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Empirically-Based Outpatient Treatment for a Patient at Risk for Suicide: The Case of "John"

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ABSTRACT

Emerging research has provided empirical support for a number of cognitive-behavioral strategies designed to reduce suicidal behaviors. In this case study of "John," I describe the application of a combination of these strategies in treating a suicidal patient who recently returned from stressful military duty in Iraq. Focusing on assisting the patient to develop problem-solving and distress tolerance skills, treatment was centered in a collaborative model emphasizing the importance of the therapeutic relationship and involvement of social support networks. Interventions were guided by continual monitoring of suicidal symptoms and general distress level using standardized outcome measures, including Lambert's Outcome Questionnaire (OQ-45) and Jobes' Suicide Status Form (SSF). The treatment involved 21 sessions and resulted in eventual resolution of the suicidal crisis and in significantly reduced emotional distress.

*Key word*s: case study; suicidal behavior; empirically-supported treatment; therapeutic relationship; standardized outcome assessment

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1. CASE CONTEXT AND METHOD

Working with suicidal patients is often an anxiety-provoking clinical activity that is commonly addressed with one of two extreme approaches: (1) an overly-cautious approach that overestimates suicide risk; or (2) an underestimation of suicide risk due to a dismissive attitude or inept assessment (Wingate, Joiner, Walker, Rudd, & Jobes, 2004). The former approach has undesirable consequences, including inappropriate deprivation of patients' rights and misuse of limited clinical resources. The latter approach, by contrast, jeopardizes patient safety and increases provider liability. Research has shown that behavioral health clinicians tend to follow the "better safe than sorry" approach, and overestimate suicide risk (Joiner, Rudd, & Rajab, 1999).

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Many clinicians assume that hospitalization is the "gold standard" for treatment of suicidal patients. A common clinical belief held by behavioral health professionals is that intensive inpatient care is the most effective strategy for reducing suicide risk. In fact, no clinical trial of inpatient hospitalization has *ever* been found to be efficacious for reducing suicidal behaviors (see Comtois & Linehan, 2006). The persistence of this myth, in combination with a shift over the past few decades in the health care system away from inpatient psychiatric services (Goldney, 2003), has contributed to considerable challenges for the outpatient behavioral health practitioner. Because outpatient treatment is currently the most likely — and most available — method for treating suicidal patients (Goldney, 2003), and the criteria for admission into the dwindling number of institutionalized treatment programs continually becomes harder to meet, it is imperative that clinicians become comfortable delivering services on an outpatient basis. Furthermore, it is imperative they do so in a way that is consistent with empirically-supported practices and standards of care.

Adding to the climate of fear and anxiety is the lack of proven treatment options for suicidal patients (Comtois & Linehan, 2006; Rudd, Joiner, Jobes, & King, 1999), which has only within recent years become an issue of increased attention. Emerging research, however, is finding promising strategies that effectively reduce suicidal behaviors. Several of these techniques will be illustrated in this case study.

The setting for the current case discussion was an outpatient behavioral health clinic located in a military hospital that serves as a major medical training facility. I served as the primary behavioral health treatment provider, with direct supervision and consultation by a senior staff psychologist. Case information for this report was obtained from my case notes documented in the patient's behavioral health chart, as well as the patient's outpatient medical record. Confidentiality was maintained in compliance with HIPAA requirements through omission of potentially identifying protected health information. The patient consented to use of de-identified case information for the purposes of training and publication.

2. THE CLIENT

The patient (who will be called "John") was a married, active-duty, Caucasian male officer in his 30's. John was a medical professional with several years of clinical experience as a civilian preceding his entry into the military. His first assignment was at a hospital located on a small military base. John enjoyed this assignment because of its tight-knit community in a relatively isolated area, with close proximity to a variety of outdoor activities (e.g., camping, hiking, and white water kayaking). The community also reminded him of the small town in which he grew up. In the year prior to the initiation of his treatment, he was re-assigned to a large military installation in a metropolitan area, which was the site of the clinic where he was treated. Within a few months of his re-assignment, John volunteered, after long discussions with his wife, for a deployment in support of Operation Iraqi Freedom (OIF) for a number of reasons. First, his wife was early in her pregnancy, so his return from deployment would coincide with the birth of their first child. Second, because his career field was experiencing a high level of

resource strain due to undermanning, his volunteering and participation would have a positive impact on his career. Finally, John felt a strong desire to medically support those military personnel being severely injured on a regular basis during ongoing military action in OIF.

John was deployed for four months to an in-theater hospital in direct support of OIF military operations. The hospital serves as a central point for early medical care, and is a primary trauma center in Iraq. Treatment is provided and triaged according to medical need, not according to national or political alliance. As such, the hospital routinely provides care to US and coalition military personnel, civilian contractors, Iraqi civilians, Iraqi military and security forces, and insurgents/enemy combatants. In light of this treatment approach, it is not uncommon for military medical providers to find themselves treating a US soldier, an Iraqi civilian, and an enemy combatant at the same time, all of them being injured in the same firefight or explosion. While deployed at this hospital, John provided direct medical care to patients with presenting problems ranging from sports-related injuries to amputations caused by improvised explosive device detonation. It was during the second half of his deployment when he reported that the unending stress of his work had become difficult to manage. Upon his return to the US, John experienced a number of major life changes in a very short period of time, including the birth of his child, a new job, and a new community.

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

Fluid Vulnerability Theory

Fluid vulnerability theory (FVT; Rudd, 2006) is a way to understand the process of suicide risk over both the short term and the long term. It is a theory that emphasizes the cognitive, behavioral, and motivational aspects of suicide, and explains why people become suicidal, how long they will stay suicidal, how severe a suicidal episode will be, and the probability of a subsequent suicidal episode. The cornerstone of FVT is the notion of the *suicidal mode* (Rudd, Joiner, & Rajab, 2001) — a specific translation of Beck's (1996) mode theory to suicide risk. A graphic representation of the suicidal mode is provided in Figure 1.

Based on empirical evidence that his original cognitive theory did not fully account for more complex psychological dynamics, Beck offered a refinement of his theory that was organized around several structural schema units — cognitive, affective, behavioral, motivational, and physiological, as reflected in the lower part of Figure 1. Central to mode theory is the reciprocal and synchronous interaction of the structural units. Accordingly, a mode can be defined as a network of systems that are simultaneously activated and maintained by their interplay. In Beck's (1996) words, the mode can be described as an "integrated cognitive-affective-behavioral network [that] produces a synchronous response to external demands and provides a mechanism for implementing internal dictates and goals" (p. 4).

According to mode theory, each individual has certain psychological vulnerabilities based upon static risk factors usually couched in demographic and historic variables. For

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example, gender, age, race, and sexual orientation seem to differentially impact overall suicide risk, as do a history of abuse, previous psychiatric diagnosis, and previous suicide attempts (Bryan & Rudd, 2006). Life stressors (e.g., relationship loss, job loss, medical illness, legal or financial problems) ultimately trigger the suicidal mode based on the individual's unique vulnerabilities. As an individual's predisposition to suicide increases, the suicidal mode becomes easier to trigger by environmental stressors.

The mode's cognitive system involves all aspects of information processing including attention, meaning making, memory, and recall. These elements form the core of the person's assumptions, rules, compensatory strategies, and beliefs about self, others, and the future. As applied to the suicidal mode, the cognitive system is referred to as the *suicidal belief system*, and consists of suicidal thoughts (e.g., "The only option is death"; "I'd be better off dead"; "I'm such a burden on others"; "Things will never get any better."). The cognitive system also includes impaired problem solving, absence of cognitive flexibility, and extreme cognitive distortions -- all of which are characteristics of the suicidal thought process (Reinecke, 2006).

The affective system produces emotional experiences that serve to shape adaptive and maladaptive thoughts and behaviors through the principles of reinforcement; specifically, negative emotions decrease the frequency of certain behaviors, whereas positive emotions increase behaviors. Because suicidal thinking and suicide-related behaviors can actually serve to decrease negative affect via the belief that relief from suffering will come soon (Brown, 1998), the suicidal mode is negatively reinforced, and therefore more easily activated in the future.

In Rudd, Joiner, and Rajab's (2001) original conception of the suicidal mode, the motivational and behavioral systems were lumped together. In clinical practice, however, it is useful to consider them as separate systems. As a part of the suicidal mode, the motivational system is referred to as intent — the purpose underlying the self-injurious behavior. Intent is the central feature of self-injurious behaviors that differentiates suicidal behaviors from other intentional self-injurious behaviors without intent to die (e.g., using the appearance of suicide for interpersonal or other secondary gain). Intent is a key variable for understanding intentional self-injury and suicide risk (Bryan & Rudd, 2006), and speaks directly to the reasons *why* the behavior is occurring.

The behavioral system includes those actions that are automatically activated in response to cognitive and affective processes, guided by intent. The system includes a wide spectrum of behaviors including self-injury (e.g., cutting or burning one's arm to reduce emotional distress through physical self-punishment); instrumental behaviors (i.e., using the appearance of suicide for an end other than death); preparatory behaviors or suicide rehearsal (e.g., buying a gun, counting pills, tying a noose); and suicidal acts (i.e., suicide attempts). The behavioral system also speaks to those vulnerability factors that contribute to suicide risk — interpersonal skills deficiencies, absence of self-soothing skills, and poor emotion regulation strategies.

Finally, the physiological system comprises those physical reactions and symptoms that are automatically activated in response to cognitive, affective, and behavioral processes. For

example, the autonomic arousal that often accompanies anxiety, stress, and anger — common emotional features of the suicidal mode — can contribute to unpleasant physical symptoms that maintain the suicidal belief system and emotional dysphoria.

In summary, the suicidal mode is a useful model for understanding the complexities of suicide risk. As the central component of FVT, suicide risk can be understood as a function of the vulnerability to activation — or triggering — of the suicidal mode across all systems. As a model of suicide risk, the suicidal mode describes the inherently time-limited nature of suicidal episodes—a fundamental assumption of FVT referred to as *acute risk*. A second assumption of FVT that is explained by the suicidal mode is that *baseline risk* — the general level of risk when a person is at their relative best — varies by individual and is determined by vulnerability factors. FVT therefore proposes a mechanism by which to understand chronically suicidal individuals: greater predispositions to suicide contribute to higher baseline risk levels with lower thresholds for triggering the suicidal mode.

