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ORIGINAL PAPER

My Approach to Psychotherapy: A Journey and Personal Reflections

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Abstract
This article describes a professional journey in the field of clinical suicidology that led to the creation and the development of an evidence-based, suicide-focused, clinical treatment called the "Collaborative Assessment and Management of Suicidality" (CAMS). Several professional challenges and successes are described along with personal experiences that have shaped this approach to working with suicidal risk. Some reflections and lessons-learned about effective psychotherapy are proffered based on over four decades of work as a clinician, researcher, teacher, and supervisor. It Is argued that evidence-based, patient-centered, psychotherapy that stresses empathy, collaboration, and honesty is an ethical and professional imperative for providing effective care and realizing optimal clinical outcomes.

Keywords Clinical Suicidology · Assessment · Treatment · CAMS · Psychotherapy

I grew up in a suburb of Cleveland Ohio, raised by archetypal "Greatest Generation" parents who met on a blind date during World War II and married six months later at the U.S. Naval Academy. Their 58-year marriage was conventional. Mom was a devoted homemaker and dad worked to support our family that included my two older brothers and me. Dad loved his electrical engineering education yet routine engineering work compelled him to transition from engineering to personnel work within a large manufacturing company making parts for airplanes, NASA, and for the U.S. military. Working in human resources became his passion as he explored "organizational development" in the nascent days of what we now call industrial-organizational psychology. He led T-groups, personal growth workshops, and applied transactional analysis to optimize human potential within his company. His home office was stacked with books on applied psychology and copies of *Fortune Magazine*, *Business Today*, *Popular Mechanics*, and *Psychology Today* were scattered around our house. I remember perusing *Psychology Today* with fleeting youthful curiosity. Some sixty years later, I now post blogs on the *Psychology Today* website under the heading "The Psychology of Life: Perspectives from a Clinical Suicidologist."

I was an academic underachiever, taking honors courses in middle school and high school and exasperating my teachers with my lackluster motivation. I then became an unfocused college student, transferring each year of college. I was a freshman at Miami (of Ohio) University and transferred to the University of Colorado (with a penchant for rock climbing). My junior year at Ohio State was personally challenging and I ended up transferring back to the University of Colorado (CU) for my senior year. I grudgingly majored in psychology when my favorite philosophy professor at CU bluntly talked me out of my plan to major in philosophy saying to my dismay, "…it's a dying field with no future, get out now and don't look back!" My atypical college education proved to be problematic when, at the end of my senior year, I realized I wanted to become a clinical psychologist after talking with a Ph.D. student in a hallway of the CU psychology building. My grades were unremarkable and I had neither applied nor research experiences—clearly, not a formula for getting into highly competitive Ph.D. programs. After graduation, I retreated back home to Cleveland to figure out what do. Unexpectedly through family friends (and plain dumb luck) I got an applied position working at a children's rehabilitation hospital as a Recreational Therapy Worker. My job was to play with toddlers and latency age children, leading field trips and organizing activities for disabled, dislocated, and often

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forgotten children. It was a dream job for an inexperienced 22 year old. I then went to the Psychology Department of Case Western Reserve University and literally went door-to-door of faculty offices to volunteer for much needed research experience. I was thrilled to get a part-time volunteer Research Assistant position conducting basic research in a perceptual psychology lab with geriatric subjects. Armed with my minimally accrued qualifications, I applied to clinical psychology Ph.D. programs with great hopes but was promptly rejected by every program. Disillusioned, I began looking into the Peace Corp as my Plan B, but an unexpected letter from American University (AU) offering to switch my application from their Ph.D. to their M.A. program changed everything. I quickly applied and to my tremendous relief was admitted.

Moving to Washington D.C. in 1982, I began graduate school at AU and frankly struggled until I finally figured how to perform academically at a graduate level. I also got a part-time job as a Psychology Technician on a locked inpatient psychiatric unit. On my second day a newly admitted patient signed-out a pair of scissors ostensibly to trim his beard and proceeded to severely stab himself. The wounds were deep and serious, yet the patient was rescued by our skillful nursing staff, the EMTs, and ultimately the surgeons who narrowly saved his life. In the moments after the self-inflicted stabbings my charge was to gather all the patients on the unit into the day room and keep them there as the EMTs rushed the gravely wounded patient to the hospital. I was mortified. The suicide attempt of this severely depressed patient was my first-ever encounter with suicide—a focus that would become my professional calling.

