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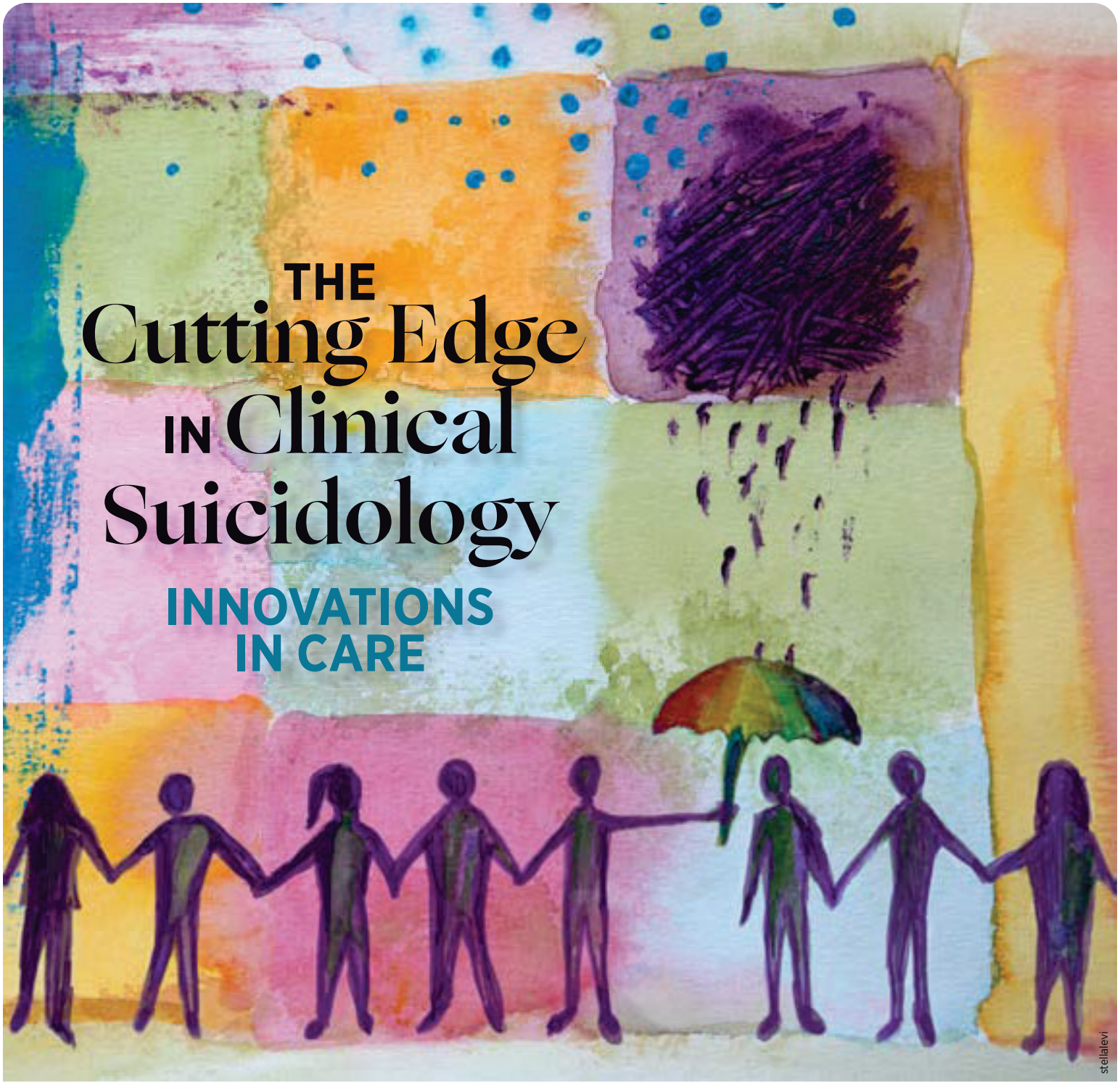

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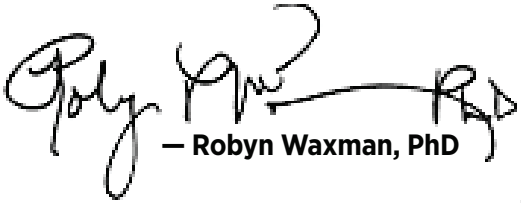
TABLE OF CONTENTS

Letter from the Editor

This issue of the TMP is an important one and I am thrilled to be able to share it with our community. The topic of suicidality among our clients is a sensitive one—both for their safety and our own mental health. When I've had parents call to inquire urgently about services for their child who is expressing some suicidal ideation, I've always referred them to an inpatient program or an ER for an assessment. I find it terrifying to have to make a determination about a child I don't know or have a relationship with. And for many years I've worked with an adult client who has always had suicide in the back of her mind. For eight years, she and I have worked to find a balance between honoring her feelings, wanting her to feel free to discuss them, and maintaining safety. Early on she revealed that she always considered the possibility of suicide but told me, "If you hospitalize me, I'll never share those thoughts with you again." We've done this dance repeatedly over the years. I've sent her to several trauma therapists, she's tried medication and ketamine—nothing has made a lasting difference. Ultimately, I've relied on promises she's made, commitments to call me if she is in danger, contracts, and I'm not ashamed to admit that I've even pulled the guilt card ("You know I would be devastated if you ended your life, especially while you're under my watch."). She recently went through a difficult time, and I sent her home with trepidation, saying a little prayer for her safety. Finally, I realized that there must be something better out there, a way to assess her risk with a little more accuracy. When I was in grad school 30 years ago, I didn't learn much about how to assess risk or provide care for a client who expressed suicidal ideation. Ironically, Dr. Dave Jobes, who is the Guest Editor for this issue, attended my school. I had the opportunity to learn from an expert in the field; however, it was not considered critical to our core studies. It was a topic I would have needed to add to my studies independently and I didn't appreciate how important it was. Today there is far more research in the field of clinical suicidology and a growing awareness that sending a client for inpatient hospitalization is not the only recourse we have, and not even the best one at our disposal. I was fortunate enough to be able to reach out to Dr. Jobes now to take advantage of his expertise, and he was generous enough to share the "cutting edge" research he and others are involved in.

Dr. Jobes has outlined a model of assessment that I know will help me moving forward. I hope that this issue might shape the way each of us responds to clients who are in deep distress, knowing that while we never gain 100% certainty, there are structured tools that can help us assess their risk with a little more accuracy...and hospitalization is not the only tool that we have for working with these clients.