In terms of clinical practice, FVT speaks to the importance of recognizing the dynamic nature of suicide risk. Clinicians who recognize the ever-changing nature of suicide risk are better positioned to respond to the short-term and long-term needs of their patients. Additionally, because the suicidal mode consists of several interrelated system, clinicians have greater flexibility in intervening with a suicidal patient, as they can assess which systems are most quickly and easily modified, as well as simultaneously targeting multiple systems to more thoroughly deactivate the suicidal mode. Most important, however, FVT necessitates a transactional — as opposed to linear — relationship between assessment and intervention because it demands continual monitoring of a constantly changing risk level, which in turn leads to appropriate changes in clinical response. Another way to say this is that in dealing with suicidal risk, assessment and treatment are one and the same.

A Collaborative Approach to Understanding Suicide Risk

The traditional model of psychological assessment and treatment involves a process by which the expert clinician sits across from the patient and attempts to uncover the underlying problem through a series of reductionistic questions (Jobes, 2006). In this approach, the clinician acts as a detective, in a one-up position of authority while the patient adopts the sick role and passively receives treatment. The clinician attempts to find the objective identifiers of suicide risk that will uncover the mystery that lies within the patient. A collaborative approach, by contrast, embraces the patient as the expert of their own unique suicidal experience. In the Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2006), the clinician literally gets up out of his or her chair to take a seat next to the patient in order to look at the subjective experience of suicide risk through the eyes of the at-risk patient. Together the clinician and patient work to understand the nature of the patient's suicide risk, and jointly develop a plan to reduce the suicidal crisis. By working collaboratively with the patient, a clinician can potentially enhance a patient's motivation and commitment to treatment, and can realize enhanced clinical outcomes (Jobes, 2006).

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The CAMS approach is philosophically oriented towards outpatient treatment, with a core feature of combining assessment and treatment during all stages of treatment. As such, it works seamlessly within FVT. Upon initial contact, the clinician and patient work together to understand those variables that are most significantly contributing to the patient's current suicidal experience. Treatment interventions are then developed to specifically target the most salient domains of risk. During subsequent contacts, domains of risk are reassessed each time to monitor change — whether positive or negative — and interventions are modified accordingly. When the suicidal episode resolves (defined as three consecutive sessions without any suicidal ideation), the patient and clinician then work together to identify those aspects of treatment that were most beneficial or effective.

CAMS, which has been developed over the course of 20 years, has demonstrated good initial empirical support, and is described extensively in Jobes' (2006) book *Managing Suicide Risk: A Collaborative Approach.* In short, CAMS is a structured framework — not treatment — for managing suicidal patients. As such, it can be effectively used by clinicians of any psychotherapeutic orientation or training.

The Importance of Understanding the Subjective Experience of Suicide Risk

Suicide actually has very little to do with death, and everything to do with psychic pain -- an important point first elaborated upon by the eminent suicidologist Edwin Shneidman, who coined the term "psychache" to describe the specific emotional state contributing to suicide (Shneidman, 1993). Suicide also has a great deal to do with relationships — or rather lack thereof. As a person feels increasingly isolated and disconnected from others, and believes that others would be better off without them (a particularly pernicious form of psychache), they become increasingly vulnerable to suicide (Joiner, 2005). Understanding the patient's subjective perspective of suicide therefore becomes the clinician's primary task, as it not only guides the development of a plan that will eventually alleviate the patient's intense pain, but also lays the foundation for establishing the relationship that is absolutely necessary for this change to occur.

4. ASSESSMENT OF THE CLIENT'S PROBLEMS, GOALS, STRENGTHS, AND HISTORY

John, a medical professional, initially presented to the outpatient behavioral health clinic with his supervisor, who expressed concern about his level of stress and had encouraged him to seek out professional help. John agreed to do so with the supervisor's support. I was the on-call clinician at the time of John's initial contact with the clinic, and met with him briefly for a risk assessment and clinical triage.

John reported a high level of distress that had been mounting over the past three months since his return from Operation Iraqi Freedom (OIF). Contributing to his distress were his recent return from OIF and subsequent transitional struggles, the recent birth of his first child, living in a new (much larger) city, and starting a new job in a large medical center known for being

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regularly undermanned due to high operational demands. John described feeling overwhelmed with all the changes in his life, with occupational stress being particularly salient. He reported an inability to concentrate while assisting with complex medical procedures, and a constant feeling that he was not doing his job well enough. John said his mind was constantly racing with thoughts about what he "should" be doing or how he could be doing things better. Although he was working extra hours to "catch up," he could not seem to finish all his many tasks and duties. John expressed certainty that his coworkers and colleagues were frustrated with his incompetence, and he was exasperated because he could not get the training he believed he needed.

John reported increased insomnia and agitation over the past few months, such that he was regularly feeling exhausted and restless during the day. He was not socially active at the time of the initial evaluation because he did not yet know many people in the area. He complained that he was unable to concentrate at work or home, which impaired his ability to adequately perform his job. He found it very difficult to enjoy life, and had stopped engaging in many activities (e.g., working out, camping, hiking, and kayaking,). John experienced an extremely high level of guilt secondary to his deployment experience, explaining that the reality of war and his identity as a medical professional often came into direct conflict and created moral dilemmas and crises that he could not resolve.

When asked about current suicidal ideation, John became visibly uncomfortable and responded, "I'm not going to do that." I pointed out that I had asked whether or not he had been *thinking* about suicide, not whether or not he was going kill himself. He was reluctant to answer the question, and responded, "It's not an option." As a follow-up, John was asked, "Let's say you were thinking about suicide, and you were to tell me so. What do you think would happen?" John's fears about hospitalization and career impact were immediately identified and discussed. The decision-making process for inpatient hospitalization was explained, and John was reassured that thinking about suicide in and of itself does not necessarily implicate hospitalization. This appeared to alleviate John's anxiety, and he quickly admitted to thinking about suicide several times per day with increasing frequency and intensity over the past several months. John reported that he first thought about suicide while in-theater, when the mounting stress of caring for the horrifically wounded troops and enemy combatants, in combination with the "chaos of war," reached a point beyond which he could reasonably manage. Surrounded daily by pain and suffering, and separated from his family and social support network, he noticed himself thinking about death without suicidal intent (e.g., "I'd be better off dead," "The only way I'll get out of here is to die") on an increasing basis. As the stress of deployment continued, these thoughts about death evolved into thoughts about self-inflicted death. In light of the many simultaneous, major life changes occurring during his transition back from OIF, John's stress only heightened. He began thinking about shooting himself in the head with a firearm, and found it difficult to control these thoughts when highly distressed. The stress began to negatively impact his marriage, which only heightened his distress more. John eventually found himself in a feedback loop of increasing emotional distress and suicidal thinking. Despite this, John expressed a low desire for death and very high desire to live, noting that he wanted nothing more than for the suicidal ideation to go away.

A full suicide risk assessment was subsequently conducted during the interview, consistent with the risk assessment model described in detail by Rudd, Joiner, and Rajab (2001) and Bryan and Rudd (2006). John denied previous psychiatric problems or treatment, although a family history of mental illness marked by bipolar disorder was reported. He denied any previous suicide attempts or a history of suicidal ideation prior to the current episode. A history of physical, sexual, and emotional abuse was denied. No evidence of reckless behaviors or impulsivity were noted, and John indicated that he generally feels in control of his behaviors and actions, although recently he had been "losing his cool" more frequently. During these episodes of dysregulation, John reported behaviors such as pulling his hair and making extremely disparaging self-statements, but never posed a risk to others. No history of violence or aggression was noted. John expressed a moderate level of hopelessness marked by ambivalence: he hoped that his condition and situation would improve, but was not yet convinced it would be possible. John reported access to lethal means (firearms in the house) that was consistent with the content of his suicidal thinking, but he denied that he had engaged in any preparatory or rehearsal behaviors. Protective factors that were identified included a positive marriage, presence of a child in his house, a desire to live, and a desire to engage in treatment.

In addition to the many protective factors in his life, John's strengths included high intelligence and considerable education. As a medical professional, he had a deep appreciation for life that fueled the motivation he needed to improve. He was highly regarded by his colleagues, and was well-liked because of his humility and concern for others. Most importantly, John demonstrated a courage that he did not initially recognize; by overcoming his fear that seeking treatment would have a negative impact on his career, John was able to reach out and establish the relationships he needed to eventually recover.

5. FORMULATION AND TREATMENT PLAN

Using fluid vulnerability theory to inform our understanding of John, the suicidal mode is first considered. John's case clearly demonstrates the interactive and self-sustaining nature of the suicidal mode: stress (affective), concentration impairment and insomnia (physiological) contribute to suicidal ideation as a mechanism for escape (motivational), which in turn feeds into feelings of guilt, shame, and anger (affective) about his "cowardice" (cognitive) and inability to effectively manage his distress (behavioral). As a compensatory strategy, John works longer hours and engages in pleasurable activities less frequently (behavioral), but this does not appear to be effective, reinforcing his belief that he is incompetent and worthless (cognitive). John perceives himself as a burden on his family and coworkers (cognitive), which heightens feelings of shame and depression (affective). All of this can be resolved through the mechanism of suicide (cognitive), which only causes him to feel more ashamed and distressed (affective), though John does not yet desire death (motivational).

Overall, John does not appear to have many historical factors that predispose him to suicide (e.g., no history of abuse or previous attempts), although a few demographic variables (Caucasian, male) might contribute to increased vulnerability. More significant, however, is

John's history (albeit a relatively recent one) of psychiatric symptoms and ongoing exposure to trauma. A family history of significant mental illness might also contribute to heightened vulnerability to suicide. Notable about John's case are the numerous stressors in his life: recent return from deployment, the birth of his first child, a new home in a new city, and a new job.

Fluid vulnerability theory thus explains how John — a person without a significant level of vulnerability to suicide — can become acutely suicidal. Furthermore, the theory explains how John's suicidal crisis sustained itself over time and became increasingly severe. Most importantly, fluid vulnerability theory provides a framework for intervening with John to deactivate the suicidal mode and resolve the acute crisis.

