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The Content of Patient-Identified Suicidal Drivers within CAMS Treatment Planning

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ABSTRACT

The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based, suicide-focused, clinical framework that effectively treats people who are suicidal across clinical settings. A central tool within CAMS is the Suicide Status Form (SSF) which is a multipurpose assessment, treatment planning, tracking, to clinical outcome tool that guides suicide-focused care from the start of CAMS treatment to completion. Previous SSF assessment research investigated the content of patient-written qualitative responses to SSF assessment prompts which were reliably coded into twelve content categories. Four coding categories captured 70% of written responses revealing the content of patients' suicidal ideation which centered on: relationships, vocation, the self, and unpleasant internal states. While qualitative SSF assessment research has thus revealed key information about suicidal ideation content, patient-identified "drivers" of suicide within CAMS treatment planning have not yet been examined qualitatively. "Drivers" of suicide are the issues that compel one to consider suicide, and ultimately become the focus of CAMS treatment; thus, it is important to examine their qualitative content. The present exploratory study investigated suicide driver content collected in the context of two randomized controlled trials of CAMS. Reliably coded qualitative content of patient-articulated drivers were comparable to previously noted SSF content assessment results, emphasizing the following driver issues: (1) Relationships, (2) Unpleasant Internal States (e.g., suffering and anxiety), (3) Role Responsibility (vocational concerns), and (4) the Self (e.g., self-hatred or esteem issues). These four coding themes captured 70% of 332 total treatment planning drivers obtained from 166 patients who were suicidal and seeking treatment. Implications of these findings are discussed.

KEYWORDS

CAMS; drivers; suicidal ideation; treatment planning

Central to effective assessment and treatment of suicide risk is the need to understand the suicidal mind. Jobes and Joiner (2019) have argued that despite an understandable preoccupation with suicide behaviors, we should consider the importance of suicidal ideation, in and of itself. Research has shown us that suicidal ideation is much more complex when we seek to understand the words of those who have suicidal thoughts. Jobes et al. (2004) studied the written responses of 119 college students and 33 U.S. Air Force Airmen who were suicidal analyzing patient-written responses to open-ended prompts on the Suicide Status Form (SSF) in a first session of the Collaborative Assessment and Management of Suicidality (CAMS—Jobes, 2016). CAMS is a suicide-focused clinical intervention with

extensive empirical support (Swift, Trusty, & Penix, 2021). The SSF is a multipurpose assessment, treatment planning, tracking to clinical outcome tool that is central to CAMS. Using a modified version of Consensual Qualitative Research (Hill, Thompson, & Williams, 1997), Jobes et al. (2004) reliably coded patients' written responses to SSF prompts related to psychological pain, agitation, stress, self-hate, and hopelessness. A total of 636 total SSF obtained written responses were coded (with high inter-rater reliability—Kappa's $>$ .80) using 12 content categories. The following four content themes accounted for two thirds of patients' written responses: (a) "relational" content was 22% of responses, (b) "role responsibility" content (i.e., vocational issues) was 20% of responses, (c) "self" content captured 15% of responses, and (d) "unpleasant internal states" (e.g., suffering or misery) was 10% of the responses. The authors observed that 90% of the suicidology literature was focused on depression and symptoms of mental disorders (i.e., unpleasant internal states). These qualitative SSF assessment results showed the content of suicidal thinking, which was markedly different from the psychopathology-focused suicidology literature.

Describing Suicidal Drivers

CAMS emphasizes the importance of identifying and treating problems that cause suicide as identified by patients who are suicidal (i.e., suicidal "drivers" in CAMS parlance—Jobes, 2016). For example, a combat Veteran might note that upsetting memories and/or guilt and shame stemming from a combat-related traumatic event causes them to feel suicidal (i.e., "combat-related PTSD" is the driver). The driver-focused CAMS treatment might then involve using a specialized treatment for PTSD or trauma (e.g., exposure type therapy). Alternatively, if a college student identifies that self-hatred causes them to consider suicide, a CAMS provider might then use cognitive therapy or insight-oriented therapy to target and treat the student's driver of self-hate. Notably, randomized controlled trials (RCTs) of CAMS show identifying and treating suicidal drivers significantly reduces suicidal ideation (Comtois et al., 2011; Jobes et al., 2017; Ryberg, Zahl, Diep, Landrø, & Fosse, 2019), overall symptom distress (Comtois et al., 2011; Ryberg et al., 2019), and hopelessness (Comtois et al., 2011; Pistorello et al., 2018), while hope and retention to care is increased (Comtois et al., 2011).

Since SSF assessments help inform CAMS driver-focused treatment, we might assume that SSF-based qualitative assessment content would be highly correlated with the content of patient-identified drivers within CAMS treatment planning. However, the content of patient-defined drivers has never been studied. The present study thus aimed to: (1) determine whether it would be feasible to use the SSF assessment response content coding scheme (Jobes et al., 2004) to code treatment planning driver content, and (2) use two RCT samples of patients engaged in CAMS to compare obtained qualitative driver content with SSF assessment response content.