A tentative curiosity about suicide was inspired by my psychopathology professor, Alan (Lanny) Berman, who was a luminary in the field of suicidology. Lanny opened countless doors and made my career in suicidology possible. He introduced me to all the 1980s leaders of suicidology including the field's founding fathers—Edwin Shneidman, Robert Litman, and Norman Farberow who founded the famous Los Angeles Suicide Prevention Center (LASPC), launching the first U.S. suicide prevention hotline in 1963, and basically creating the field of suicidology in America. Ed Shneidman founded the American Association of Suicidology (AAS) in 1968 and this organization and its annual conference became central to my professional journey. My first professional presentation was at the 1984 AAS conference where I presented my psychological autopsy research and Bob Litman—one of the creators of the technique—was my discussant. After my presentation, Bob invited me to visit the LASPC which I did after the conference and meeting Ed Shneidman convinced me to pursue a career in suicidology. At a later AAS conference reception, I introduced myself to Aaron (Tim) Beck who was kind and happily chatted with me. Years later Tim became an advisor and supporter of my early research. At yet another AAS conference, Lanny introduced me to Marsha Linehan (the founder of Dialectical Behavior Therapy—DBT) who would have a pivotal and transformative mentoring role in my professional life.

Upon reflection, my relative professional success can be attributed to hard work but also good timing and some lucky breaks. For example, as a graduate student I was invited to present my master thesis on use of psychological autopsies (Jobes et al., 1986) to a newly formed working group of senior medicolegal experts convened by the Centers for Disease Control to improve the validity and reliability of certifications of suicide as a manner of death. After presenting my work, these august experts invited me—a mere graduate student—to join their working group that convened several times across the country to create new operational criteria for the medicolegal certification of suicide in the U.S. (Rosenberg et al., 1988). My early exposure to such high-level professionals and publishing articles in graduate school was exciting, but in truth I secretly felt like a pretender. As Lanny's protégé, I was apparently seen as an up-and-coming suicidologist but in reality I had neither the content expertise nor sufficient experiences to warrant any "rising star" label. Nevertheless, the early and generous support I received from leaders in the field enabled me to work through my private insecurities and inspired me to develop genuine expertise as I increasingly transitioned towards clinical aspects of suicidology.

I was completing my clinical internship at the Washington DC VA Medical Center in 1987 when a friend told me about a job at The Catholic University of America. I applied and surprisingly got the job, for which I was utterly unprepared. I worked 2/3 time in the CatholicU Counseling Center as a staff counselor and 1/3 time in the Department of Psychology as an assistant professor. In the Center I saw 15 clients, supervised two clinical externs (who each saw 8 clients), and led the group therapy program. In the Department I taught (for the first time) a graduate course on personality theory. While struggling to master various aspects of my new job, I was also was feverishly working to complete my dissertation. I was immersed at the time in personal psychotherapy and I additionally received two hours of clinical supervision per week accruing hours towards licensure. Consequently, my first year at CatholicU was exhilarating and exhausting and ultimately laid the foundation for my subsequent professional life.

The Counseling Center Director, Peter Cimbolic, valued my work in suicidology and charged me with creating a new approach for identifying, assessing, and tracking suicidal risk within the agency. To this end, I conducted a national survey of clinicians through the AAS Risk Assessment Committee to gain valuable insights about how clinicians

assess suicidal risk (Jobes et al., 1995). In turn, this survey prompted a new line of assessment-focused research using the "Suicide Status Form" (SSF). My ongoing supervision with Pete was cognitive-behavioral and I received secondary supervision from a gifted private practice clinician—Steve Stein—who had expertise psychodynamic theory (focused on object-relations and self-psychology). Steve also facilitated specialized training in clinical hypnosis which significantly influenced both my assessment skills and shaped my approach to psychotherapy. I was hired to teach the Rorschach Inkblot Test to our Ph.D. clinical psychology students and thus developed expertise in the approach. Taken together, these early influences and professional experiences were collectively formative, synergistic, and became indispensable to my future work in clinical suicidology.