— Robyn Waxman, PhD

A Note from the Guest Editor Regarding The Maryland Psychologists' Fall 2024 Edition

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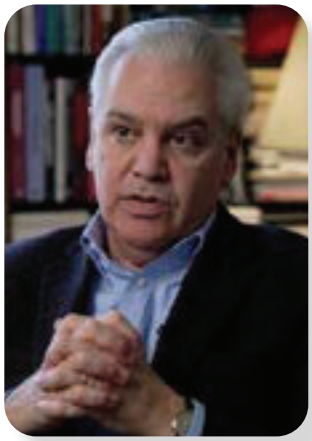


David Jobes completed graduate school at American University in Washington DC and he interned at the DC Veterans Affairs Medical Center. He joined the clinical psychology faculty at Catholic University in 1987 and has spent his entire career conducting research on suicide prevention. Dr. Jobes created the "Collaborative Assessment and Management of Suicidality" (CAMS) which is one of a handful of proven suicide-focused treatments. He leads the Suicide Prevention Laboratory at CatholicU which is dedicated to clinical suicidology—the assessment and treatment of suicidal risk, related training, ethics, and risk management considerations.

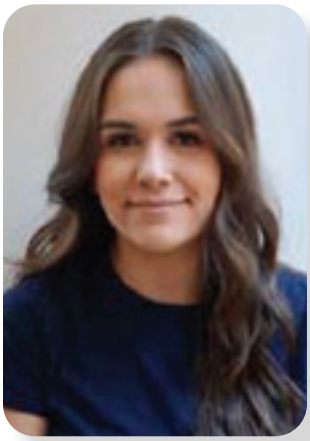
In 2023 16,600,000 American adults and adolescents reported having *serious thoughts of suicide* (SAMHSA, 2024) and 2,356,000 Americans attempted suicide. A total of 49,476 Americans died by suicide in 2022—the highest number in US history—making suicide the 11th leading cause of death in the U.S. (CDC, 2024). In the state of Maryland there were 608 suicides in 2022. These epidemiological data are startling but beyond the numbers, these deaths are children, parents, siblings, grandparents, and friends—precious lives to their loved ones. It follows that the interpersonal and emotional costs of suicide are enormous. As my colleague Julie Cerel has noted, there are upwards of 30+ loved ones who are meaningfully impacted by each death as suicide "loss survivors." The economic costs of suicide in the U.S are also staggering. For example, in 2022, suicide and self-harm cost over $500 billion in medical costs, work loss costs, value of statistical life, and quality of life costs. Bottom line, suicidal suffering and related behaviors represent a major mental and public health challenge in the state of Maryland, the larger United States, and around the world. With millions having serious suicidal thoughts and the rising rates of suicide, we are now seeing the utter inadequacy of existing suicide prevention approaches overall and the abject failure of our standard clinical care responses for patients who are suicidal.

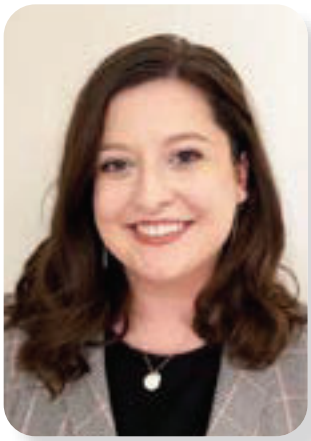
To this end, I am delighted to serve as Guest Editor for this edition of the *Maryland Psychologist* to address this major mental health issue and to feature the work of the Suicide Prevention Laboratory (SPL) that I direct at The Catholic University of America (CatholicU) in nearby Northeast Washington DC. For over thirty years the SPL has endeavored to study suicide in many forms with a particular emphasis on "clinical suicidology" that centers on the clinical assessment, intervention, and treatment of suicidal risk with implications for professional training and risk management. As a longtime resident of Maryland, I am pleased to have this chance to share the work of the SPL featuring articles by my doctoral students in clinical psychology at CatholicU. The articles that follow we will discuss screening and assessment of suicidal risk, acute interventions for stabilization, and evidence-based clinical treatments that effectively reduce suicidal ideation and behaviors (supported by randomized controlled trials). We hope this series of articles helps raise awareness to improve clinical practices among psychologists in Maryland so that they may better decrease the suffering of their patients to help save lives.

— David A Jobes, Ph.D., ABPP

Assessment of Suicidal Risk

Francesca Fernandez, M.A. and Jessica Gerner, M.A.





Francesca Fernandez, M.A.
Francesca is a clinical psychology doctoral student at Catholic University, where she works in the Suicide Prevention Lab as well as the Depression and Suicide Cognitions Lab. She earned her bachelor's degree from Colgate University and a master's from Northwestern University Feinberg School of Medicine. With broad experience in both assessment and treatment, she has worked with youth, emerging adults, and adults. Presently, she provides individual therapy at Catholic University's counseling center, helping students with a variety of mental health, behavioral, and learning concerns. Francesca is especially passionate about assessing and treating suicidal thoughts and behaviors, with a focus on adolescents and young adults.

Jessica Gerner, M.A.
Jessica is a doctoral student in the Suicide Prevention Lab at the Catholic University of America. She earned her Bachelor of Science in Psychology from the University of Cincinnati and her Master of Arts in Psychology from Louisiana State University. Jessica's research in suicide prevention began during her time as a post-baccalaureate fellow at the National Institute of Mental Health. She has extensive clinical experience in both inpatient and outpatient settings, working with individuals facing a range of psychopathologies, including suicidal ideation and severe mental illness. Currently, Jessica provides individual and group therapy to Veterans with severe mental illness through the VA Maryland Health Care System in Baltimore.

Overview/ Purpose of Assessment for Suicide Risk

Predicting suicide with absolute certainty has proven to be close to impossible. However, there are therapeutic approaches and instruments that clinicians (i.e., healthcare providers) can use to assess for, and detect, risk of suicide. This article acts as a guide for clinicians, promoting the use of evidence-based tools and semi-structured interviewing approaches, while offering key recommendations and considerations for the assessment of those with suicidal thoughts.