Treatment Plan

The treatment plan emerged from the first treatment session. The process of its development is described in detail below in the portion of section 6 (Course of Therapy) devoted to this first session. In brief, the initial treatment plan focused on reducing the frequency and intensity of suicidal ideation through behavioral skills training and cognitive restructuring of the suicidal belief system. Secondary treatment goals were reduction of emotional distress associated with combat trauma through cognitive reprocessing and participation in a combat PTSD group. The agreed-upon primary treatment modality was individual cognitive-behavioral therapy on a weekly basis. Evidence for reducing suicidal behaviors through cognitive-behavioral treatments has been demonstrated in several clinical trials (e.g., Brown, Have, Henriques, Xie, Hollander, & Beck, 2005; Linehan, Comtois, Murray, Brown, Gallop, Heard, et al, 2006; Rudd, Rajab, Orman, Stulman, Joiner, & Dixon, 1996).

An important part of Collaborative Assessment and Management of Suicidality (CAMS) involves the careful and systematic monitoring of ongoing treatment. At the beginning of each clinical contact, John completed the Outcomes Questionnaire-45, (OQ-45; Lambert et al, 1996; Lambert, 2007), which is a 45-item questionnaire designed to assess four domains of functioning: "symptoms of psychological distress (primarily depression and anxiety); interpersonal problems; social role functioning (e.g., problems at work or school); and quality of life (positive aspects of life satisfaction)" (Lambert, 2007, p. 2). Each item is scored on a 5-point scale (0 = *never*, 1 = *rarely*, 2 = *sometimes*, 3 = *frequently*, 4 = *almost always*), yielding a total, global assessment score range of 0 to 180, with higher values indicating higher pathology. (The total, global score was used in monitoring John and will hereafter be called simply the "OQ-45 score.") The measure has accrued considerable internal-consistency reliability and concurrent validity (Lambert, 2007).

Item #8 on the OQ-45 specifically probes for frequency of suicidal ideation (0 = *never*, 1 = *rarely*, 2 = *sometimes*, 3= *frequently*, 4 = *almost always*), and serves as a screening item to determine suicide status. The Air Force recommended outpatient clinic approach for integrating the OQ-45 with CAMS (see Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005) is to place patients who endorse a 2 or higher on item #8 on "suicide status." Once this suicide status is activated, the patient and clinician collaboratively complete the "Suicide Status Form" (SSF;

Jobes, 2006), which is the core clinical tool within CAMS. The SSF proper (see Appendix 1 for a blank form) consists of four sections: Section A, completed by the patient in session, consists of Likert ratings and qualitative responses for suicidal symptoms; Section B, completed by the clinician in session, consists of an assessment framework based on empirically-based risk factors for suicide; Section C, completed by the physician together with the patient in session, is the treatment plan; and Section D, completed by the clinician post session, consists of a mental status exam, diagnosis, and clinical notes.

In Section A, patients are first asked to rate the severity of six suicidal constructs on a scale of 1 (*low*) to 5 (*high*) (Jobes, 2006, p. 10):

1. *Psychological pain*: "hurt, anguish, or misery in your mind; not stress; not physical pain)
2. *Stress:* "your general feeling of being pressured or overwhelmed"
3. *Agitation:* "emotional urgency; feeling that you need to take action; not irritation; not annoyance"
4. *Hopelessness:* "your expectation that things will not get better no matter what you do"
5. *Self-hate:* "your general feeling of disliking yourself; having no self-esteem; having no self-respect"
6. *Overall risk of suicide*

Each of these constructs is followed by a prompt for patients to write additional information regarding their subjective experience of each symptom (e.g., "What I find most painful is…"). Patients are then asked to rank these constructs in order of importance.

The second part of Section A captures information regarding the ambivalence inherent in the suicidal dilemma (Jobes, 2006). Patients are asked to rate the extent to which their suicidal state is influenced by self or others, to list and rank order their reasons for living and dying, and to independently rate their desire for both life and death. Section A is concluded by a prompt for the patient to write the one thing that would most contribute to a reduction in suicidal feelings.

Section B consists of a framework for conducting a suicide risk assessment based on empirical findings. Table 1 lists those empirically-based categories of a full risk assessment on which Section B is based.

Section C includes the treatment plan, in which "self-harm potential" is identified as the primary clinical problem, with "outpatient safety" being the goal (Jobes, 2006). Clinicians and patients work together to develop the nature of the interventions.

Finally, Section D provides space for a mental status exam, diagnosis, and classification of suicide risk level (see Bryan & Rudd, 2006, for full discussion of risk level), which is completed by the clinician after the session has ended. By completing all sections of the SSF, the clinician has completed all major components of effective treatment: thorough assessment of suicide risk and appropriate clinical response.

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Follow-up sessions are initiated by completing a shortened version of the SSF called the "Suicide Tracking Form" (STF; Jobes, 2006). Specifically, as can be seen in Appendix 1, the STF involves the six suicidal construct Likert ratings from the SSF, a treatment plan update, a mental status exam, and a rating of the patient's overall suicidal risk level. Suicide status is resolved when patients report a score of 0 or 1 on the OQ-45 item #8 for three *consecutive* sessions, and at this time the STF form is discontinued (unless OQ-45 item #8 later goes up beyond 0 or 1 in a consistent way). Using the CAMS approach, the clinician and patient can collaboratively track changes in suicidal symptoms across the course of treatment, and modify interventions appropriately. During the course of John's treatment, the CAMS model's SSF and STF tracking measures were critical not only in understanding John's unique experience of his suicidal crisis, but also in alerting me to changes in risk status that directly led to modification of clinical interventions. The CAMS approach, including all forms and paperwork used in the treatment of John, is fully discussed in Jobes (2006).

John's OQ-45 scores and his 6 construct scores on the SSF and STF across the course of treatment are displayed in Table 2. Figure 2 graphically displays the change in OQ-45 scores across treatment. Based on group studies of both non-clinical and patient samples, the OQ-45 score has been normed such that scores below 63 are considered to indicate normality; scores between 63 and 76, mild pathology; scores between 77 and 90, moderate pathology; scores between 91 and 105, severe pathology; and scores 105 and higher, extreme pathology. These group studies with the OQ-45 score also form the basis for clinically interpreting changes in the score, as described in note 2 of Figure 2.

6. COURSE OF THERAPY

Initial Clinical Contact

The initial clinical contact with John, during which a suicide risk assessment was conducted, is described above in section 4 on Assessment. During the risk assessment phase of this contact, John expressed an interest in initiating psychological treatment to target depression and suicidal ideation. He was therefore scheduled for the first available full intake evaluation slot, which was three weeks in the future, with phone contacts between John and myself during the 3-week waiting period to address his suicidal thoughts and risk as they came up.

When working with suicidal patients, the primary treatment emphasis is always the maintenance of outpatient safety, since — simply put — it is not possible for a patient to improve if he or she is dead. As such, steps must be taken to limit access to potentially lethal means, to seek out the involvement of social support networks, and to develop contingency plans in the event of escalating suicide risk. In line with this goal, during the initial contact, a crisis response plan was also developed with John's input to provide specific behavioral steps to aid problem-solving during periods of suicidal mode activation (cf. Rudd, Mandrusiak, & Joiner, 2006):

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1. Recognize that my suicidal thoughts are temporary and will go away.
2. Do something I enjoy: go for a walk
3. Talk with someone about how I'm feeling: wife
4. Repeat all of the above
5. Call outpatient behavioral health clinic: [clinic phone number provided]
6. After hours or during weekends, go to the ER
7. In an emergency, call 911

Because John reported access to firearms at his house, the limitation of access to lethal means became a primary task to ensure his safety. In the initial contact session John agreed to allow me to contact his wife via telephone. I notified John's wife of the current situation, and asked her if she could change the combination to the gun safe and keep it secret; she indicated she would do so immediately. I informed John's wife of the current treatment plan, and assured her that John's current problems could be effectively treated. John and his wife then spoke with one another briefly over the phone. Since John's marriage appeared to be a very powerful protective factor, he was asked to sign an informed consent to release information to his wife so she could be communicated with at any point in the future as a part of treatment; John agreed to this. John was also notified that I would contact him within three days to see how he was doing, but he was encouraged to contact me before then, if needed. At the close of the initial evaluation, John reported a slight decrease in distress, and expressed hope that his symptoms would improve with treatment.

Initial diagnostic impressions included a provisional diagnosis of Adjustment Disorder With Mixed Anxiety and Depressed Mood, with "rule outs" for Posttraumatic Stress Disorder and Major Depressive Disorder. Based on John's presentation at the time of initial contact, suicide risk was categorized as acute (no previous suicide attempts, presence of significant risk factors), and was assessed as mild (moderate psychiatric symptoms, current suicidal ideation, no suicidal intent or plan, no preparatory behaviors, and presence of significant protective factors). For mild suicide risk, outpatient treatment is indicated (Rudd, Joiner, & Rajab, 2001; Bryan & Rudd, 2006). The full risk assessment and resulting clinical responses were documented thoroughly, consistent with the requirements of clinic policy and professional standards of care (e.g., Berman, 2006).

Short-term Follow-Up During 3-Week Waiting Period

Because suicide risk is inherently dynamic in nature (Rudd, 2006), ongoing monitoring is critical for appropriate and reasonable clinical care. In John's case, where the next available appointment was three weeks in the future, as mentioned above it was important to maintain contact via telephone in the interim to monitor ongoing suicide risk. Three days following the initial contact, I called John to assess current symptomatology and any changes in risk level. He reported increased hopelessness with continued occupational stress and intrusive memories of deployment experiences. John also complained of significant onset and maintenance insomnia that did not improve with the use of over-the-counter sleep aids. He reported continued suicidal

ideation with no changes in frequency, intensity, or duration since the initial evaluation. His wife confirmed that she had locked up all the firearms in the house and had not given John the new combination.

Over the phone, John was educated in sleep hygiene behaviors in response to his sleep complaints, and was encouraged to begin using them immediately. In light of John's reported increase in hopelessness and agitation in the presence of continued suicidal ideation, his risk level was increased to moderate. Consistent with Air Force and clinic policy, John was placed on the clinic's high interest log, which is a mechanism designed to enhance tracking of high risk cases and to foster professional consultation and multidisciplinary collaboration. His intake appointment was rescheduled for an earlier date, four days in the future. As a final intervention, the crisis response plan was reviewed with John and his wife.