While early SSF assessment research was promising (e.g., Jobes et al., 1997), a strictly quantitative approach provided an incomplete understanding. My colleague George Bonanno helpfully suggested adding a qualitative focus to better understand the suicidal mind leading to a valuable line of research (e.g., Jobes & Mann, 1999; Jobes et al., 2004). At this time, Lanny received a request to conduct a "process improvement" (PI) project in a large managed healthcare system in the intermountain West. He invited me and several of my PhD students to join the PI effort as the medical director of this system was keen to use the SSF. In a PI meeting in Lanny's office I first conceived the "Collaborative Assessment and Management of Suicidality" (CAMS) as a novel way to administer the SSF. Undoubtedly influenced by my Rorschach work, I proposed a side-by-side seating arrangement to help facilitate a collaborative, patient-centered, suicide assessment method using the SSF. What the patient rated and narratively wrote on the SSF would be the assessment "gold standard" (i.e., the patient knows best). Thus, within a CAMS administration of the SSF, a clinician's singular task was to see the patient's suicidal struggle *through the eyes of the patient*. At the time, this phenomenological approach was a major departure from a purely risk factor approach that was in vogue wherein the clinician knows best. Moreover, side-by-side seating when using CAMS meta-communicates: *I am with you in your suffering and together we will "co-author" a treatment plan to address the "drivers" that make you consider suicide* (Jobes, 2023).

What followed was the most exciting and then the most devastating experience of my early career. We obtained a modest private foundation research grant to support a feasibility randomized controlled trial (RCT) of CAMS within this healthcare system. There were countless hours of hard work and three dissertations were embedded into the PI effort. Many trips were made out West to further develop the RCT and then train clinical providers. The RCT was finally launched with great expectations that were abruptly dashed when the study was terminated within weeks because the clinicians we trained refused to use CAMS in defiance of the medical director. My three students were devastated as we had to create new dissertations (adding another year of graduate school). The first CAMS RCT ended before it even got started. Needless to say, I too was distraught as I ignominiously returned the unspent grant funding to the foundation in the wake of the study's failure. It was a profoundly sobering indoctrination to clinical trial effectiveness research and the experience was heartbreaking.

Paradoxically while my clinical trial research program was in ruins, I was elected President of AAS. Even while the RCT failure was painful, I remained steadfast about the idea of CAMS. Around this time I happened to reconnect with a former CatholicU undergraduate research assistant—John Drozd—at a community workshop that I was leading in Colorado Springs. John had become a Captain in the U.S. Air Force and he told me over lunch that every third Airman seen in two outpatient clinics were actively suicidal. Still reeling from the failed CAMS RCT, I gladly agreed to help John do something therapeutic for these patients. The following week I "trained" John in CAMS via fax machine and long distance phone calls using the CAMS manual we wrote for the failed trial. As a gifted psychologist, John immediately understood the approach and was especially excited about the key CAMS idea of keeping a patient who is suicidal *out of the hospital* if at all possible—a controversial notion at that time. John's enthusiasm led him to offer an internal staff training on CAMS and some of his colleagues began to use the approach while others did not. An organic non-randomized clinical trial of an early version of CAMS (in comparison to usual care) was conducted accordingly (Jobes et al., 2005). There were exciting correlational results from this naturalistic clinical trial showing significant reductions in suicidal ideation, emergency department visits, and primary care visits in comparison to usual treatment. This pivotal study provided crucial early correlational support for CAMS. This work also marked the start of a long and productive involvement with the celebrated U.S. Air Force Suicide Prevention Program which led to many years of rewarding professional work with the U.S. Navy, Marine Corp, Coast Guard, and ultimately the Army.