Suicidologists have been studying, and assessing for, suicide risk for decades. Many attempts have been made to routinize such assessment. And, most of these assessment guidelines have commonalities, including assessing for: suicidal thoughts, behaviors, and plans; access to lethal means; intent; desire; and prominent risk factors such as hopelessness and stressful life events (e.g., Berman & Silverman, 2014; Chu et al., 2015; Shea, 2009; Silverman & Berman, 2014). Each of these commonalities have value. However, what is most noteworthy is that there is no "one size fits all" answer. Rather, it is most important for clinicians to take a flexible, and nuanced, approach with their patients and clients. No two people are alike, and no two suicide risk assessments are identical. Clinicians are advised to develop a unique style of their own, incorporating their own "usual and

customary" practices to working with those at risk of suicide. This includes identifying go-to measures and methods of suicide assessment (Jobes, 2020).

Broad Considerations

While there is room for "creative license" in clinical work, which includes assessing individuals' suicide risk levels, the importance of standardized and validated approaches should not be glossed over. Valid assessments are "non-negotiables" and the cornerstones upon which good and life-saving clinical practice is built. Much like other assessments, such as those in other health-related fields, sensitivity and specificity is key. Suicidology researchers have worked tirelessly to develop and validate assessments tools with both high sensitivity and high specificity—or the ability to differentiate "true positives" from "false positives," respectively. Their research ensures that we can trust our tools to accurately assess if a client is at risk for suicidal thoughts and/or behaviors. These tools are vital to our field's ability to effectively discriminate suicidal risk among our patients. Therefore, licensed mental health professionals' jobs include staying up to date on recent clinical research findings, given their dedication to upholding ethical standards of "do no harm" (i.e., beneficence and nonmaleficence). They must critically consider their go-to tools and ensure their practices are evidence-based for the populations they treat.

The reason this staying updated process must be dynamic is due to our field's bias towards clinical judgment. Clinician's accuracy in making future suicide risk judgments is often overestimated. However, the reality is that clinical intuition and prediction of future risk is no better than other wildly available tools (i.e., statistical modeling and standardized assessments) (Nock et al., 2022). It is realities like this one that underscore the importance for the continued development of evidence-based tools and guidelines. Our field has done just that. Over the last decade, suicide assessment initiatives have become more commonplace. Back in 2016, The Joint Commission announced their Alert 56 which calls for universal suicide screeners across settings (i.e., inpatient and outpatient) and developmental periods (i.e., from youth to adulthood) (The Joint Commission, 2016). The American Psychological Association updated their assessment recommendations at the start of the decade to account for the diversity of needs across clinical populations (Knapp, 2020). They made sure to highlight that no individual tool or measure is superior to other in either sensitivity or specificity. Rather, we as a field must continue to tailor our risk assessments to reflect the environments and individuals in which they will be implemented—fitting their use to the "who" "what" "where" "when" and "why."

It is a well-known fact that many individuals who go on to die by suicide have some sort of healthcare provider interaction (e.g., primary care, emergency department, outpatient, inpatient care, etc.) within 30 days of their death (Ahmedani et al., 2019). To enable proper "safety nets," assessments and screeners must be customized to fit the needs of patients within these various settings. Again, there is no perfect or universal assessment. Instead, adaptations must be made. It is important to note that adaptations of suicidality assessments were accelerated in the wake of the COVID-19 Pandemic, as telemedicine became more palatable for providers and patients alike. Prior to the global pandemic, most assessments of suicidality were conducted face-to-face. COVID-19 Pandemic forced the field to improvise and resulted in some silver linings: timely access to life-saving treatments (such as assessment and safety planning), cost-effectiveness, better care continuity, and mindfulness of patient access and barriers. There are many complexities and considerations to be had while conducting telehealth assessments (e.g., confidentiality concerns, immediate lethal means accessibility, technological shortcomings). National Action Alliance's guidelines (2020) are a helpful first stop for clinician's considering virtual practices.

It is understandable that for many clinicians suicide risk assessments are stress and anxiety provoking interactions (Roush et al., 2018). Therefore, it is essential that our field finds ways to appropriately prepare clinicians and help them to achieve competency in providing this type of care. Even just brief access to training resources has been linked to increases in clinical confidence during suicide assessments (Wakai et al., 2020). Through training, clinicians should be reminded that a composed

and empathetic approach is preferable, one where they refrain from misjudging one's risk (i.e., over- or under-estimations, "setting off alarms," etc.). They should know how to make real-time adjustments to their interview to meet the core competencies of suicide assessments such as gathering information about one's suicidality experience and symptom management (Bernert et al., 2014).

Individual-Level Considerations

It is abundantly clear that a patient-centric approach to assessing their suicidality aligns with "best practices." Suicide risk assessment is akin to a case formulation approach—assessors should be aiming to collect a variety of data to help encapsulate a client's ambivalence or their relative risk and stability. Keeping with a patient-centric viewpoint, it is fundamental to include a sociocultural component to their case conceptualization. While a foundational awareness of larger and subpopulation trends is important, clinicians' knowledge should go further.

An always important area of consideration in assessment is diversity factors. No two clients are alike, and the many identities they may hold uniquely intersect and affect their suicide experience and risk. Take for example one's age. Recent estimates have youth—which includes individuals as young as 10-years-old—suicide rates growing at an increasingly worrisome pace (Curtin & Garnett, 2023). Developmentally appropriate assessments should be able designed to capture suicidality across the lifespan. This also begs the practice of including secondary reporters. Clinicians should consider, with proper clearance, engaging and interviewing parents and caregivers (both for youth and elders) to gain supplemental information prior to making risk assessment judgments. Moreover, beyond age, one's biological sex and gender identity factor in as well. Despite females have greater prevalence of suicidal thoughts and behaviors, males tend to die by suicide more frequently (Bommersbach et al., 2022). We would be remiss to not also highlight further readings on gender nonconformity and suicidality. Surace and colleagues (2021) in their meta-analysis uncovered that youth experiencing gender dysphoria had greater prevalence rates of suicidal ideation and behaviors than their same-age cisgender peers. Their often-stigmatized identities unfortunately fosters experiences of social isolation, minority stress, and peer victimization which overlap and increase their relative risk.