METHOD

Participants

The "Operation Worth Living" (OWL) RCT compared CAMS to Enhanced Care as Usual (E-CAU; Jobes et al., 2017). CAMS treatment planning data was used from

89 active-duty U.S. Army Soldiers with significant suicidal ideation (i.e., > 12 on the Scale for Suicidal Ideation-Current). All study procedures were conducted at the Department of Behavioral Health at an Army Medical Center on an infantry military installation. The OWL study sample included Soldiers who spoke English, were at least 18 years old, and had significant suicidal ideation. Participants were excluded based on the following three criteria: (1) the inability to understand, benefit or consent from study procedures due to psychosis, paranoia, or where psychosocial therapeutic care was otherwise contradicted, (2) judicial order to treatment, and (3) separation change of station or deployment expected within the next twelve weeks. Pregnant Soldiers and Soldiers in the warrior transition unit were also excluded as per military requirements (Jobes et al., 2017). Patient-identified drivers obtained from first sessions of CAMS were used. Two drivers are routinely identified in CAMS treatment planning, which yielded a total 178 first-session drivers. The "Aftercare-Focus Study" (AFS) RCT compared CAMS to Usual Care (Comtois et al., 2022) and was comprised of 77 adult outpatients who had recently been discharged from inpatient psychiatric care following a recent—or historic—suicide attempt and received CAMS. The AFS sample included participants from two university medical centers with the following inclusion criteria: (1) inpatient or emergency department admission for suicidal risk, (2) suicide attempt in the past month, (3) no appropriate outpatient mental health appointment within two weeks, (4) a NDA (next day appointment) as an appropriate disposition plan, and (5) consent to study procedures. The following exclusion criteria were used for participants in this study: (1) under 18 years of age, (2) insufficient English, (3) too psychotic or manic, aggressive or cognitively impaired, (4) patient not stable enough to be discharged 24 hours before the NDA, (5) court-ordered to outpatient or, (6) lived too far away (Comtois et al., 2022). A total of 154 first-session drivers were obtained from the CAMS arm of the AFS RCT. When considering the two samples in our current research, the commonalities across the two samples was evident. That said, AFS participants were somewhat more severe in that they were recently discharged inpatients who have made suicide attempts (Comtois et al., 2022). In contrast the OWL was a bit more high functioning as active-duty outpatients performing military service.

Measures

The Suicide Status Form (SSF-4)

The SSF is a multi-purpose assessment, treatment planning, tracking, to clinical outcome tool that is used across CAMS-guided care. The validity and reliability of the SSF Core Assessment has been extensively studied (Brausch et al., 2019; Conrad et al., 2009; Jobes, Jacoby, Cimbolic, & Hustead, 1997). There are also qualitative studies of the SSF assessment (Jobes et al., 2004; Jobes & Mann, 1999). The driver-focused treatment plan section of the SSF has become a recent focus of study (e.g., Gregorian, 2021). The present study extracted patient-identified driver responses as recorded by providers in first sessions of CAMS from the OWL (Jobes et al., 2017) and AFS (Comtois et al., 2022) RCTs.

Analytic Procedure

To code patient-identified driver content, we initially used the methodology described by Jobes et al. (2004) for coding of SSF assessment response content. This coding system had twelve content category themes: (1) Relational (e.g., "a break-up"), (2) Self (e.g., "I hate myself"), (3) Helpless (e.g., "nothing will help"), (4) Global/General (e.g., "everything, my life sucks"), (5) Unpleasant Internal States (e.g., "my depression, misery"), (6) Unsure/un-code-able (e.g., "I can't say"), (7) Role Responsibility (e.g., "college life;" "being a mother;" "my job"), (8) Situation-Specific (e.g., "when I go to bed"), (9) Compelled to Act (e.g., "something has to change"), (10) Future (e.g., "realizing my dreams"), (11) Internal Descriptors (e.g., "I am a coward"), and (12) External Descriptors (e.g., "I am fat and ugly").

To code treatment driver content, we therefore began using the SSF assessment coding system which was then modified to capture any novel content that arose in our investigation of treatment driver content. To this end, we retained 10 of the original content coding themes and eliminated Internal Descriptors (which was absorbed into Self) and Compelled to Act (both of which occurred rarely within driver responses). We added Problematic Behaviors as a new content theme given the frequency of these responses (e.g., "my drinking;" "my gambling") resulting in a final list of eleven treatment driver content theme coding categories.

RESULTS

The revised coding scheme reliably captured the treatment driver content obtained from the two RCTs. We had excellent inter-rater reliability for the coding of the OWL treatment driver content with an overall Kappa value of .979. Three coding categories captured 63% of all code-able responses: Unpleasant Internal States (28%), Relational (21.9%), and Role responsibility (14%). Similarly, we obtained strong inter-rater reliability for the coding of the AFS treatment driver content with an overall Kappa value of .784. Four coding categories captured 72% of code-able responses: Relational (27.9%), Self (18.8%), Unpleasant Internal Statues (14.9%), and Role Responsibility (11%).