I publicly presented CAMS for the first time as part of my Presidential Address at the 1999 AAS Annual Conference (Jobes, 2000). Immediately following my speech, a Swiss psychiatrist named Konrad Michel raced up to the dais and with great excitement invited me to attend a think-tank that he was convening in Switzerland and I instantly accepted. This unexpected encounter ultimately led to a key collaboration with Konrad creating the "Aeschi Approach" to assessing suicidal risk resulting in ten conferences (initially in

Switzerland and later Colorado) and an edited book (Michel & Jobes, 2011). The "Aeschi movement" and related conferences were a perfect incubator to further develop and present my SSF research and early CAMS research. It was largely through Aeschi that I came to know John (Terry) Maltsberger, an eminent psychoanalyst at Harvard, who was known for his pioneering work on countertransference and suicidal risk. One of my favorite early publications was a chapter we wrote describing the "therapist-voyeur" who out of "empathic dread" avoids patients who are suicidal. In contrast we advocated for the "therapist-participant" who actively engages patients who are suicidal and we spoke to the countervailing need of "empathic fortitude" (Jobes & Maltsberger, 1995). Terry became a close friend and mentor and was a huge influence. Luminaries from around the world attended the intimate clinically-focused Aeschi meetings. Among the repeat attenders at Aeschi was Marsha Linehan (who had also started her career in my Department at CatholicU before transitioning to the University of Washington). During one particular Aeschi meeting, Marsha firmly pressed me to move beyond my assessment-oriented research and pursue grant funding to conduct RCTs of CAMS, and she generously offered to mentor me. While I was flattered, I was honestly quite apprehensive and daunted about living up to Marsha's high standards. Nevertheless, how I could I possibly say no?

Marsha said my need of further research mentorship helped her appreciate a larger problem and she declared, "I need to transform the field!" True to form, Marsha promptly set about convening a series of meetings in Seattle in the early 2000's to mentor young investigators. We paid our own way and were invited to bring along 2–3 students to learn about suicide research and grant writing. Marsha also asked senior colleagues—people such as Steve Hollon, Marc Williams, Greg Carter, and Keith Hawton—to provide sage wisdom on research design, RCTs, and writing grants. At the first meeting I met a key future clinical trial collaborator—Kate Comtois—and many current leaders of contemporary suicidology gratefully attended such as David Rudd, Matt Nock, Cheryl King, Greg Brown, Barbara Stanley, Marjan Holloway, Thomas Joiner, Shireen Rizvi, among other notables (with apologies to those I am not recalling). Inspired by Marsha and these meetings, I wrote my first NIMH R-34 CAMS RCT grant proposal recruiting college students form five Washington D.C. university counseling centers with Marsha and Greg Brown (who worked with Tim Beck at Penn) serving as research consultants. After an initial positive review on our first grant proposal, the follow-up proposal failed to even be reviewed. While the grant with Marsha and Greg failed, the experience was still priceless given what I learned and this work cemented my relationships with Marsha and Greg. Undeterred, and with new zeal for grant-writing, I wrote several more CAMS RCT grant proposals to the Air Force and the American Foundation for Suicide Prevention (AFSP) and was not funded. All told, I wrote grant proposals for almost ten years before Kate Comtois finally obtained an AFSP grant to conduct a feasibility RCT in Seattle comparing CAMS to treatment as usual (TAU) and I happily served as Co-Principal Investigator. In this breakthrough RCT we ultimately found that when compared to TAU, CAMS significantly reduced suicidal ideation and overall symptom distress, while CAMS significantly increased hope and decreased hopelessness. We were further pleased to see that patients significantly preferred CAMS over TAU (Comtois et al., 2011).