The last to be mentioned, but nonetheless important, is an individual's ethnic and racial identities. We have plenty of alarming statistics that orient us to the growing rates of suicide in minoritized populations—such as African American youth and Hispanics (Ivey-Stephenson et al., 2022; Meza & Bath, 2021). Even more troubling is that our development of culturally informed assessment tools is falling behind that growing suicide risk for minorities (Molock et al., 2023). At this point, it is impossible to have a bank of validated assessments precisely matched to an individual's multifaceted identity. Our hope in outlining these trends is not to support the assumption that clinicians should be basing their clinical judgments off these statistics. Rather, these larger trends can be used to remind clinicians how various identities may interact to alter risk. A clinician must be respectfully curious when engaging clients in suicide assessments. The goal of this assessment is to prevent suicide, and in order to save lives, individuals should be provided with nonjudgmental environments where they feel safe to share their suicide experiences, as well as what their socio-cultural identities mean to them and how they impact factors relating to this context.

Other individual-level considerations clinicians should be mindful of include their client's willingness to share their suicidality experiences as well as their motivation for seeking care. Clinicians who adopt an open and respectful approach should remain aware that due to a lot of historical missteps (e.g., involuntary treatments, invasions of privacy; Sheehan et al., 2019) individuals may be hesitant to report their suicidal thoughts or behaviors. Suicide assessments must be conducted in stigma free environments, where clinicians are ever mindful of the impact of language they use. For example, being cognizant that using terms such as "failed attempts" and "commit suicide" only further the criminalizing view and stigma around suicide. Based on the historically alarmist reactions our field and society at large has taken towards suicide, it takes an incredible amount of courage for individuals to speak up about their

experiences. Therefore, individuals may display both direct and indirect forms of communicating their suicidal risk. Direct communication relates to explicit disclosure. Age is an important factor in direct communication frequency. Someone who is 65+ is not likely to seek support from the same people and within the same settings a 16-year-old client will (Choi et al., 2023). Gender roles may influence treatment seeking and suicidal disclosure tendencies. Racial and gender minority youth often chose not to disclose based on fear of judgment (Shin et al., 2023). In cases of nondisclosure, context clues (i.e., instances of preparatory behaviors, rejecting help, enduring hopelessness) may help to demonstrate suicidal intent. This is all to say that assessing for suicide risk is no simple feat. As we've outlined, clinicians must ground their clinical approaches in evidence-based practice yet remain flexible and culturally aware as to not alienate their clients. From the onset, clinicians are recommended to take an empathetic and validating approach. Early alliance building is sure to benefit future collaborative discussions on safety and treatment planning—the backbone of suicide prevention.

Process of Information Gathering

Two of the most widely used assessment measures of suicide risk are the Ask Suicide-Screening Questions (ASQ; Horowitz et al., 2012) and the Columbia Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011). These two measures are both user-friendly, and free for use. The ASQ is a brief screening tool originally developed for use with adolescents, and has since been broadened for use with adults. Its brevity is often seen as an advantage in screening and research settings. When used in clinical settings, it is important to note that the tool lacks depth in key areas such as suicide planning and preparation. The CSSRS is one of the most widely used instruments in suicide research literature, demonstrates strong psychometric support and covers a wide breadth of key areas for assessment. Other commonly used assessment measures of suicide risk include the Beck Scale for Suicidal Ideation (BSSI; Beck et al., 1979, 1988) and the Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001). It is important to note that the BSSI is a proprietary measure available for purchase, an option that may not be accessible to all clinicians. And, given that the PHQ-9 includes only one question relevant to suicide (i.e., "Thoughts that you would be better off dead, or of hurting yourself"), we recommend against using it as the sole source of suicide risk screening.

Although the above instruments can be a helpful tool for clinicians to gather information quickly, there are downsides to using suicide risk instruments (Bryan & Rudd, 2006). Most notably, self-report measures have a high rate of false-positives, and may not be sufficient in differentiating those at heightened risk for suicidal behavior. Additionally, the generalizability of these measures may be limited to only the populations within which they were developed and studied. Therefore, as suggested by Bryan and Rudd, that standardized assessments should be integrated into a more comprehensive clinician interview. Despite their limitation such assessments can provide beneficial supplementary or clarifying information and supplement the medical record which can help decrease liability exposure.

When conducting an assessment, there are specific domains that are essential to gaining a thorough understanding of a patient's suicidality, including: suicidal thinking, suicide planning, suicide preparation, history of behavior, precipitating stressors, psychiatric symptoms, and protective factors. While the actuarial assessment measures mentioned above may include some of these domains, clinicians will likely need to ask follow-up questions in order to cover each one in its entirety. Suicidal thinking refers to the patient's experience of suicidal thoughts, including their intensity, frequency, and duration. Suicide planning refers to any plans a patient has made for suicide, which can include a place, method, and access to lethal means. Generally, more specificity of planning is indicative of greater risk. Suicide preparation refers to any steps that a patient has taken to prepare for suicide, which could include steps such as accessing lethal means or giving away belongings. History of behavior refers to the patient's history of suicidal behavior, including the time since the last attempt, the frequency and context around the behavior, and the method of any previous or aborted attempts. Generally, risk is thought to increase in individuals

with two or more suicide attempts. Precipitating stressors refers to any recent stressors that may have occurred, impacting the patient's suicidal thoughts and behaviors. Some examples of precipitating stressors include loss of a loved one, changes in relationship status, or health problems. Psychiatric symptoms refers to any symptoms that may be related to psychiatric diagnoses (e.g., bipolar disorder, anxiety, schizophrenia, etc.) any symptoms such as sadness, anxiety, fatigue, hopelessness, impulsivity, or substance use. Finally, protective factors are any factors that may protect an individual from suicidal behavior. These can include the presence of social support, positive coping skills, reasons for living, religion or a sense of meaning in life, and actively participating in treatment.

Conclusion

Ultimately, no single instrument or technique stands above others for screening suicide risk in terms of accurately detecting and differentiating individuals at risk. Instead, clinicians should develop a comprehensive and personalized practice that incorporates actuarial assessments, essential competencies, and clinical judgment. Employing a balanced, empathetic, and patient-centered approach that considers each patient's unique and diverse needs is crucial for effective risk assessment. Additionally, establishing flexible yet consistent practices that can account for the dynamic and evolving nature of suicidality is key for accurately assessing suicidal thoughts and behaviors.

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—Continues on page 20

Acute Stabilization Interventions for Suicidal Risk

Ethan W. Graure, M.A. & David A. Jobes, Ph.D., ABPP

Ethan is a clinical psychology doctoral candidate at The Catholic University of America, where he is a member of the Suicide Prevention Lab. He received his bachelor's degree in psychology from American University and his master's degree in psychological science from Catholic University. Ethan has presented on suicide prevention research at local, national, and international conferences. His current research is focused on the identification of "prescriptive" client-centered treatment selection models for suicidal thoughts and behaviors. He has trained in Veterans Affairs Medical Center, college counseling center, and private practice settings.