Session 1: Developing a Therapeutic Relationship, Detailed Assessment of Suicidal Thoughts and PTSD-Related Problems, and Treatment Planning

As mentioned above in section 3 (Guiding Conception), suicide actually has very little to do with death, and everything to do with psychic pain and feeling cut off from others (Schneidman, 1993). This requires the clinician to begin treatment by focusing on the patient's subjective perspective of suicide, both in the development of a treatment plan for alleviating the patient's intense pain and in laying the foundation of an effective therapeutic relationship

In light of this, the primary task for the clinician is to move *towards* the suicidal patient—so close that the clinician can see the patient's unique symptomatic experience through their own eyes. In CAMS, this movement is accomplished both figuratively and literally: the clinician actually takes a seat physically *next to* the patient to work collaboratively on understanding the suicidal state. As applied to the case of John, CAMS provided a framework within which he and I could navigate the process of suicide risk to gain a better understanding of how he arrived to this point, and how the we could work *together* to render obsolete John's consideration of suicide as an option.

During the clinical interview during the first session, John was asked to complete the Suicide Status Form (SSF; Jobes, 2006; see Appendix 1) collaboratively with me. I asked for his permission to sit next to him on the couch while we worked on this form, to which he agreed. The SSF was handed to John on a clipboard, and was completed together using the recommendations and guidelines described by Jobes (2006). A suicide risk assessment (see section B of the SSF and STF in Appendix 1) was then completed, consistent with professional standards of care. Upon completion of the risk assessment, I returned to my chair across from John to complete the clinical interview, using the information already gained from the SSF.

The content of the clinical interview revolved primarily around John's deployment experiences in Iraq. While deployed, John was frequently exposed to trauma in which others were routinely dying or suffering from severe injuries. Worries about his own death lurked constantly in the back of his mind, since the base where he was deployed was typically mortared

multiple times per day. John described feeling trapped and emotionally overwhelmed by these experiences, and he was haunted by intrusive memories and dreams about specific patients and events he encountered while deployed. Guilt was the primary emotion associated with these memories, but at the time of the clinical interview he was unable to elaborate further. Since his return from Iraq, John found it emotionally distressing to work in the hospital's trauma center because exposure to the sights, sounds, and smells of severely injured patients elicited memories of his deployment. This interfered with his ability to concentrate adequately on the injured patients. As such, John started to avoid the emergency room, and would find excuses to send other medical personnel to do his work in his stead. He found it difficult to talk about his deployment experiences with coworkers and family, and would often withdraw when the topic came up. John described a sense of emotional confusion — as if he were not feeling the "right" emotions. His concentration and sleep were severely impaired, and he found himself unable to control his temper, which had never been a problem for him before. When intensely distressed, he would pull his hair and hit himself in the head, which terrified his wife and strained their relationship. Based on the results of the clinical interview, Posttraumatic Stress Disorder (PTSD), Chronic, appeared to best account for his cluster of symptoms, and was diagnosed at that time.

The model of the suicidal mode was explained to John during the first session, and the information he provided on the SSF was plugged into the model in Figure 1 to diagram his unique experience of suicide. Mode theory was also used as a framework for understanding the various symptoms of PTSD. John was informed that his reported symptoms were consistent with PTSD, and was educated about how PTSD develops and is maintained in accord with cognitive-behavioral theory. He agreed to engage in an exposure-based, cognitive-behavioral approach to treatment for PTSD (Cigrang, Peterson, & Schobitz, 2005), and agreed to consider enrollment in a combat trauma group at a neighboring military installation, although he did not feel comfortable with the group setting and in fact never attended any of the sessions. He expressed significant concerns about the negative impact of behavioral health treatment on his career, and verbalized a belief that he would be discharged from the military for being suicidal or "crazy." He also worried that treatment could have an impact on future career opportunities. These fears were discussed, and military policy was referenced to alleviate John's concerns. The process of documenting treatment notes in his behavioral health chart and his outpatient medical record were clearly explained. John was also informed that he could have access to his chart to review his notes with me at any time to clarify or address any documentation that he believed was potentially damaging or inappropriate. This seemed to satisfy John, although fears about negative career impact remained an underlying theme throughout the treatment process.

In reviewing John's SSF subjective responses, the primary role of negative self-evaluation, particularly with respect to occupational performance, could be clearly seen. John's responses to the five primary scales in section A of the SSF (see Appendix 1), in order of most to least important symptoms (with Likert ratings of intensity on a scale of 1 = "low" to 5 = "high" in parentheses) were:

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- Stress (4): *What I find most stressful is*: "I've created stress myself because I put it aside, not wanting to deal with it, which is not like me."

- Hopelessness (4): *I am most hopeless about*: "worried about ACLS [mandatory life support training], I don't want to be at work, I just need to simplify."

- Self-hate (4): *What I hate most about myself is*: "I just don't feel like I'm good at my job right now, I just want to be good again and people to look up to me. I feel guilty about thinking this."

- Agitation (4): *I most need to take action when*: "right now I feel like I've got to study and get things done and get organized and learn where things are, but people can't help me."

- Psychological pain (3): *What I find most painful is*: "the fact that I'm feeling down in the dumps and not on top of the world or my game."

- Overall risk of suicide (1): *Extremely low risk (will not kill self)*

John rated stress (i.e., feeling pressured or overwhelmed) as the symptom contributing most to his suicidal experience, explaining that he perceives his stress as a product of his own making. In fact, many of John's responses were marked by extreme self-criticism, pointing to the centrality of negative self-regard as a maintaining factor for his distress. He reported elsewhere on the SSF that his suicidal state is completely due to feelings about himself, and not at all due to feelings about others. Low self-esteem was such a pervasive reason for wanting to die that improving his self-esteem was the single most important factor that John believed would make him feel less suicidal (*The one thing that would make me no longer feel suicidal would be*: "feel better about myself"). The SSF also has a part in section A in which the patient is directed to list reasons for living and reasons for dying, so that the ambivalence inherent in the suicidal crisis can be better understood (Jobes, 2006). John listed two reasons for living — religious beliefs against suicide, and his wife and child; and three reasons for dying — wanting to rest, low self-esteem, and feeling like quitting. Importantly, John's reasons for living had greater subjective weight than his reasons for dying.

One of the great benefits of the CAMS approach is the intimate connection of assessment and treatment. By completing the SSF, John and I had not only gained an understanding of his unique suicide risk, but had simultaneously identified those areas of John's life that could be mobilized for support (e.g., family involvement), as well as those areas that could be targeted for clinical improvement (e.g., self-esteem, stress management, occupational problems). Treatment planning for John therefore flowed directly from the SSF.

Because change in treatment typically begins with improvement in subjective well-being that precedes symptomatic relief and, finally, change in maladaptive and habitual behaviors that have been learned over time (Howard, Kopta, Krause, & Orlinsky, 1986), the overall design of John's treatment was to start with the development of those behavioral skills deficits that contributed to and maintained his affective distress. Through the acquisition and refinement of

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these skills, John's symptoms were expected to improve, which would reinforce the belief that his condition could improve. This would pave the way for more complex treatment goals targeting the cognitive domain — specifically, uncovering and restructuring those distorted self-perceptions of incompetence and worthlessness that fueled his suicidal belief system. As John adopted a more realistic and balanced view of himself and the world, it was expected that he would begin interacting with the world in more adaptive ways that would contribute to improved self-esteem and life satisfaction — both of which would serve to protect against future suicidal episodes.

The initial treatment plan focused on suicide risk as the primary problem, with an identified goal of reducing the frequency and intensity of suicidal ideation. Several interventions were identified to target suicidal ideation, the most important of which was cognitive restructuring of John's suicidal belief system to reduce negative self-statements. Other interventions included problem solving skills training to target hopelessness, relaxation training to reduce agitation, and behavioral activation strategies (e.g., increased exercise and pleasurable activities) to elevate mood and reduce stress. Secondary treatment goals were reduction of emotional distress associated with combat trauma through cognitive reprocessing and participation in a combat PTSD group. The agreed-upon primary treatment modality was individual cognitive-behavioral therapy on a weekly basis. Three primary treatment goals were set: (1) resolution of suicidal ideation (defined as three consecutive sessions with scores of 0 or 1 on the OQ-45 item #8); (2) decreased suicidal symptoms (measured by SSF ratings); and (3) decreased emotional distress (measured by OQ-45 total score). John agreed with this initial treatment plan. The use of psychotropic medications for symptom management was also proposed and discussed, though John was hesitant to pursue this treatment option. As such, medication evaluation was maintained as an avenue for future treatment directions, but was not actively pursued at the outset of treatment.

Sessions 2-7: Increasing Rapport, Instilling Hope, and Early Symptom Management

The perception that one is disconnected from social relationships increases risk for suicidal behavior (Joiner, 2005). Social withdrawal often precedes suicide (Trout, 1980), and loneliness is frequently reported by suicidal persons. Furthermore, the belief that one is a burden on others (e.g., "You'd be better of without me") has been identified as a particularly pernicious cognitive process contributing to suicide, whereas a sense of connectedness with—or importance to—others seems to have a positive impact on the desire for life (Joiner, 2005). Because relationships are critical for reducing suicide risk, it is imperative that clinicians place considerable emphasis on developing and maintaining positive therapeutic relationships with suicidal patients. Clinical research has clearly shown that a positive therapeutic relationship is essential to positive clinical outcomes (Garfield, 1994).

In light of John's concerns about the negative career impact of behavioral health treatment, it became necessary for me to reassure John on a regular basis and frequently reinforce his decision to seek help. To achieve this end, I had to reframe his belief that help-

seeking behaviors are a sign of weakness (e.g., "It really takes a great deal of strength to face these problems and get help for them."). John's fear of negative career impact was a recurring theme of our relationship, requiring me to maintain an interpersonal presentation of confidence in the treatment process. The conveyance of certainty that John would eventually improve in functioning provided the necessary avenue to engage him fully in treatment. It was much later in treatment, during our termination session, that John acknowledged a primary contributor to his continued participation in treatment (especially in the early sessions) was trust in my unwavering confidence in the treatment process, which outweighed the lack of confidence in himself.

Stress management was a significant skills deficit, and was identified by John on the SSF as the primary source of his suicidal crisis. As such, it became the first target of intervention in treatment. John was trained to use deep breathing during the second session as a brief, focused method for managing the physiological symptoms of stress. He was directed to practice deep breathing several times per day in between sessions. Upon follow-up during the third session, he reported decreased emotional distress and suicidal ideation, although he continued to feel emotionally overwhelmed at work. John tended to overestimate the importance of relatively minor and inconsequential tasks ("Everything has to get done now"), and assumed responsibility for others' problems (e.g., "If you want something done right, you have to do it yourself"). These beliefs were directly challenged during the third session through problem-solving and prioritization skills training. John was trained to measure tasks according to two dimensions—urgency and importance (cf. Covey, 1989) — and to prioritize his actions according to both dimensions. His between-session assignments were to develop a list of tasks on a daily basis that he would rate according to both dimensions, then prioritize according to a mutually agreed-upon classification system (ordered from highest to least priority): "A" tasks had both high urgency and importance, "B" tasks had high urgency but low importance, "C" tasks had low urgency but high importance, and "D" tasks had both low urgency and important. He was directed to focus only on the "A" and "B" categories at any given time, and to disregard lower priority tasks until higher priority tasks were completed.