During my grant writing travails, I became convinced that writing a book on CAMS could be helpful. Marsha initially opposed the idea arguing that I should wait for more RCT support. In a rare instance of respectful disagreement, I told her that I was going to pursue a book anyway which I felt was warranted given my SSF assessment research. I noted that I could write follow up editions as CAMS RCTs were accrued. Marsha ultimately agreed and then graciously insisted on introducing me to her editor at Guilford Press (with whom she had published her DBT work). I was delighted when Ed Shneidman enthusiastically agreed to write the foreword and I eagerly dug into writing the new book during a sabbatical. Upon reflection, the relative success of CAMS directly coincides with the publication of three editions of this book. The original text largely focused on the assessment aspects of CAMS (Jobes, 2006), while the second edition increasingly focused on RCT-supported treatment of patient-defined "drivers" of suicide within CAMS-guided care (Jobes, 2016). Finally, the third edition (Jobes, 2023) solidified the overall CAMS Framework that was robustly supported by replicated clinical trial evidence. The final book of this series focused on the full course of "standard" CAMS—from the initial first session, through interim sessions, to the outcome/disposition final session and emphasized the ultimate pursuit within CAMS of a life worth living with purpose and meaning—the ending capstone focus of effective CAMS.

Another key development centered on CAMS training and dissemination. Marsha noted that if I wanted CAMS to be routinely used, I would have to create a business to train clinicians saying "…you can't train everybody and clinicians won't learn by osmosis!" Indeed, this is exactly how DBT became world famous because when there was sufficient RCT support, Marsha founded Behavior Technology to scale-up the use of DBT around the world. In 2014 my wife Colleen and I co-founded "CAMS-care." Led with business savvy by our friend Andrew Evans, CAMS-care has trained over 60,000 clinicians around the world and there are CAMS training hubs in the U.S. and abroad. The

idea of interconnected CAMS training centers came from a dinner conversation I had with Steve Hayes (the creator of Acceptance and Commitment Therapy—ACT) to help ensure quality training and adherence to the RCT evidence-base. The CAMS "Integrated Training Model" for using CAMS with adherence has been supported by empirical research (Bowers, 2021) and CAMS-care now offers this training approach both in person and online.

Over the past 25 year there has been growing interest in CAMS and an increasing number of investigators have conducted clinical trials of CAMS in the U.S. and abroad. For example, there were inpatient trials at the Menninger Clinic led by Tom Ellis (e.g., Ellis et al., 2017). In Denmark colleagues conducted a superiority RCT of DBT vs. CAMS (with CAMS doing well in terms of self-harm and suicide attempts—Andreasson et al., 2016). Wars in Afghanistan and Iraq led to an increase of suicide-focused grant funding from the Department of Defense. I obtained a DoD grant and led a RCT of CAMS with US Army Soldiers at Ft. Stewart in Georgia (Jobes et al., 2017). Independent RCTs further replicated previous findings that CAMS reliably and significantly reduces suicidal ideation and overall symptom distress (e.g., a Norwegian RCT by Ryberg et al., 2019). A NIMH-funded RCT with college students showed that CAMS significantly reduced suicidal ideation and depression in comparison to TAU (Pistorello et al., 2020). A research breakthrough occurred when an independent meta-analysis of nine CAMS trials was published (Swift et al., 2021) that largely put to rest persistent critiques of CAMS. The biggest effect of CAMS they found was its ability to increase hope while decreasing hopelessness (one of my all-time favorite research findings). A rigorous inpatient RCT of CAMS in Germany showed CAMS significantly reduced suicide attempts after discharge from inpatient care and further replicated other improvements across several treatment outcomes (Santel et al., 2023). At the time of this writing, there are now five funded ongoing RCTs of CAMS in the U.S. with a handful of other trials being pursued abroad in China, the Netherlands, Denmark, Australia, Greenland, and a national multisite RCT across Italy. CAMS is now being studied in RCTs with adolescents, Veteran, and inpatients who receive somatic interventions such as Intravenous-Ketamine and Electroconvulsive Therapy. Important new clinical trial data supporting the single session use of CAMS—referred to "CAMS-Brief Intervention" (e.g., Oakey-Frost et al., 2024)—is currently being studied in a half dozen clinical settings. At the time of this writing, CAMS has been supported by 14 published open trials, 7 published RCTs, and 2 published meta-analyses (see review by Jobes & Rizvi, 2024). Young investigators are increasing studying the use of CAMS for suicidal risk which should lead to further developments and future adaptions of the CAMS framework.