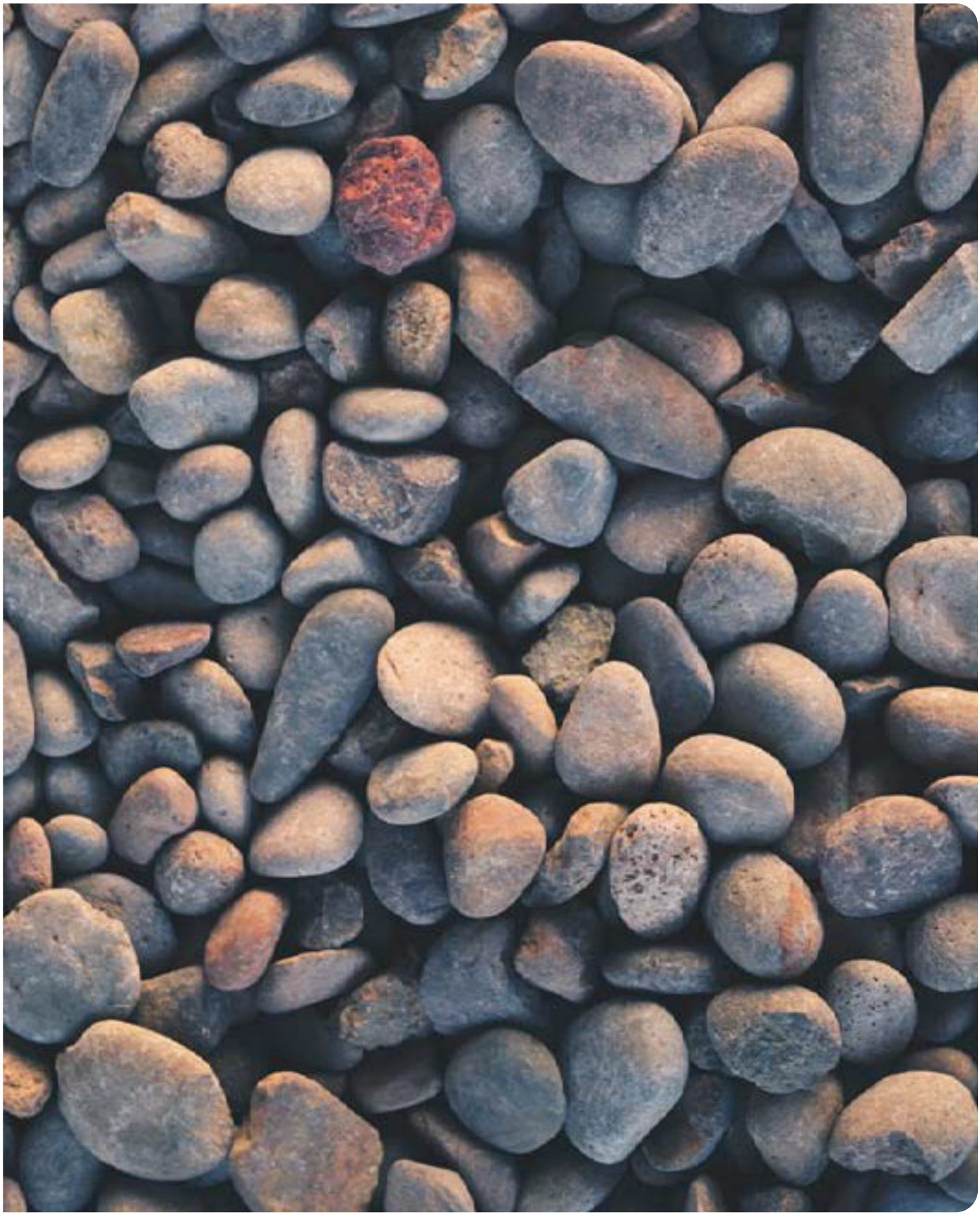
What are Acute Stabilization Interventions?

For many decades, methods for treating psychological crisis were centered on no-harm contracts, involuntary civil commitments, and lengthy hospital stays. Contemporary theoretical and empirical evidence has suggested that these methods are ineffective and often iatrogenic for patients. In light of clinical advances in the field of suicidology, the need for acute intervention arose and a number of promising evidence-based interventions have begun to emerge.

As clinicians already know, certain modes or modalities of treatment are better suited for some patients than others. In light of this, a "stepped-care" approach can be used for a systems-level understanding of how patients in need of care can be routed to the most effective but least restrictive form of psychotherapeutic support or treatment. Specifically, one stepped-care model outlines six levels of suicide-specific care with the intention of identifying the most "evidence-based, least-restrictive, and cost-effective" (Jobes et al., 2018, p. 244) levels of care for each patient. As cost of care rises successively through the model, so does restrictiveness (beginning with crisis hotline support, then brief interventions, outpatient care, emergency respite care, partial hospitalization, and lastly inpatient psychiatric hospitalization). This is a "prescriptive" model, in which patients' needs and characteristics are central in determining the appropriate levels of suicide-focused care with a reliance on patients themselves taking responsibility for their own care and stability.

While patients experiencing suicidal thoughts and behaviors have historically been routed to inpatient units to ensure safety, relevant literature increasingly indicates iatrogenic experiences are associated with inpatient stays (Carstensen et al., 2017), and indeed, suicidal risk is well known to increase immediately after an inpatient discharge (Ward-Ciesielski & Rizvi, 2020). Given this, less restrictive treatment options have become increasingly compelling to support patients through suicidal crises.

While suicidal thoughts and behaviors are idiographic in nature and each situation differs from the next, the reality is that acute interventions can provide effective and non-restrictive options for many people experiencing suicidal ideation across different circumstances. However, the effectiveness of acute interven-



tions relies on key conditions. For example, patients in crisis may be best suited for acute intervention so long as (1) they are alert and oriented (2) they are amenable to engaging in efforts to increase their stabilization, and (3) they are not an imminent danger to themselves or others. When one or more of these criteria are not met (or other potential idiographic factors), acute intervention may not be appropriate for particular patients.