Following the Jobes et al. (2004) approach, we then combined both samples to obtain a larger and more diverse dataset of 166 patients who identified a total of 332 drivers. The combined results are shown in Table 1 where we see that 70% of all patient identified treatment driver content was reliably captured under four content themes: (1) Relational (24%), (2) Unpleasant Internal States (22%), Role Responsibility (12%), and Self/Internal Descriptors.

DISCUSSION

This study is the first qualitative investigation of patient-identified treatment driver content that emerges in the course of CAMS treatment planning. In the present study, treatment driver content focused on: (1) Relationships, (2) Unpleasant Internal States (e.g., suffering and misery), (3) Role Responsibility (vocational concerns), and (4) the Self (e.g., self-hatred or esteem issues). These coding categories captured 70% of 332 total treatment planning drivers obtained from 166 patients in the two RCTs.

TABLE 1. Combined AFS and OWL Drivers ($n = 332$).

	Frequency	Percent
Relational	82	24.6988
Unpleasant Internal States	74	22.2892
Role Responsibilities	42	12.6506
Self/Internal Descriptors	41	12.3494
Uncodable	32	9.6386
Global/General	17	5.1205
Helpless/Hopeless	14	4.2169
Situation Specific	9	2.7108
External Descriptors	8	2.4096
Problematic Behaviors	8	2.4096
Future	5	1.5060
Total	332	100.0000

Before the present investigation, there was every reason to believe that the content of patient-identified drivers of suicide within CAMS treatment planning would be quite similar to CAMS SSF assessment content seen in the Jobes et al. (2004) study. As we examine the results of the present study, we see distinct similarities between previous assessment content findings (Jobes et al., 2004) and the current driver content findings, but there are some noteworthy differences. What is most clear from both qualitative studies of suicide ideation content, is that relational issues are the primary concern for those who consider suicide. Similar to the Jobes et al. (2004) assessment content findings, the present driver-focused study also confirmed the significance of what people do vocationally and a-vocationally (i.e., Role Responsibility) and struggles within themselves (Self) as major content foci within suicidal thinking. However, in the present study we see a notable focus in driver content related to suffering, misery, depression, upset, etc. (i.e., Unpleasant Internal States) with a percentage that is twice as great as was seen in the Jobes et al. (2004) SSF assessment content study. Perhaps there is a difference between assessment queries and treatment-focused queries that may reveal an urgent desire for a treatment that will help them feel less miserable. And to this end, it is particularly noteworthy that a major replicated finding seen across various CAMS clinical trials is that use of CAMS causes a significant decrease in overall symptom distress (i.e., unpleasant internal states) when compared to control care (refer to a meta-analysis of CAMS trials by Swift et al., 2021).

There are of course limitations to this study. As with any qualitative coding system, our system to code driver content had breadth to account for the full range of responses but lacked depth and specificity. For example, "Unpleasant Internal States" would be coded for a range of psychic suffering content, from feeling "icky," to "profound emptiness." Additionally, one may consider the collapsing of data across the two samples used as problematic as they are different. Similar to the Jobes et al. (2004) assessment content study, the present driver content study did not have any a-priori hypotheses. This research was purely exploratory in nature as we endeavored to examine whether the content of suicide ideation revealed in assessment prompts would be similar or different to content derived during suicide-focused treatment planning. As with any research there are cultural factors to consider when performing qualitative coding as was done in this project. As qualitative researchers, we recognize that our attributes, previous life experiences, and inherent internal biases impact what we see and the conclusions that we draw.

Importantly, the treatment planning driver content we studied comes directly from patients who described in their own words what compels them to consider suicide with direct implications for additional theory, research, and clinical practice. Future research may benefit from further examining this descriptive and reliable qualitative driver content coding system with larger and more diverse samples to help inform suicide-specific theories and treatments. It may also be beneficial to examine this qualitative driver content coding system in relation to other coding systems and/or established quantitative measures to determine what measures comprise the most clinically useful and comprehensive assessment and treatment of suicidal risk.

In summary, this brief article explored how treatment-seeking patients who are suicidal think about suicide. It is noteworthy that the vast majority of people who die by suicide do not seek mental health care (Jobes & Chalker, 2019). But for those who do seek mental health care, too often that "care" is a brief inpatient admission and perhaps medication, both of which have limited empirical support. Upon reflection, should we not ask our patients, what makes you suicidal and then set about trying to treat those exact concerns? Within the CAMS approach to suicide-focused care, this is exactly how we provide treatment to help patients to understand and manage their suicide risk so that they may better pursue a life they want to live.

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AUTHOR NOTES

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