Reflections on Psychotherapy

All my life I have been a seeker—intellectually, spiritually, and experientially. While I was lackluster underachieving student early on, I nevertheless devoured books on philosophy, spirituality, personal growth, and my dad's applied psychology texts. I explored world religions and practiced transcendental meditation; spirituality has been central to my worldview. I recently relished the opportunity to teach our undergraduate students during a semester abroad at the CatholicU Rome Center in Italy where I taught two of my favorite courses entitled the "Psychology of Living" along with a seminar class entitled "Clinical Psychology." As a lifelong seeker, and a dedicated student of life, I have personally endeavored to live intentionally, determined to realize a life-worth living, guided by thoughtful plans and goals, purpose and meaning, and an unwavering pursuit of truth.

Candidly, I have always had a counter-phobic coping approach to deal with my fears. When I was bullied by a classmate in second grade, I sought out and developed a lifelong love of martial arts. With an undeniable longing to go beyond my relatively sheltered suburban life, I got a job in high school to save money to attend Outward Bound in Colorado when I was 17. During Outward Bound I learned to deal with my fear of heights and then became an avid technical rock climber and mountaineer. Given this coping style, it is perhaps not altogether surprising that I developed depth-expertise in suicidology. While relative professional success has been realized, it is important to plainly acknowledge countless moments of discouragement, immense frustration, and seemingly almost constant setbacks. Moreover, as a young clinician, I struggled with my inability to ultimately stop a patient from taking their life. I was honestly terrified by the prospect of professional embarrassment, certain malpractice litigation, and the inevitable guilt that I would certainly feel if I failed to save a patient from suicide. These musings were disconcerting and haunted me for years. However, my counter-phobic coping style compelled me to develop depth-expertise in clinical suicidology and helped me master many of these clinical fears.

To this end, my work in clinical suicidology for over four decades has ultimately taught me a fundamental and liberating clinical truth: *all I can do is all I can do*. I can conduct an excellent—even therapeutic—assessment of a patient's suicidal suffering. I can promote and effectively use stabilizing interventions for acute suicidal states (e.g., lethal means safety, resources like 988 and the Crisis Text Line, and safety-planning type tools). Even more importantly, I

can provide an evidence-based suicide-focused approach to treat what causes a patient to consider suicide. As a clinician I can thus reliably render high quality suicide-focused care, and a patient *may still take their life.* This is a hard truth. Yet it is an important clinical reality to metabolize. Other health professionals are undoubtedly haunted by similar anxieties and yet go on to provide clinical care to the best of their ability. While psychotherapy is not surgery, we should nevertheless collectively work to provide the best possible care we can, relying on evidence-based approaches, even though difficult outcomes may occur (Jobes & Barnett, 2025).

During my VA clinical internship there was a terrible suicide of a veteran with whom I had done psychological testing only several days before his death. There have been serious suicide attempts within my private clinical practice and there have also been several suicides (out of thousands we have treated) within randomized controlled trials of CAMS. The RCT-related suicides have been especially painful for me (and members of my lab) because we closely watch videos of CAMS sessions rating them for adherence and fidelity and to provide consultation and guidance to providers who are using the approach. In other words, we become quite invested in these cases. I nonetheless came to see that one cannot spend decades working to create an evidence-based treatment for suicide risk and be immune to difficult outcomes. While it has been challenging, I have made relative peace with this truth. If I did not, I would have to leave the field. In my lab we always remind ourselves of the countless people we have helped over decades of work and there is some measure of comfort in promoting a proven treatment, that patients like, and helps the suffering patients who receive it. Providing evidence-based care is always in the patient's best interest, however our preferred outcomes are never guaranteed. As part of this hard-earned understanding, I have learned to recognize and accept the limits of my influence as a clinician, as a researcher, and as a person. After a lifetime of challenges and successes, I appreciate the privilege of a career that has enabled me to create and contribute an effective form of clinical care for those who suffer with serious thoughts of suicide. Nevertheless, I have also come to appreciate and I endeavor to accept that it is always the *patient's* life. The best I can do is the best I can do.