There are a wide range of interventions that can be used to help stabilize a person in an acute suicidal crisis. Herein, we will illustrate several potential forms and their relative utility. Together, these interventions posit that less is more; not every passing suicidal thought should be met with the restriction—and expense—of an inpatient psychiatric stay. Instead, if we lead with empathy and psychotherapeutic support such patients can find methods for increasing their stabilization. Our discussion will focus on the fundamental interventions of stabilization before considering some brief contact interventions that have been increasingly studied in recent years.

Stabilization Fundamentals

A task force of the National Action Alliance for Suicide Prevention (NAASP) developed "Recommended Standard Care for People with Suicidal Risk" which highlights simple evidence-based interventions for suicide-focused care across a range of settings (for full report refer to: https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf). Among their various recommendations, the "low hanging fruit" of relatively easy to use, evidence-based, and affordable interventions include the use of crisis lines, discussions of lethal means, and safety planning type interventions. Importantly, providers can readily integrate these interventions into care with any patient who is suicidal.

988 Suicide & Crisis Lifeline

The 988 Suicide & Crisis Lifeline is a landmark development in the field of suicide prevention that provides excellent supportive counseling handling calls, text, and chat (https://988lifeline.org/?utm_source=google&utm_medium=web&utm_campaign=onebox). There is also a national crisis text line that can similarly provide support, by texting the word HOME to 741741 (https://www.crisistextline.org/). These crisis resources should be a given whenever working with a patient who might become suicidal—they are excellent resources, with supportive evidence, and they are free.

Lethal Means Safety

Discussions of lethal means safety is another simple intervention that may well be the single most effective intervention there is for ensuring safety and stability by literally removing or creating barriers to lethal means. Firearms need to be removed or locked up, pills and poisons need to be secured. An unlocked door to a rooftop may need to be locked. For patients in treatment, candid discussions about reducing access to lethal means can increase therapeutic trust and might be a clear sign that a patient does not need to be admitted to an inpatient unit. One popular and free source of guidance is Counseling on Access to Lethal Means (CALM) which is an excellent resource for clinicians and concerned loved ones (https://zerosuicide.edc.org/resources/trainings-courses/CALM-course).

Safety Planning Type Interventions

A final consideration in stability fundamentals are safety planning type interventions. These are the remedy of no-harm or no-suicide contract that were widely used in the 1980's and 1990's. The best known is the Stanley-Brown Safety Plan (https://sprc.org/online-library/stanley-brown-safety-plan/). There are similar interventions such as the Crisis Response Plan developed by Rudd (see Bryan & Rudd, 2018) or the CAMS Stabilization Plan (Jobes, 2023) that are also effective in their ability to focus on what a patient can do if they should be in a suicidal crisis. These tools should be routinely integrated into the clinical care of anyone who is suicidal.

Brief Contact Interventions

As noted, a fairly new area of clinical suicidology research has focused on brief contact interventions (BCI) which tend to be low-cost methods of intervening or contacting patients who are potentially in crisis over periods of time. BCIs are characterized by a lack of face-to-face contact with patients and their ease of implementation. They have predominantly been

implemented after patients present to emergency departments for self-harm and may include letters sent to a patient once per week for two months post-discharge, or it could be brief daily phone calls for a week after discharge (Kapur et al., 2010). While the literature on BCI's efficacy is somewhat mixed (Milner et al., 2016), they do provide an intriguing complement to more formal interventions. Data indicate that BCIs should emphasize the care and support provided to the patient by the person implementing the BCIs, and should work to increase the patient's knowledge about suicidal behaviors or self-harm (Milner et al., 2016). We will thus review several BCI's with promising empirical support that may serve as a compelling alternative approach to more traditional mental health courses of care.

Attempted Suicide Short Intervention Program

The Attempted Suicide Short Intervention Program (ASSIP; Michel & Gysin-Maillart, 2015) is a brief suicide-specific person-centered treatment. ASSIP has a particular role within the acute intervention landscape, as it was designed for and is modally implemented with individuals who have attempted suicide. Data indicate that ASSIP is effective in reducing suicidal behavior (Gysin-Maillart et al., 2016) and is relatively low-cost (Park et al., 2018). With ASSIP, a narrative interview encourages patients to detail the chain of events leading up to their suicide attempt. Clinicians uncover and empathize with the idiographic vulnerabilities and triggers for suicide from the patient's perspective. Critically, the first session is recorded with the patient's consent. It is reviewed in session two, where the patient's earlier mental state is "reactivated" and further explored to outline and reconstruct the links between their thoughts and feelings to the subsequent suicidal behavior. Both the patient and therapist leave the session with homework: the patient is to complete the "Suicide is Not a Rational Act" worksheet, and the therapist is to draft a case conceptualization. The third and final ASSIP session begins with a collaborative review of the case conceptualization. Patients leave the final session with a note listing warning signs, goals, and safety strategies as well as a crisis card listing contact information. Clinicians commonly follow-up periodically with BCIs; often thoughtful letters that remind participants of long-term goals, safety strategies, and a couple of personal statements from the clinician.

Teachable Moment Brief Intervention

Developed by O'Connor and colleagues, the Teachable Moment Brief Intervention (TMBI; 2015) targets suicidal ideation by engaging those who have very recently attempted suicide (i.e., those temporarily residing on an inpatient unit). Related behavioral science research indicates that patients are considerably more open to new information related to problematic behaviors shortly after an event related to the 'problematic' behavior (Boudreaux et al., 2012; McBride et al., 2003). In this light, clinicians can take advantage of the time available during a patient's inpatient stay to utilize the heightened emotional state, build on a patient's proximal understanding of their own risk and protective factors, and clarify (and emphasize) external relationships. TMBI capitalizes on the opportunity for therapeutic intervention immediately before a patient enters a historically high-risk period post-discharge (Chung et al., 2017; Ward-Ciesielski & Rizvi, 2020). This can be critical for mitigating proximal suicide risk as a patient re-enters the community.

CAMS-BI

The Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2023) is an evidence-based, suicide-focused, and patient-centered treatment framework with extensive empirical support (Swift et al., 2021). More will be said about CAMS in the next article on treatment of suicidal risk. However, within our consideration of acute interventions there is an emerging use of CAMS for only one session that is called CAMS-Brief Intervention (CAMS-BI). CAMS-BI was first successfully used in a Louisiana medical center for psychiatric inpatients, emergency department patients, and within consultation-liaison psychiatry on medical-surgical units (Oakey-Frost et al., 2023). The idea of CAMS-BI is to simply conduct the first session of CAMS wherein the patient experiences a therapeutic assessment, completes a thorough CAMS Stabilization Plan, and has increased awareness of the two self-identified "drivers" of their suicidality which invariably needs further treatment

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Treatment of Suicidal Thoughts and Behaviors

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Treating Suicidal Risk

Historically, there has been variability in how the field of clinical psychology treats suicidal thoughts and behaviors (STBs) and currently, there are multiple approaches for STB treatment (Jobes et al., 2015). Before exploring specific treatments, understanding how these treatment approaches were developed can be helpful.

