it** instead of **die from** it?

Options we can consider together are listed here. And what we decide can be entered in the corresponding box of the CAMS Treatment Plan.

If those goals are where we’re headed, what are the specific steps that help us to get there? Those assessment opportunities, skills, protocols, or referral options are the **interventions** we want to list. Any assessment/skill/protocol is “right” if used to address the specific pain

suicide is trying to solve!

The more specific our understanding of the narrative, the more interventions will feel “right.” And the more specific our intervention selection becomes, the easier it is to know the **duration** we want to set for focusing our work in this way.

Whether you are newer to CAMS and looking to build skills in its application or more seasoned and looking for something new to consider in tricky cases, I hope you find this form helpful. You are certainly welcome to download/print/give to any clients or colleagues you’d like to share with!

I’m so grateful to my colleagues **Leah Meilander** and **Heidi Hamamoto** for their partnership in formatting and executing these.

Looking forward to speaking with you again soon! Please don’t hesitate to reach out if I can be helpful in the meantime.

Happy Holidays!

kevin.crowley@cams-care.com