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Having described some key lowlights and highlights from my professional career and some of my personal approach to life, I would like to offer some reflections that are central to my thinking about psychotherapy along with suicide-focused perspectives. As a university professor for almost 40 years, I have taught dozens of Ph.D. students in an interview assessment class and a foundational course in psychotherapy. For decades I have supervised hundreds of cases seen by second year Ph.D. students in a psychotherapy practicum within the CatholicU Counseling Center. As part of our adherence and fidelity work, I have faithfully watched countless of hours of clinicians providing CAMS across a number of randomized controlled trials. As an active clinical practitioner, I have maintained a private practice since the start of my career in Washington DC and in Maryland. Moreover, my thoughts on psychotherapy are heavily influenced by teaching a graduate course and innumerable workshops on professional ethics and risk management (which is further informed by my work as a forensic expert). Based on these collective experiences, I would like to tender the following personal reflections, acquired observations, and key perspectives about providing effective psychotherapy with additional viewpoints about suicide risk.

- Paraphrasing Carl Rogers, clinical practitioners should aspire to *optimize conditions for change.* Simply stated, it is the *patient* who must do the changing. No matter how clinically skilled one is, we providers ultimately cannot change the patient perforce.
- Effective psychotherapy is always about *perspective cultivation* within a shared therapeutic venture that enables a patient to intentionally think, feel, and/or behave differently (or not). Perspective cultivation has many names, such as observing ego, mindfulness, and cognitive diffusion to identify a few related terms. No matter the name we use, facilitating a shift in perspectives is fundamental and essential to effective psychotherapy.
- If a psychotherapist does their job well, they make themselves *systematically obsolete* because the patient has learned, internalized, and grown—and therein has ready access to what has been experientially gained from an effective course of psychotherapy.
- *Behind every fear is always a legitimate need.* Psychological fear can be utterly paralyzing; shifting attention to legitimate needs behind every fear can be liberating and help facilitate change. By its very nature, fear can be extraordinarily distracting from needs that we all have (e.g., stability, trust, security, love, validation, appreciation, and the like). Thus, we must help our patients discover their legitimate needs and endeavor to help them get such needs met.
- It is human nature to be drawn to what is familiar, with a common assumption that any and all possible alternatives will invariably be worse. Change is hard. Even things we know are not good for us, can still be compelling simply because they are well-known to us.
- People often stay with persons who may treat them poorly—even abuse them—because the abject fear of being alone seems so utterly unbearable. Decades ago, Object-Relations theorists (e.g., Guntrip, 1992) asserted:

It is better to have a bad object (i.e., a person) than no object.