The majority of these treatments were developed based on specific variables that researchers and clinicians hypothesize might predict and influence STBs (Franklin et al., 2017). Some researchers consolidate their findings into etiological theories of suicide in order to inform treatment methods. For example, the cubic model, a theory proposed by Edward Shneidman (Shneidman, 1987), states that individuals will reach a point of engaging in suicidal behaviors to escape the culmination of pain (i.e., psychache), press (i.e., stress), and perturbation. This early theory of suicide influenced a more recent theory of suicide: the Three Step Theory (3ST), an idea-to-action frame work (Klonsky & May, 2015). The 3ST argues that SI originates from experiencing pain and hopelessness, which might escalate if the individual is isolated. The final step of the 3ST states that three aspects of suicide capacity (i.e., dispositional, acquired, practical) progresses an individual from SI to action (i.e., a suicide attempt) (Klonsky & May, 2015). Lastly, some clinicians begin with an assessment aimed to identify personal, longitudinal predictors (i.e., risk factors). Some STB risk factors include previous suicide attempts, psychopathology, social isolation, physical

illness, unemployment, and family conflict (Van Orden et al., 2010). Many researchers theorize that by identifying the risk factor, mental health providers can predict STBs and, ultimately, tailor treatments to effectively treat risk factors (Franklin et al., 2017). However, a recent meta-analysis of 365 studies found that the prediction of STBs using risk factors was barely more accurate than chance (Franklin et al., 2017).

With the field moving away from relying on risk factors as a way to assess suicide risk, there has been an evolution of thinking to warning signs (Rudd, 2003 & Rudd, 2006) and "drivers" (Jobes et al., 2011) of suicide (Tucker et al., 2015). Warning signs can be thought of as the symptoms that alert an individual to seek medical care. Warning signs take suicide risk factors one step further, however the field is still unsure of how clinically useful they are (Fowler, 2012). Rather, using a collaborative, patient-specific approach to identify the factors that are driving an individual's STBs is recommended (Jobes et al., 2011). This approach is utilized in the Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2023). The remainder of this article will primarily aim to review three psychotherapy treatments for STBs and will conclude by suggesting alternative approaches for the treatment of STBs.

Collaborative Assessment and Management of Suicidality: CAMS

CAMS is a suicide-focused therapeutic framework that allows the clinician and patient to collaboratively understand what role suicide plays in a patient's life and to identify the patient's drivers for suicidal ideation (SI) (Jobes, 2023). The four pillars of CAMS are empathy, collaboration, honesty, and a suicide-focus (Jobes, 2023). Within the CAMS framework, clinicians

have the flexibility to utilize evidence-based treatments, such as cognitive behavior therapy (Beck & Dozois, 2011) or dialectical behavior therapy (Linehan, 1987), to treat drivers (Jobes, 2023).

In the initial CAMS session, the clinician-patient dyad complete an assessment to identify the patient's drivers for SI and to collaboratively develop a treatment plan that both members of the dyad believe has the ability to appropriately treat the aforementioned drivers (i.e., CAMS Suicide Status Form [SSF]) (Jobes, 2023). The SSF is made of multiple sections including: core constructs (i.e., what patients find to be the most painful, stressful, when feeling most agitated, hopeless, and self-hateful), overall suicide risk, reasons for living and dying, identifying whether their SI is related to thoughts and feelings about others or about themselves, their wish to live and wish to die, and what one thing would help them no longer feel suicidal. As CAMS is a therapeutic framework, each interim CAMS session begins with an abbreviated version of the initial session SSF and ends with checking in on the patient's drivers and updating the treatment plan, as necessary.

The CAMS approach has been continuously researched to establish its clinical utility. The results of these randomized control trials and one meta-analysis indicate that when compared to a treatment as usual, CAMS surpasses these other interventions in reducing SI (Comtois et al., 2011; Ellis et al., 2017; Ellis et al., 2015; Jobes et al., 2017; Pistorello et al., 2021; Ryberg et al., 2019). Additionally, one meta-analysis showed that CAMS has the ability to effectively increase hopefulness, has fewer attrition, and higher patient satisfaction (Swift et al., 2021).

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT) is an evidence-based therapeutic approach developed by Dr. Marsha Linehan, designed particularly for treating individuals with chronic self-harming behavior and high suicidal risk. Integrating cognitive-behavioral techniques along with mindfulness practices, DBT provides skill-building for clients to tolerate distress, regulate emotions, and improve interpersonal relationships. An integral aspect of DBT is its dialectical nature, emphasizing a balance between accepting one's own experiences and seeking behavioral change. Individuals experiencing emotional pain and struggling to find alternatives to suicidal behavior often find this dialectic approach particularly useful (Linehan, 1993).