During the fourth session, use of deep breathing, problem-solving, and prioritization skills were refined and reinforced. A plan for increasing physical activity and exercise was developed since these were activities that John had previously enjoyed, but had abandoned following his return to the US. Physical activity has been associated with elevated mood and decreased emotional distress (Stathopoulou, Powers, Berry, Smits, & Otto, 2006); combined with the fact that such activities were previously enjoyable for John, it was believed these simple strategies would have a positive impact on his functioning. John continued to express a belief that he was incompetent and deficient in his work capacity, despite receiving overwhelmingly positive feedback from colleagues and supervisors. John dismissed these statements, however, explaining that his coworkers were "just being nice" to him. When this thought process was challenged, John agreed it was unlikely that his coworkers were lying to him, as doing so would put patient safety at risk. This session also emphasized practice of communication and assertiveness skills, which John used to approach his supervisor to discuss strategies for reducing occupational stress. The meeting with his supervisor was a success, with an agreed outcome to transfer John to another clinic with less stressful clinical work.

Cognitive restructuring continued through session 5, during which John was asked to develop a list of reasons for living (RFL). This treatment intervention is based largely on the work of Marsha Linehan, who argued that more RFL would be associated with lower suicide risk (Linehan, Goodstein, Nielsen, & Chiles, 1983). Jobes and Mann (2000) have similarly found that the consideration of reasons for living can be a valuable addition to understanding the suicidal dilemma, and can provide information about what aspects of the suicidal patient's life can be enhanced to reduce suicide risk. As an intervention, encouraging patients to focus on the *good* things in life can contribute to positive emotion states, which have been linked to positive gains in problem-solving attitudes (possibly through enhanced cognitive flexibility), which in turn mediates improvement in suicidal symptoms (Joiner et al, 2001). John struggled to list reasons for living; he was only able to identify two — God and family — which frustrated him considerably and served to support the notion that he was deficient and incompetent. To jumpstart his thought process, I asked him to list the name of every single family member he could think of, which resulted in more than 30 individuals. I pointed out that in the span of five minutes, his list had dramatically increased. John's use of cognitive "shortcuts"— one inclusive term or idea (e.g., "family") used to replace a large number of individual items — was identified as a symptom of his rigid cognitive style. John was directed to write these reasons for living onto an index card that he would keep in his pocket to review at least three times a day. Additionally, whenever he thought of a new reason for living, he was directed to add it to the list.

During session 6, John noted that his index card of reasons for living was no longer sufficient for his needs because he had identified so many additional reasons for living he now required a sheet of paper to list them all. He reported improvement in mood and suicidal symptoms, though he still continued to experience a high level of physiological and emotional stress secondary to critical self-statements. Psychotropic medication was again discussed as an adjunctive treatment to better manage physiological symptoms. John admitted during this session that his family has a considerable psychiatric history marked by recurrent major depression and bipolar disorder. Encouraged by his wife, John agreed to a trial period of antidepressant medication. Because the wait period for an evaluation by a psychiatrist was several weeks in the future, he was encouraged to schedule an appointment with his primary care manager for treatment initiation, after which ongoing medication monitoring could be coordinate with a psychiatrist.

John's primary care manager decided to initiate a trial of Effexor. Within three days, however, John was experiencing extreme agitation, insomnia, concentration impairment, nausea, and increased suicidal ideation. These side effects seemed to contribute to increased hopelessness because they were interpreted as a sign that "nothing will make me feel better." When John called me to report these side effects, I consulted with a clinic staff psychiatrist, who stated these were common side effects of the medication, and usually abated in seven to ten days. The psychiatrist recommended continuing the medication for at least four more days, but if symptoms did not decrease to discontinue the medication. John was informed of these recommendations, and since the weekend was approaching, he agreed to continue the medication for a few more days.

At the following appointment (session 7) a few days later, John stated that he had discontinued the Effexor and was no longer experiencing the side effects. Because of the severity of his side effects, he was not willing to consider a trial with a different antidepressant. Content of the session again focused on restructuring unrealistically high standards and dichotomous thinking (i.e., "right" versus "wrong" ways to do things). This session marked the third consecutive appointment with a score of 0 or 1 on item 8 of the OQ-45, which indicated the end of "suicide status." John was asked to complete the Suicide Tracking Outcome Form (Jobes, 2006; see Appendix 1), which is a variant of the SSF, on which he identified those aspects of treatment that were most helpful in resolving his suicidal crisis. The intervention that John felt was most helpful was the reasons-for-living list; and the most significant lesson learned during treatment that he listed reflected the positive strength of the therapeutic relationship: "There is always someone here to help." Finally, in preparation for a planned vacation during the following week, the session concluded with a review of John's crisis response plan (including the clinic phone number with the name of my supervisor) and a review of the skills learned thus far in treatment.

Session 8: Renegotiation of the Therapeutic Relationship

Following John's removal from suicide status, a period of limited clinical contact ensued for several weeks due to my vacation, one cancellation by John due to work schedule changes, and two no-shows. Contact during this four-week period was restricted to brief (i.e., less than 10 minutes) phone calls conducted on a weekly basis. During each of these phone calls, John reported continued stress secondary to occupational demands, but reported no further suicidal ideation and overall symptom management through use of skills learned in treatment.

Following John's third consecutive missed appointment, his wife contacted me to express concern about his lack of treatment adherence due to increased emotional distress and suicidal ideation. I contacted John via telephone about this, during which he admitted that he had not been completely honest with me over the past few weeks. His recent increase in symptoms and suicidal ideation had demoralized him, and he was afraid that he would be hospitalized. In asking John about his suicidal symptoms, he described daily thoughts about suicide without a clear plan or intent to die, and the assertion, "I'm not going to do that," which he repeated several times. Although his emotional distress had clearly heightened, his lack of resolved plans or preparations suggested that he was only at mild risk for suicide, which does not indicate hospitalization. After explaining my decision-making process regarding hospitalization, John seemed to relax slightly. The importance of treatment adherence was stressed, and an appointment was scheduled within the week to review and reconsider treatment goals.

On the day before the next appointment, I received an email from John's wife in which she described her observations of John: agitation, extreme insomnia, impulsivity, uncontrolled crying spells, and mild self-injurious behaviors (e.g., pulling his hair, punching walls) in response to emotional lability (notably anger). John's wife expressed concern that John could not adequately manage his emotions, and she worried that he would unintentionally harm their child or himself. John's wife stated a desire to address these concerns during the appointment on

the next day, as she was planning to attend as well. I contacted John's wife to talk about her concerns and to explain the process by which hospitalization would be recommended; she agreed to become much more involved in the treatment process to better support John. I then called John to confirm the appointment for the next day, and to notify him that I had spoken briefly with his wife about her concerns. He did not disagree with her behavioral observations, and agreed it would be helpful for him to have her more involved in his treatment.

During the subsequent session (session 8), John's OQ-45 total score reached 95 (severe), with self-reported suicidal ideation frequency increasing to "sometimes." He explained that his reluctance to fully disclose his severe level of distress was due to continued fear that ongoing behavioral health treatment would have a negative impact on his career. The importance of honest disclosure was emphasized as an essential ingredient for full symptom remission. Assuming a much more directive approach, I outlined my expectations for continued treatment provision in the form of a Commitment to Treatment Statement (CTS; Rudd, Mandrusiak, & Joiner, 2006). Each of the points in the CTS (see Figure 3 for John's CTS) was discussed in detail, and was modified collaboratively as needed. After the CTS was fully reviewed, John was asked to make an important decision about his health and well-being: he could choose to retain me as his behavioral health provider, but only if he agreed to comply with the terms of the CTS, or he could choose to work with another provider, which I would help him to arrange. John chose the former option, again citing our therapeutic relationship as a primary motivator.

John's treatment plan was revised based on the renegotiation of the treatment expectations. Reduction of suicidal ideation remained the primary goal, with a modified goal of no suicidal ideation (OQ-45, Item 8 = 0) for three consecutive sessions. Reduction of depression and agitation were identified as secondary treatment goals. Additional skills deficits were identified for refinement: distress tolerance, relaxation, and mindfulness. The duration of treatment sessions was extended to 90 minutes, split into two "modules." The first 45 minutes of the session reviewed specific problems occurring since the previous session, with an emphasis on trouble-shooting use of learned skills to increase adaptability and flexibility. The second 45 minutes were spent learning new skills (or new applications of previously learned skills) to be practiced between sessions. Finally, inclusion of John's wife in subsequent treatment sessions was agreed to for several reasons, including emotional support during sessions, increased social support and assistance for skills practice between sessions, and provision of an independent perspective on behavior change.

Once the new treatment plan and expectations had been agreed upon, we moved immediately into skills training to directly target the increased symptomatology and suicide risk. John and his wife were educated about mindfulness and were guided through several mindfulness exercises for practice. Pilot studies of mindfulness-based cognitive therapy emphasizing moment-by-moment awareness and a nonjudgmental, accepting attitude, have demonstrated promise as an intervention for reducing the recurrence of suicidal behaviors (Williams, Duggan, Crane, & Fennel, 2006). Mindfulness is considered a "core" skill in Dialectical Behavioral Therapy (DBT), which is a treatment package that has demonstrated remarkable efficacy in reducing recurrent suicidal behaviors among chronically suicidal patients

diagnosed with borderline personality disorder (Comtois & Linehan, 2006). Mindfulness is a feature of many "third wave" cognitive-behavioral therapy approaches, and is unique in that it stresses acceptance rather than change and increased awareness of how negative emotion states impact the body, as opposed to suppression or avoidance of these emotional states (Williams et al., 2006). An adaptation of Linehan's (1993) protocol for mindfulness skills training was used to teach these skills to John, including several practice exercises. He was encouraged to adopt an attitude in which he accepts his emotional distress as a useful tool for understanding what is happening to him in life, instead of attempting to expend tremendous amounts of energy trying (unsuccessfully) to avoid it. John was directed to practice these exercises a minimum of three times each day in between sessions, and was given a daily log to track his practice.