- As a relational psychotherapist, I embrace the importance of reacting to my patient differently than any other person in their life otherwise does (i.e., a skilled clinician does not provide the expected interpersonal response that the patient anticipates). For example, if a patient criticizes or verbally attacks me, I will neither react defensively nor attack back. In part, this is exactly how the therapeutic relationship can be a "corrective emotional experience" over the course of care when a patient is able to understand, integrate, and hopefully accept a uniquely different and helpful interpersonal experience from what has become familiar and anticipated.
- Good psychotherapists appreciate the importance of being able to "mentalize." According to Bateman and Fonagy (2010), mentalization is a valuable and cultivated ability that can be developed in order to: *see oneself from the outside while seeing others from the inside.*
- Assessment of unconscious defenses can help us understand how a patient manages their anxiety, preserves a sense of self, and characteristically function in relationships. Appreciating defenses can help inform how a psychotherapist should be with any given patient (McWilliams, 2020). In other words, clinicians should not be exactly the same with every patient—thoughtful adjustments are always needed to better respond to and help the person they are seeing.
- Along these lines, clinical hypnosis emphasizes the importance of close observation of even modest changes in the person being hypnotized to inform and incrementally shape the clinician's induction directives. For example, changes in the patient's respiration and body posture can cue the use of a softer voice or a slower cadence within a hypnotic induction. Accordingly, effective psychotherapists should endeavor to make complementary adjustments as we interact with our patients that are akin to moving skillfully with a dance partner.
- Suicidal suffering is invariably understandable if the clinician sincerely endeavors to respectfully and earnestly understand the nature of a patient's suicidal experience—the who, what, when, where, how, and why of suicide that has made it a compelling coping option. Relatedly, voices of people with "lived experience" (of being suicidal) are now advancing the field of clinical suicidology.
- Contemporary clinical suicide prevention is haunted by medieval notions about mental illness and there is an overreliance on carceral and controlling approaches to suicidality. Based on our clinical research, patient autonomy should always be encouraged as much as possible.
- The field is also overly preoccupied with *suicidal behaviors*, which is understandable, but there is not enough awareness and clinical focus on *suicidal suffering* which accounted for 16,900,000 American adults and teens in 2024 (SAMHSA, 2025). I would argue if clinicians in the field were better at identifying, assessing, and actually treating suicidal ideation upstream, there would be fewer suicide attempts and deaths downstream. Indeed, the single biggest challenge in suicide prevention today are those who suffer with serious thoughts of suicide (Jobes & Joiner, 2019).
- Licensed mental health professionals have a duty to protect patients from themselves. For my part, I endeavor to *not* hospitalize a patient who is suicidal (if at all possible) and I have never committed a patient against their will. I carefully reassure a patient that they can choose to end their life *later* once they are no longer within a clinical relationship with a provider who is statutorily compelled to stop them. When this is done sincerely with care, this clinical position can avert common power struggles about whether the patient can or cannot end their life. It also has the redeeming virtue of complying with statutory law while being 100% true.
- Effective clinical care for those who are suicidal should center on empathy, collaboration, honesty/transparency, with a particular and unwavering focus on those issues and problems, as reported by the patient, that compel them to consider suicide as a means of getting their needs met. These constructs are the central "pillars" that define the CAMS approach to effectively decreasing suicidal suffering within a singular pursuit to help clinically save lives from suicide.

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In closing I want to share a final cherished view on psychotherapy from a seminar I had with Margaret Rioch in the fall of my second year of my PhD program. Margaret was a trail-blazer in the 1950's and a prominent figure in psychoanalytic circles of Washington DC in the 1980's. Margaret first taught in my department at CatholicU (the same Rorschach class that I taught decades later). She then worked at the National Institute of Mental Health (NIMH) and went on to became an emeritus professor at American University. At NIMH Margaret famously conducted a line research training homemakers to provide effective psychotherapy (Rioch et al., 1963). This research inspired the aforementioned Bob Litman at the Los Angeles Suicide Prevention Center to birth the first suicide prevention hotline in the U.S. relying on trained paraprofessionals to handle crisis calls—a truly revolutionary idea in the 1960s!

Margaret was in her 80s' when I took her second year seminar in psychotherapy. Students who took this infamous

course were of two minds—many feared her while others loved her (I was in the latter camp). The strong reactions evoked by this dignified and eminent maven of psychotherapy may have been due to her seemingly uncanny ability to see right into the depths of your soul. It was a remarkable experience and for some it was unsettling. Moreover, she could be uncomfortably direct. Margaret's seminar was conducted in the basement of her elegant home in Bethesda Maryland and she graciously provided coffee and cookies. Her beloved "yorkie" dog was always settled comfortably on her lap during our seminar meetings. The six students in my cohort would present cases and anxiously await her penetrating and blunt commentary. As a preeminent expert on groups, Margaret ran our seminar as a group process which terrorized many students (and given my coping style, I loved it). She was always insightful and unfailingly fair-minded. Still, Margaret could be quite tough with her feedback and she did not suffer fools lightly. I distinctly remember a session from that fall when Margaret seemed particularly exasperated by our collective shortcomings as we struggled to present our cases. Rather suddenly she threw up her hands, her yorkie hopped off her lap, and in frustration she brusquely said: "Oh you young people! Don't you see? *The truth is highly underrated in psychotherapy!* You simply must seek the truth!" Without even thinking we dutifully scribbled in our notebooks "the truth is highly underrated in psychotherapy!" Now in the twilight of my career—some 42 years later—when I personally reflect on the topic of psychotherapy, I appreciate Margaret's simple wisdom anew. For my part, I seek the truth.

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Declarations

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