Kevin Crowley's

CAMS Clinical Corner

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Throughout National Suicide Prevention Month, I found myself asking a question over and over again, whether I was leading trainings for clinicians or consulting with systems around their suicide care pathways:

Is your ultimate goal in providing suicide-focused care to STOP someone from dying or START moving them towards a life worth living?

It's a tricky question.

In posing this, I certainly am not trying to decry the usefulness or the importance of "suicide prevention" as a goal. I'm simply suggesting that prevention as the end goal in and of itself is **NOT** the same as treatment. Making sure someone *survives* is **not** the same as helping them feel like they're *thriving*.

This is an essential distinction. And it's one that we've long recognized as being poorly addressed in graduate studies or post-graduate training. I'm sure many of us find it unfortunate to track the number of clinicians and students who say that either: a) they have not gotten training in evidence-based assessment. management, OR treatment for suicide, or b) they know some questions to ask but have no idea "what to do in session 2."

To that end, I'd like to offer some thoughts about the role of CAMS as an evidence-based **treatment**. And very specifically, I hope to share perspective around a question we get *very* commonly in our consultation calls:

If I'm an individual therapist, when should I use CAMS over another evidence-based protocol, like Cognitive Therapy for Suicidal Patients (CT-SP) or Brief Cognitive Behavioral Therapy (BCBT)? Or, vice versa: when would another evidence-based protocol, like CT-SP or BCBT make sense compared to CAMS?

Here's the bottom line up front: I think providers should get training in both CAMS and CT-SP/BCBT. CT-SP and BCBT are similar protocols that are **wonderful** options to consider for suicide-specific treatment. And they overlap with CAMS in several notable ways. For example:

- They are among the few approaches (along with DBT) that meet the gold standard of having independent support demonstrated in randomized controlled trials.
- They all align philosophically on the essential premise that suicidal thoughts/behaviors are **not** symptoms of a problem, but a problem that needs to be directly and collaboratively targeted in treatment.
- They all explicitly emphasize the role of safety planning type interventions (i.e., the Safety Planning Intervention, the Crisis Response Plan, or the Stabilization Plan) as essential strategies for crisis management.
    - *However*, they all also view those interventions as necessary but not sufficient treatment ends, in and of themselves.
- They all explicitly seek a goal of changing someone's relationship with suicide, such that suicide does not feel as "compelling" of an option in the future.

So, then, how to differentiate?

I don't believe this question boils down to a simple "which is better." Instead, perhaps as always, it's a question of considering **which approach is better for THIS person seeking care and THIS clinician providing it.** And when we look through that lens, useful considerations emerge with each option's respective initial assessment processes, underlying conceptualizations/treatment implications, and evidence base to date.

Let's briefly consider each together.

Initial Assessment Processes

CAMS has always occupied an interesting place in “treatment” conversations because of how well it straddles the fence between evidence-based assessment and intervention. The core of CAMS, the **Suicide-Status Form,** is a narrative-based tool that has extensive reliability and validity data. It is, in many ways, the heart of the framework. And it has been used to both start courses of therapy with someone seeking ongoing care and initiate connects with someone “cold”/serve as a stand alone contact in high acuity settings. (The latter reflects our CAMS Brief Intervention work in EDs, ERs, mobile crisis, etc.)

The versatility of the SSF puts CAMS in quite a unique position; while CAMS can be a “specialty care” treatment referral option (like CT-SP and BCBT are typically considered), it does not need to be. Clinicians can choose to deliver a single session of CAMS using the Initial SSF as a stand alone contact that spans deep dive risk assessment/determination, stabilization planning, and treatment planning/. In other words, a single SSF-focused clinical contact could help you determine what treatment is ideal for this person, while offering a therapeutic contact in its own right!

CT-SP and BCBT each suggest general recommendations and evidence-supported domains for initial risk determination assessment. However, they do not consistently recommend one specific standardized tool for this. In fact, many CT-SP and BCBT providers have highlighted the usefulness of the SSF for being their “lead in.”