Sessions 9-11: Skills Training

I called John a few days after session 8 to assess his adherence to treatment recommendations. He reported that he was using mindfulness skills and deep breathing throughout the day to manage emotional distress. John and his wife also practiced mindfulness skills each night during extended shared activities (e.g., giving each other massages, eating dinner, listening to music). He described his mood as "much better" since the previous session.

During session 9 John asked to speak about his experiences in Iraq, which still caused considerable distress for him. John described a significant level of guilt resulting from many of the medical decisions he made while in-theatre, noting that his "philosophy of medicine" was often at odds with the realities of the combat environment. Because US military policy was to treat all casualties without consideration of nationality or political affiliation, John often found himself confronted by situations in which the objective rules of medical treatment required him to provide care to and utilize finite resources on enemy combatants instead of American military personnel. These decisions sometimes resulted in the loss of American military lives. When I informed John that such personal conflicts are frequently reported by deploying medical professionals, he seemed comforted by the fact that he was not alone in his suffering. John's assumptions that life should be fair, and that he should be able to make sense out of the overwhelming confusion of the combat environment, were directly challenged. John was encouraged to use mindfulness skills to observe and describe the "inherent chaos of war" without judgment, and was further encouraged to accept the possibility that he was okay in spite of what he experienced. Although initially skeptical of the notion that his guilt and horror were perfectly acceptable — and expected — responses to his combat experience, by the end of the session John reported a significant reduction in guilt. Empowered by the knowledge that he was not "crazy," and that other medical professionals were reporting similar experiences, John decided it would be helpful for him to start talking about his deployment with those colleagues who had also deployed.

Distress tolerance skills training was the focus of Session 10. John was using mindfulness skills on a regular basis by this time, to the point that they were become automatic responses to intense emotional states. An adapted version of Linehan's (1993) distress tolerance skills training module was used to teach a wide range of strategies for managing emotional

distress (e.g., distraction, self-soothing). John already used many of these skills in his daily life, though he was unaware of it. For example, activities such as taking a break outside to enjoy a cup of coffee served to manage stress during the work day. Increasing the intentionality and mindfulness of these behaviors was expected to heighten their impact. John's cognitive tendency to dichotomize experiences into extremes were also targeted during this session following a comment about how "things were going so good, but then I had a bad day." I suggested instead that "bad" days are necessary to have a benchmark for measuring "good" days; in other words, without "bad" days there would be no such thing as "good" days. The ability to accept negative life experiences—and more importantly the capability to tolerate them no matter how undesirable (what Linehan has called "radical acceptance") — became a recurring theme throughout the remaining course of treatment.

By the eleventh session, John was using mindfulness and distress tolerance skills automatically. He started exercising again, started attending worship services, and reported taking a fishing trip over the weekend — two activities he had abandoned for almost a year. Mindfulness and distress tolerance skills were further refined by focusing on the limits of John's responsibilities and capabilities. In particular, it was important for John to understand and accept that there were many things in life that were beyond his control, but his reactions to these events were completely within his control. John was presented with a choice: he could either expend energy worrying about how things are awful and might turn out undesirable, or he could focus his energy on how to respond to life's challenges in ways that would result in the best possible outcome for him. Evidencing the change process he was undergoing, John made the next cognitive step: "And the best *possible* outcome isn't necessarily what I want, but it's the best I can do at that time."

Sessions 12-19: Personality Refinement and Relapse Prevention

Once John had learned several basic skills — mindfulness, distress tolerance, engaging in enjoyable activities — distress and suicide risk dropped. Treatment then moved to strengthening the use of these basic skills in increasingly diverse situations. This included (a) facilitating the automatic activation of these skills, where appropriate, replacing negative and self-defeating "automatic thoughts" and associated behaviors (Hollon & Beck, 2000); and (b) relating these skills to John's broader, interrelated patterns of cognition, behavior, motivation, affect, and physiology — all associated with Beck's general mode theory and with what many psychologists mean by "personality." In sum, to reduce the likelihood of future activations of the suicidal mode, it was imperative that John adopt a new way of viewing and interacting with himself, others, and the world — that is, to modify his personality.

By session 12, John's period of acute distress had abated, and his reported suicidal ideation had decreased considerably in frequency and intensity. Although he still experienced thoughts of suicide on occasion, he reported a sense of mastery over them, and was no longer significantly distressed by them. A predominant theme that cut across sessions 12 through 19 was career indecision concerning the military. Specifically, John found himself stuck between two truths: on the one hand, his work in the military was a source of considerable distress and

contributed to tremendous amount of dissatisfaction in all areas of life, and on the other hand, he believed separating from the military would be akin to "abandoning" those military personnel who were risking their lives on a daily basis and needed his medical care. John could not help but view his desire to separate from the military as a sign of weakness and inadequacy. Therapy session content therefore focused on the application of mindfulness and distress tolerance skills notably acceptance and nonjudgment — to his self-identity and worldview.

Over the course of sessions 12-19, John gradually turned away from a dichotomous "all or nothing" worldview in which decisions were either "right" or "wrong," and moved towards a frame of mind in which "all roads lead to Rome." This process was aided by subtle challenging of his cognitive rigidity. For example, he was routinely asked to identify both the good and less good aspects of experiences and choices he faced to reinforce a more balanced and fluid thought process. He was then encouraged to consider options in terms of adaptability or functionality rather than in terms of "good/bad" or "right/wrong." In other words, given that multiple options will likely result in the desired goal, which one fits best with the current demands of life? Such a perspective reinforces cognitive fluidity, as it requires recognition that decisions require a certain level of flexibility that fluctuates with situational variables. Cognitive fluidity directly undermines the heart of the suicidal mode, which is primarily defined by an inability to consider strategies other than death to alleviate psychache. During session 15, John reported that he had made the decision to separate from the military, and had filed the necessary paperwork to do so. With the decision finally made, John found it much easier to relax and think about future goals and options. "It's like a weight was lifted off my shoulders," he explained.

With John's decision to change careers, a natural termination point for treatment was established—six months in the future, concurrent with his separation. It was agreed that treatment would reduce in frequency (to once per month) in order to foster greater independence of skills utilization, and move towards a relapse prevention model. Sessions 16-19 therefore focused on problem-solving obstacles to effective skills use (see Reinecke, 2006), and my role as treatment provider shifted towards that of a consultant or "coach." During this phase of treatment, John initially reported increased emotional distress as a result of decreased session frequency; he was insecure about his ability to manage distress without regular assistance. It was agreed to utilize phone contact between sessions to provide support and review skills use, but once John's struggles were normalized and identified as an expected result of increased self-reliance, his confidence was restored and no longer felt he needed between-session phone contacts.

Presenting problems during sessions 16-19 were very different from the problems identified in early treatment. John reported stress related to moving, deciding whether or not to go back to school, and how to be a better father and spouse. Bibliotherapy was utilized heavily during this phase of treatment: John was assigned readings to review alone or with his wife, then consider how it applied to his life. John would bring these readings into session with him to talk about any issues or areas that he was working on understanding or resolving. These conversations provided opportunity to further reinforce an attitude of acceptance, nonjudgment, and flexibility. They also provided an avenue to discuss the possibility of symptom recurrence,

and what lessons John had learned over the course of treatment to manage distress in the future. To further develop cognitive flexibility, I would engage John in "what if" exercises during which a scenario would be presented for him to problem-solve his way out of. As he developed a solution, I would present a "what if" condition that would render the solution ineffective, thus forcing John to develop an alternative strategy. Though challenging, John gradually become increasingly adept at this exercise, suggesting significantly enhanced flexibility in problem-solving.

Sessions 20 through 21: Termination

During his final sessions, John still had not found a new job, but reported that he was okay with this. His treatment goals were reviewed, all of which had been achieved and sustained for several months. Reflecting on the course of treatment, John identified the stability and consistency of the treatment relationship as the most important "curative" factor. He also highlighted the renegotiation of the treatment expectations — captured in the commitment-to-treatment statement (see Figure 3) — as a critical moment in his health improvement, because my increased directiveness had demonstrated to him concern and commitment to his welfare. The least helpful intervention for John was the failed antidepressant trial — not surprising in light of the severe side effects he experienced. When asked about concerns regarding termination, John reported that in the weeks leading up to our final session, he experienced some anxiety because he would be losing an important source of support and stability in life. He had come to realize, however, that he was confident in his ability to use skills and managing his distress on his own. "I'm ready," he noted during his final session.

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

A main method employed for monitoring the therapy involved (a) the administration of the Suicide Status Form or Suicide Tracking Form at the beginning of sessions 1-7, until John's risk of suicide had decreased substantially; and (b) administration of the OQ-45 questionnaire at the beginning of each session throughout the therapy. The results on these measures are presented in Table 2 and Figure 2. The uses of these data in helping to guide the therapy have been described in the previous section on the therapy process, and they are discussed in the section below on concluding evaluation.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

John demonstrated initial positive response to treatment, as indicated by a decrease in self-reported distress that leveled off within the mild range of the OQ-45 (Table 2). Suicidal symptoms (measured by SSF scores) also decreased in intensity during the first three months of treatment, although John's reported level of overall stress did not change significantly (Table 2). A period of approximately one month marked by very limited clinical contact followed this initial phase of treatment, during which John's symptoms returned and intensified, prompting a

change in treatment strategy. John's self-reported distress declined dramatically following this change in treatment, and eventually leveled off in the sub-clinical "normal" range of OQ-45 symptom scores. By the end of treatment, John was self-reporting a very low level of distress.

Overall, John came in with an OQ-45 score of 85 and left with one of 42. Note 2 in Figure 2 states that according to the developers of the OQ-45, "Individuals are defined as recovered when they leave therapy with an OQ-45 score that has improved by at least 14 points and is below 64" (Lambert, 2007, p. 2). By this definition, not only did John leave therapy as recovered, but he did so by over three times the number required for clinical significance.

In consideration of John's case, several major points are particularly salient to me:

- *Utilizing assessment measures as a routine component of the treatment process.* Routine assessment of symptoms during each clinical contact provided the opportunity to track John's treatment progress, and to regularly monitor his changing risk level. More importantly, it provided clues for targeting fluctuating symptoms to optimize treatment impact.