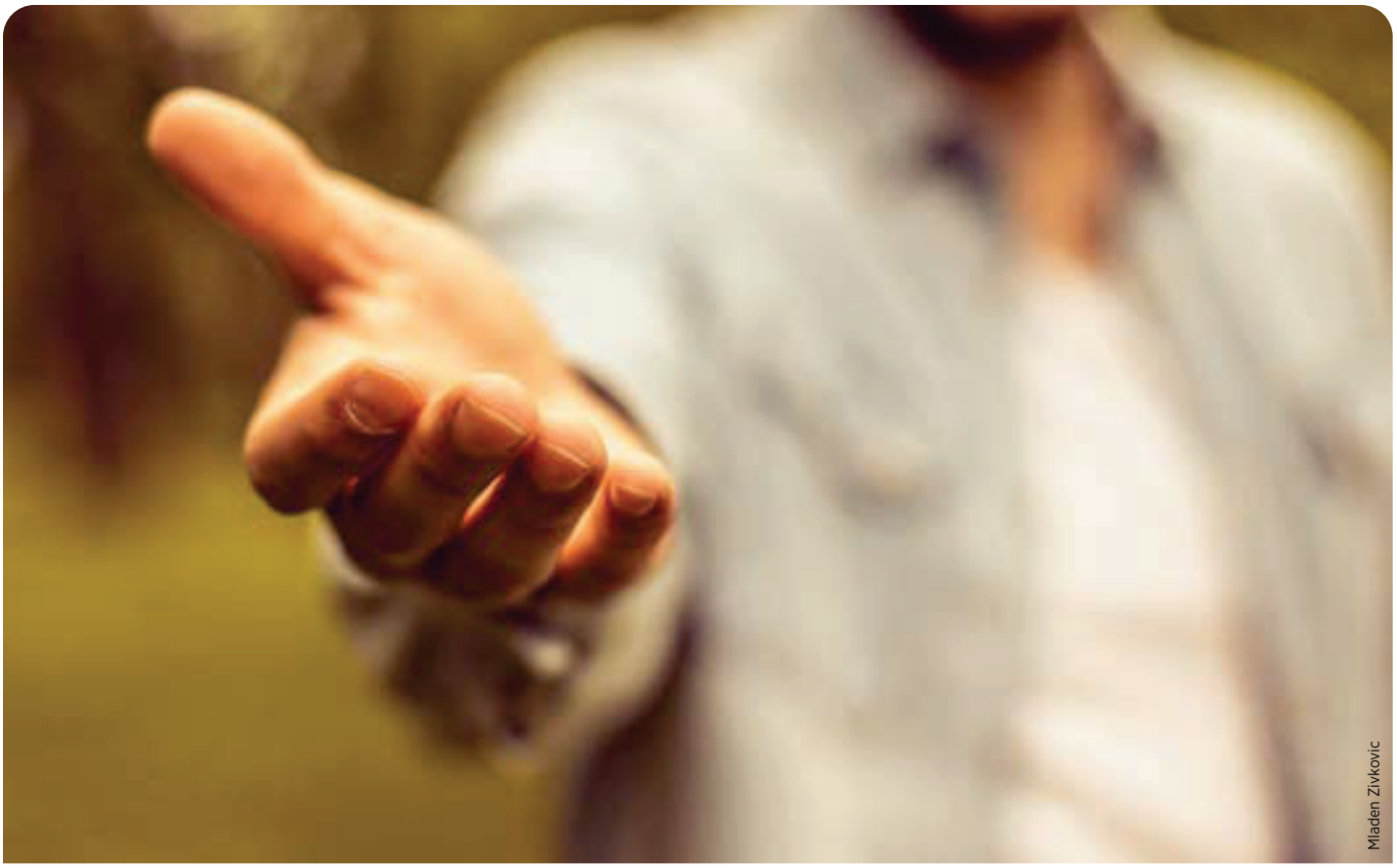
Research shows that DBT effectively reduces suicidal behaviors, especially among individuals with Borderline Personality Disorder (BPD), whose lives are often marked with chronic instability and high suicide risk (DeCou et al., 2019). DBT is not only theory but is structured and comprehensive. Individual therapy is paired with phone coaching, skills training groups, and a therapy consultation team. The skills are intentionally practical and concrete in order to manage overwhelming emotions and reduce the likelihood of engaging in self-harming behaviors (Linehan, 2015).

Studies have also found DBT to be effective for other populations at risk for suicide, such as adolescents, while being adaptable for use in inpatient, outpatient, community, and residential settings (Groves et al., 2012). Its emphasis on problem-solving and emotion regulation allows the treatment to be robust and flexible to addressing the complex needs of clients with suicidal risk. Given its consistent success in real world and clinical settings, DBT remains a gold-standard treatment for reducing suicidal risk.

Additional Treatments

Cognitive Behavioral Therapy (CBT), widely regarded for its efficacy, remains one of the most well-established treatments for those at risk of suicide (Bryan, 2019). Stemming from the belief that thoughts shape feelings, CBT targets maladaptive thought patterns and cognitive distortions, which often fuel self-criticism and hopelessness. Clients learn how to identify and implement not only more positive and productive ways of thinking but also behavioral strategies, like exposure techniques and activity scheduling, to better engage in life and reduce suicidal harm (Wenzel et al., 2009).

Pharmacological interventions, while not a panacea, can be valuable component in managing and treating suicidal risk, particularly for those with underlying psychiatric conditions, like depression, schizophrenia, or bipolar disorder (Zisook et al., 2023). Antidepressants, especially Selective Serotonin Reuptake Inhibitors (SSRIs), have shown effectiveness in reducing suicidal ideation for those with major depressive disorder. Those with mood disorders and fluctuations



have experienced benefits from mood stabilizers, like lithium. Ketamine has shown promise as an important treatment for addressing acute suicidal crises as well.

Beyond psychotherapy and medications, safety planning and other crisis intervention strategies have been vital for reducing immediate suicide risk (Stanley & Brown, 2012). If the broad definition of "treatment" is medical care for an illness or injury, then safety planning certainly counts. As a written plan collaboratively developed to include coping strategies and sources of support, this brief intervention is both simple and effective, which is why it is often used in emergency care settings. Altogether, the combination of psychotherapeutic intervention, pharmacological treatments, and safety planning offer a comprehensive approach to treat, manage, and ultimately reduce suicidal risk.

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post-discharge. Use of CAMS-BI has been shown to significantly reduce subjective units of distress and to increase a desire to live (Oakey-Frost et al., 2023). Given this preliminary success, there are now several efforts to replicate this exciting new use of CAMS.

Caring Contact Follow Up

A final consideration that we noted early on is the use of caring contact outreach that can be done via a letter, email, card, or phone call. This is a simple communication that says: "you have not been forgotten, please let us know if you require any resources of further support." While some of the data are mixed, early research using caring contacts showed an actual effect for decreasing deaths by suicide (for full review see Luxton et al., 2013).

Conclusion

Acute interventions for stabilizing suicidal risk is an exciting and relatively new frontier in clinical suicidology. The promise of these interventions is that they may sufficiently stabilize patients who suicidal such that expensive and often unhelpful emergency department and/or inpatient admissions can be averted. We discussed fundamental interventions such as crisis lines, lethal means safety, and safety-planning type interventions that should be a part of routine clinical care with any patient who is suicidal. Beyond these basic interventions, we also discussed new brief contact interventions that are emerging with growing empirical support. The interventions we have discussed hold the promise of providing evidence-based, least restrictive, and cost-effective care that works in the patient's best interest and can make a real difference for those in acute suicidal crises helping to reduce their suffering and suicidal behaviors.

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