Because these protocols are often established as specialty care referrals/pathways, it is not uncommon for some initial suicide-focused assessment and possibly safety planning to have been completed before either protocol is initiated. That baseline work allows for CT-SP and BCBT providers to shift in the direction of assessments like narrative timelines of attempts or supplementary tools like the Scale for Suicidal Ideation or the Suicide Cognitions Scale.

Notably, CAMS and the CT-SP/BCBT protocols align on the necessity of narrative-driven assessments beyond just completing “check lists.” Both agree that, whether approaching broad risk determination with a tool like the SSF or monitoring symptom

reduction/treatment outcomes, accurately catching this person's idiographic experience is necessary and therapeutic.

Conceptualizing Suicide and Implications for Treatment

CAMS: Understanding the Individual's Suicidal Drivers

CAMS conceptualizes suicidality as an existential option that is always on the table. But it also proposes that we do not have to eliminate the possibility of suicide to provide effective treatment; instead, we can use the window patients offer by coming in as an opportunity to see what ***drives*** suicide to the top of their option list.

This concept of **suicidal drivers** - patient-identified problems that suicide functions to solve - becomes the direct focus of CAMS treatment.

CAMS clinicians endeavor to "see suicide" the way their patients do, and then the dyad collaboratively uses these drivers to develop a treatment plan. This treatment plan offers opportunity to flesh out this person's narrative of *how and why* these problems connect to suicide and what it would take to help foster a life worth living.

And this is where the distinction between *prevention* and *treatment* becomes especially important.

If we can change or solve the problem(s) this person identified, that is wonderful and often the most satisfying outcome for both parties! But sometimes an identified problem cannot be changed. In those cases, we can still help someone change their relationship with the problem (and thus their relationship with suicide) by changing how they think about it, or develop new ways of coping with it, or build the acceptance and resilience to live with it instead of die from it. And **any** of these can ultimately serve to reduce suffering.

That is why I think of the patient's suicidal drivers as CAMS's North Star. They help us collaboratively decide what to target. They help us decide whether the interventions we are using make sense. And they give us something to redirect to if treatment starts to feel like it is drifting into "generic therapy."

In fact, one of the things I appreciate about CAMS is that the treatment plan is intentionally iterative. At the end of each session, we check in to consider if we are still working on the things that are actually driving this person's suicidality. If not, perhaps it is time to change course.

This also gives CAMS its transdiagnostic and flexible quality. The drivers maintaining suicidality may look very different from one patient to another—and our interventions should be different too. Each provider can choose how to address this person's driver(s) based on their own theoretical orientation and technique preferences, provided the decision is collaborative.

It is for this reason that CAMS is often referred to as a **therapeutic framework.** It is not a manualized protocol; it is an opportunity for "framing" contacts (however many we have) around safety, stability, and pain. Each clinician can bring their expertise in and do wonderfully effective CAMS therapy, provided they don't lose the "person" for an intervention.

CT-SP and BCBT: Understanding the Individual's Suicidal Mode

CT-SP and BCBT, in contrast, are manualized protocols that operate from a cognitive-behavioral conceptualization. Each targets understanding and responding more effectively to this person's **suicidal mode**, which is a characteristic suicidal state unique to the individual that consists of specific thoughts, emotions, physiological responses, and behaviors. By mapping the suicidal mode, the situations that trigger it, and this person's underlying vulnerabilities, the dyad can then select specific CBT strategies to counteract mode activation and empower other responses beyond suicide.

Essentially, the goal becomes fostering insight around **what the suicide mode is, what activation looks like, and how people can respond to activation without choosing suicide as an option**.

Both protocols offer several strategies intended to facilitate emotion regulation and cognitive flexibility along these lines. And as skills are developed and mastered, clients have the specific opportunity to **rehearse** responses for future crises through

exercises in which their suicidal mode is thoughtfully triggered together with the clinician.

I've always valued this rehearsal approach as a wonderful opportunity for relapse prevention; it can be *transformative to* demonstrate that a future crisis can and will look different because of the direct work accomplished in targeting specific mode domains with concrete skills. Particularly when a client actually *feels and experiences* the skills having this effect, in real time!

So, in some ways, the differences between CAMS and CT-SP/BCBT reflect respective emphasis.