- *The importance of working collaboratively with the patient.* By taking the time to understand John's subjective experience of the suicidal crisis from the very beginning, I was able to strengthen the therapeutic relationship and more accurately identify the most important problem areas for intervention.

- *Use of treatment interventions informed by scientific research.* Having a clinical repertoire of interventions demonstrated to reduce suicide risk was only the first step for effective treatment planning. The next step was to work with John to provide the interventions in a way that best fit the unique nature of his suicidal problem.

- *The utility of mobilizing resources outside of the treatment clinic.* For John, inclusion of his wife in the treatment process was a particularly helpful strategy.

- *The primacy of the therapeutic relationship.* For John, the most important treatment factor contributing to a reduction of suicide risk and emotional distress was the therapeutic relationship itself. Without a strong relationship, John would have been unwilling to follow-through with treatment interventions, and likely would have dropped out of treatment prematurely.

John's case also illustrates a critical feature of suicide that is gaining increased attention and understanding amongst suicide researchers: the importance of agitation as a central symptom of suicide risk. A growing body of evidence is finding symptoms including racing/crowded thoughts, irritability, insomnia, psychomotor agitation, and reckless behavior as a particularly pernicious symptom cluster for suicide risk (e.g., Dilsaver et al, 2005; Marangell et al, 2006; Benazzi, 2005), especially when in the presence of a depressive episode. In fact, such mixed episodes seem to account for suicidal behaviors much more than unipolar depressive episodes (Akiskal & Benazzi, 2005; Balazs et al, 2005). Akiskal and Benazzi (2005) have proposed that

mixed episodes misdiagnosed as unipolar depression may be the mechanism underlying the increased suicide risk associated with antidepressant treatment for some patients. John's particular symptom presentation seems consistent with the notion of "agitated depression" or mixed episode: racing/crowded thoughts, psychomotor agitation, and irritability. His poor response to antidepressant treatment — marked by increased psychomotor agitation and restlessness — further suggests the presence of a mixed episode.

Related to this, it is interesting to note that John's diagnosis of PTSD was never *directly* targeted through traditional behavioral interventions (e.g., by prolonged individual exposure or by group therapy, since, as mentioned above, he never attended the group recommended to him for this purpose), though his arousal and emotional symptoms were. It is possible that agitation/arousal symptoms could be the mechanism underlying the elevated risk for suicide among populations diagnosed with PTSD. For John, the combination of agitation reduction through mindfulness and cognitive restructuring seems to have indirectly resolved his PTSD.

John's case therefore highlights several important lessons for routine clinical practice. First, clinicians will likely benefit most from directly targeting symptoms of agitation and psychomotor arousal. This might be the mechanism by which mindfulness interventions reduce suicide risk. Second, although antidepressants have overall contributed to significantly decreased suicide rates, for a small subpopulation of depressed patients, antidepressant treatment seems to increase risk (Bostwick, 2006; Rihmer & Akiskal, 2006). Close monitoring and follow-up is therefore critical for adequate treatment of *any* patient following the initiation of antidepressant treatment.

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Table 1. Categories for Suicide Risk Assessment

I: Predisposition to suicidal behavior

Previous history of psychiatric diagnoses; previous history of suicidal behaviors; recent discharge from inpatient psychiatric treatment; same-sex sexual orientation; male gender; history of abuse

II: Identifiable precipitant or stressors

Significant loss (e.g., financial, interpersonal relationship(s), identity); acute or chronic health problems; relationship instability

III: Symptomatic presentation

Depressive symptoms (increased risk when combined with anxiety and substance abuse); hypomanic-spectrum symptoms; anxiety; schizophrenia; borderline and antisocial personality features

IV: Presence of hopelessness

Severity and duration of hopelessness

V: The nature of suicidal thinking

Frequency, intensity, and duration of ideation; presence of suicidal plan (increased risk with specificity); availability of means; lethality of means; explicit suicidal intent

VI: Previous suicidal behavior

Frequency and context of previous behaviors; perceived lethality and outcome; opportunity for rescue and help-seeking; preparatory behaviors

VII: Impulsivity and self-control

Indicators of poor self-control (e.g., substance use, reckless behaviors, aggression)

VIII: Protective factors

Social support; problem-solving skills and history of coping skills; active participation in treatment; presence of hopefulness; children present in the home; pregnancy; religious commitment; life satisfaction; intact reality-testing; fear of social disapproval; fear of suicide or death

Table 2: John's Change in OQ-45 Total Score, Item 8 (Suicidal Ideation), and Suicide Status Form (SSF) Scores Across Treatment

Session	OQ-45		SSF Scores					
#	Total	Item 8	Psyc Pain	Stress	Agitation	Hopeless	Self-hate	Risk
1	85	2	3	4	4	4	4	1
2	74	1	3	3	3	2	2	1
3	69	1	1	2	2	3	2	1
4	77	2	1	4	2	4	3	1
5	72	1	1	3	1	1	2	1
6	70	1	1	1	1	1	1	1
7	74	1[a]	1	4	2	2	1	1
8	97	2						
9	76	1						
10	73	1						
11	49	0						
12	62	1						
13	65	0						
14	57	0						
15	55	0						
16	63	0						
17	63	1						
18	70	1						
19	57	0						
20	66	1						
21	42	0						

[a] The Collaborative Assessment and Management of Suicidality (CAMS) system was discontinued due to three consecutive sessions with Item 8 = 0 or 1.

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Figure 1: The Suicidal Mode

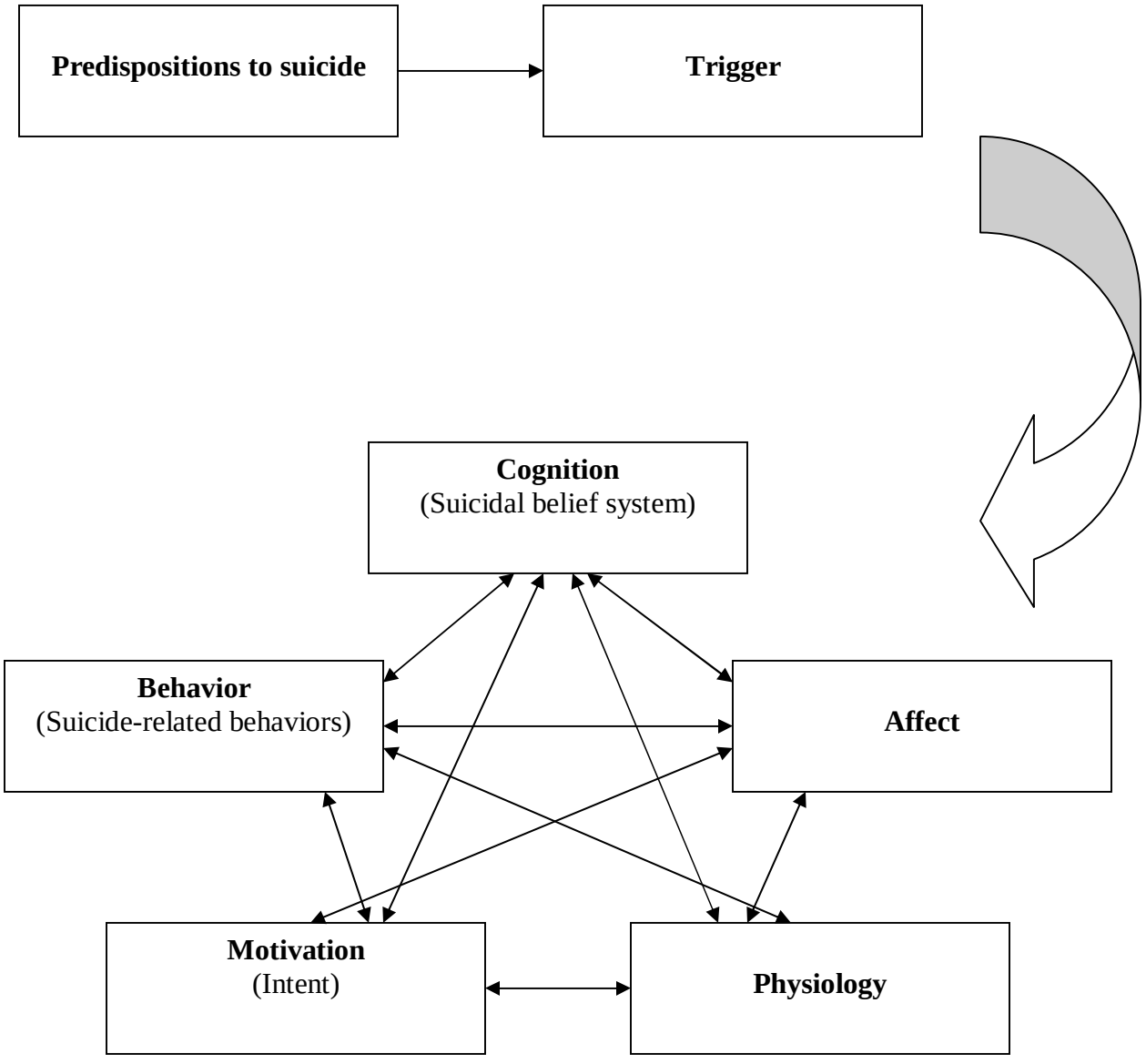

Figure 2: Change in OQ-45 Total Score Across Treatment

Note 1. The solid line indicates the cutoff for the "normal" range of the OQ-45 total score. The dashed line indicates the cutoff for the "mild" pathology range. Higher scores indicate more pathology.

Note 2: Based on a number of normative group studies, Lambert provides the following way to clinically define changes in OQ-45 scores over time: "Individuals are defined as recovered when they leave therapy with an OQ-45 score that has improved by at least 14 points and is below 64. Patients who improve by 14 points are considered improved, and those who worsen by at least 14 points are regarded as deteriorated if they leave treatment in the dysfunctional range" (2007, p. 2).