CAMS asks us to understand the individual patient's suicidal drivers and then flexibly select interventions to address them using any theoretical orientation providers choose.

CT-SP and BCBT operate from a cognitive behavioral theoretical model, and each similarly seek to develop an individual conceptualization of suicidal risk. But instead of identifying patient identified drivers, these protocols target patient-specific skill deficits that increase the likelihood of suicidal mode activation/future attempt behaviors.

Evidence to Date

So what about the evidence?

As mentioned, all of these have strong empirical support at the "gold standard" randomized controlled trial level. But they do not have identical evidence bases, and they have not been studied in identical populations or against identical control conditions.

CAMS has been evaluated in multiple randomized trials and meta-analyses, with evidence corroborating significant reductions and changes in suicidal ideation, overall suffering/psychological distress and hopelessness; increases in hope and willingness to live; and positive effects on suicide attempts and self-harm behaviors. Compared to

treatment as usual conditions, CAMS is at least on par at reducing suicidal behaviors, but has been shown to be **superior** in reducing **suicidal ideation.**

CT-SP is supported by a seminal early study showing significant reductions in suicide attempts compared to treatment as usual. Although this study has not been replicated, BCBT has amassed significant and repeated support. Randomized trials, starting with military and veteran populations, have consistently yielded reductions in suicide attempts among patients receiving BCBT compared with comparison conditions. More recent work has extended this evidence into other populations and remote delivery and has also demonstrated positive effects on suicide ideation and hopelessness.

Very interestingly, the support for these protocols seems to be the mirror opposite of the support for CAMS. While each protocol has shown to be at least on par to control conditions at reducing ideation, they have been shown to be **superior** in reducing **suicidal behaviors.**

This is a really important distinction that reflects a fact receiving recent attention and focus:

Suicidal ideation and suicidal behavior are not the same outcome.

We sometimes talk about “reducing suicidality” as though that is one thing. It isn't. It’s possible for a treatment to reduce how frequently someone thinks about suicide without demonstrating a specific effect on suicide attempts. Conversely, a treatment might have an important effect on suicidal behavior even when differences in suicidal ideation between treatment groups are less apparent.

So when we look at the literature, we need to ask: *What outcome are we actually talking about? For whom? Compared with what? And over what period of time?*

And then, beyond that: *What does THIS client need for staying alive AND making life worth living?*

Summary and Conclusion

Taken together, what might this suggest in terms of intervention selection?

CAMS might make particular sense when...

- You want to select an evidence-based, therapeutic risk assessment for initial determination and engagement.
- You want to conceptualize what specifically actually driving this person's suicidality, and what needs to be addressed to foster a post-suicidal life/life worth living.
- You want a flexible, suicide-focused framework that can incorporate your existing therapeutic approach and that is not tied to one specific theoretical orientation.
- You can effectively navigate risk with a safety/stabilization plan and want to address the pain underlying suicidal ideation.

CT-SP and BCBT might make particular sense when...

- The patient has a recent suicide attempt and/or recurrent suicidal behavior is a central treatment concern.
- You are looking for a brief, structured, CBT protocol specifically designed around and shown to be effective for suicide prevention/treatment.
- The patient can engage in cognitive restructuring, behavioral strategies, problem solving, and relapse-prevention work.
- Primary treatment targets necessitate skill acquisition to prevent future behaviors and rehearsing these skills.

Perhaps another way of summarizing is:

CAMS asks:

What is making this particular person suicidal, and how can we collaboratively address those drivers?

CT-SP and BCBT ask:

What cognitive-behavioral processes are activating and maintaining this person's suicidal mode, and how can we interrupt them? And, how can we help this person master a particular set of skills to prevent future attempt behavior?

In any event, I am very grateful that there are multiple effective, evidence-based approaches for *actually* treating suicidality.

Each uses “survival” as necessary start, not the “final destination.”

Each attempts to move someone in the direction of changing a relationship with suicide.

Each strives to empower someone feeling that life is worth living.

What a great “end point.”

Looking forward to connecting again soon! Please don’t hesitate to reach out if we can be helpful for you or your team in the meantime.

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