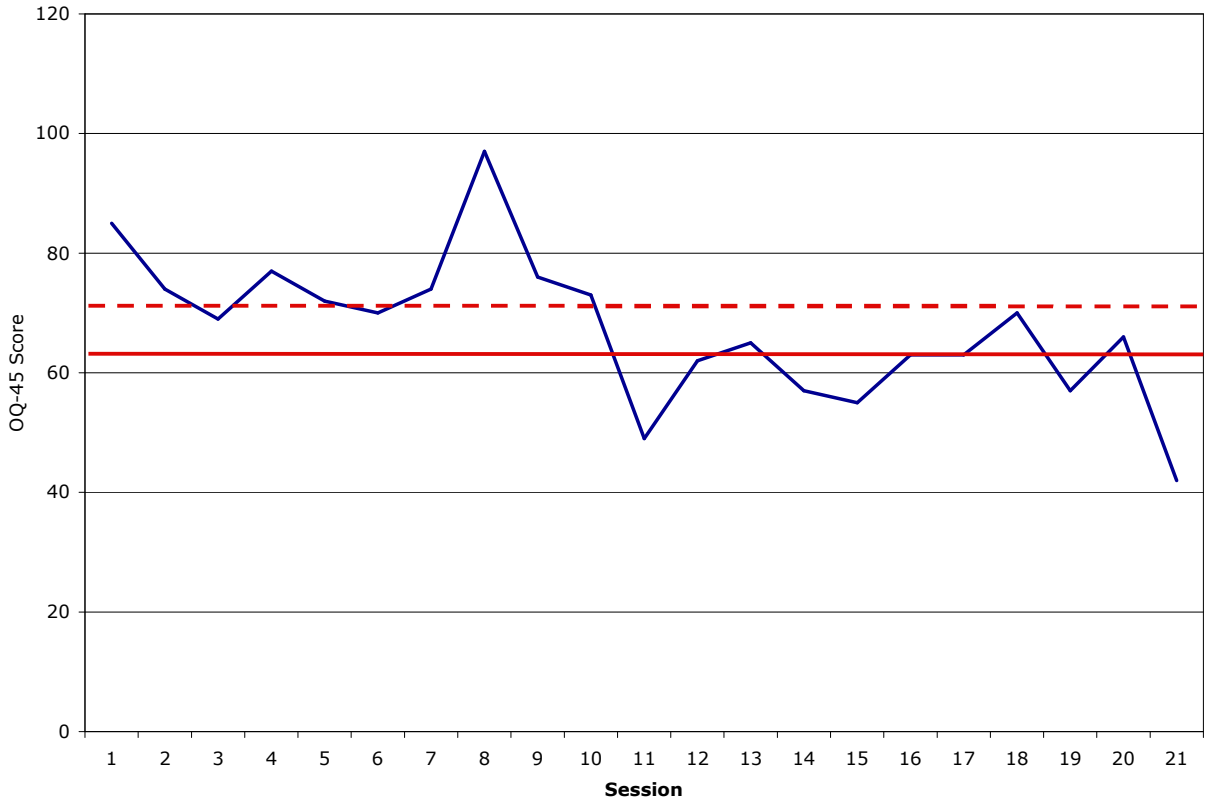

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Figure 3: John's Commitment to Treatment Statement

I, John, make a commitment to the treatment process. I understand this means I have agreed to be actively involved in all aspects of treatment including:

- Attending sessions (or letting you know when I cannot make it)
- Voicing my opinions, thoughts, and feelings honestly and openly, whether negative or positive
- Being actively involved during sessions
- Completing homework assignments
- Experimenting with new behaviors and new ways of doing things
- Being evaluated for antidepressant treatment, and taking medication as prescribed
- Implementing my crisis response plan

I also understand that, to a large degree, my progress depends on the amount of energy and effort I make. If it is not working, I'll discuss it with my therapist. In short, I agree to make a commitment to living.

(Signed by John) (Signed by provider)

SUICIDE STATUS FORM-III (SSF-III) INITIAL SESSION

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rate and fill out each item according to how you feel right now.
Then rank in order of importance 1 to 5 (1=most important to 5=least important).

Rank	
____	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain: 1 2 3 4 5 :High pain** What I find most painful is: _____
____	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress: 1 2 3 4 5 :High stress** What I find most stressful is: _____
____	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low agitation: 1 2 3 4 5 :High agitation** I most need to take action when: _____
____	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness: 1 2 3 4 5 :High hopelessness** I am most hopeless about: _____
____	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate: 1 2 3 4 5 :High self-hate** What I hate most about myself is: _____
N/A	6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk: 1 2 3 4 5 :Extremely high risk (will not kill self) (will kill self)**

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all: 1 2 3 4 5 : completely**
2) How much is being suicidal related to thoughts and feelings about others? **Not at all: 1 2 3 4 5 : completely**

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	**Rank**	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: _____

_____

SUICIDE STATUS FORM-III INITIAL SESSION (PAGE 2)

Section B (*Clinician*):

Y N Suicide plan: When: _____
Where: _____
How: _____ Y N Access to means
How: _____ Y N Access to means

Y N Suicide Preparation Describe: _____
Y N Suicide Rehearsal Describe: _____
Y N History of Suicidality
- Ideation Describe: _____
  - Frequency _____ per day _____ per week ____ per month
  - Duration _____ seconds _____ minutes ____ hours
- Single Attempt Describe: _____
- Multiple Attempts Describe: _____

Y N Current Intent Describe: _____
Y N Impulsivity Describe: _____
Y N Substance abuse Describe: _____
Y N Significant loss Describe: _____
Y N Interpersonal isolation Describe: _____
Y N Relationship problems Describe: _____
Y N Health problems Describe: _____
Y N Physical Pain Describe: _____
Y N Legal problems Describe: _____
Y N Shame Describe: _____

OUTPATIENT TREATMENT PLAN (Refer to Sections A & B)

Section C (*Clinician*):

Problem #	Problem Description	Goals and Objectives Evidence for Attainment	Interventions (Type and Frequency)	Estimated # Sessions
1	*Self-Harm Potential*	*Outpatient Safety*	***Crisis Response Plan:***	
2				
3				

YES ____ NO _____ Patient understands and commits to outpatient treatment plan?
YES ____ NO _____ Clinician Signature and Date

_____ _____
Patient Signature Date Clinician Signature Date

Section D (*Clinician PostSession Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS:	ALERT DROWSY LETHARGIC STUPOROUS OTHER: _____
ORIENTED TO:	PERSON PLACE TIME REASON FOR EVALUATION
MOOD:	EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT:	FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY:	CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL OTHER: _____
THOUGHT CONTENT:	WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY OTHER: _____
ABSTRACTION:	WNL NOTABLY CONCRETE OTHER: _____
SPEECH:	WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT OTHER: _____
MEMORY:	GROSSLY INTACT OTHER: _____
REALITY TESTING:	WNL OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

PRELIMINARY DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____

_____

Axis II _____

_____

Axis III _____

Axis IV _____

Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ❑ **No Significant Risk**
- ❑ **Mild**
- ❑ **Moderate**
- ❑ **Severe**
- ❑ **Extreme**

Explanation:_____

_____

_____

_____

CASE NOTES (diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date):

_____

_____

_____

_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____ _____

Clinician Signature Date Supervisor Signature Date

SSF-III SUICIDE TRACKING FORM

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rate each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):	**Low pain:**	**1**	**2**	**3**	**4**	**5**	**:High pain**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):	**Low stress:**	**1**	**2**	**3**	**4**	**5**	**:High stress**
3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):	**Low agitation:**	**1**	**2**	**3**	**4**	**5**	**:High agitation**
4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):	**Low hopelessness:**	**1**	**2**	**3**	**4**	**5**	**:High hopelessness**
5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):	**Low self-hate:**	**1**	**2**	**3**	**4**	**5**	**:High self-hate**
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will not kill self)**	**1**	**2**	**3**	**4**	**5**	**:Extremely high risk (will kill self)**

Section B (*Clinician*):

Resolution of suicidality: ☐ 1st session ☐ 2nd session

Complete **SSF-III Suicide Tracking Outcome Form after third consecutive resolved session

Y __ N __ Suicidal Thoughts?
Y __ N __ Suicidal Feelings?
Y __ N __ Suicidal Behaviors?

Patient Status:

☐ Discontinued treatment ☐ No show ☐ Referral to: _____
☐ Hospitalization ☐ Cancelled ☐ Other: _____

TREATMENT PLAN UPDATE

Problem #	Problem Description	Goals and Objectives Evidence for Attainment	Interventions (Type and Frequency)	Estimated # Sessions
1	*Self-Harm Potential*	*Outpatient Safety*	***Crisis Response Plan:***	
2				
3				

_____ _____

Patient Signature Date Clinician Signature Date

Section C *(Clinician Post-Session Evaluation):*

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS
OTHER: _____

ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE

THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
OTHER: _____

THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS
MORBIDITY OTHER: _____

ABSTRACTION: WNL NOTABLY CONCRETE
OTHER: _____

SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
OTHER: _____

MEMORY: GROSSLY INTACT
OTHER: _____

REALITY TESTING: WNL
OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____

_____

Axis II _____

_____

Axis III _____

Axis IV _____

Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ❑ **No Significant Risk**
- ❑ **Mild**
- ❑ **Moderate**
- ❑ **Severe**
- ❑ **Extreme**

Explanation:_____

_____

_____

_____

CASE NOTES (diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date):

_____

_____

_____

_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____ _____

Clinician Signature Date Supervisor Signature Date

SSF-III SUICIDE TRACKING OUTCOME FORM

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rate each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):	**Low pain:**	**1**	**2**	**3**	**4**	**5**	**:High pain**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):	**Low stress:**	**1**	**2**	**3**	**4**	**5**	**:High stress**
3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):	**Low agitation:**	**1**	**2**	**3**	**4**	**5**	**:High agitation**
4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):	**Low hopelessness:**	**1**	**2**	**3**	**4**	**5**	**:High hopelessness**
5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):	**Low self-hate:**	**1**	**2**	**3**	**4**	**5**	**:High self-hate**
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will not kill self)**	**1**	**2**	**3**	**4**	**5**	**:Extremely high risk (will kill self)**

Were there any aspects of your treatment that were particularly helpful to you? If so, please describe these. Be as specific as possible.

_____

_____

_____

What have you learned from your clinical care that could help you if you became suicidal in the future?

_____

_____

_____

Section B (*Clinician*):

Third consecutive session of resolved suicidality: ____ Yes ____ No (if No, continue Suicide Status Tracking)

OUTCOME/DISPOSITION (Check all that apply):

___ Continuing outpatient psychotherapy ___ Inpatient hospitalization

___ Mutual termination __ Patient chooses to discontinued treatment (unilaterally)

___ Referral to: _____

___ Other. Describe: _____

Next Appointment Scheduled (if applicable): _____

_____ _____

Patient Signature Date Clinician Signature Date

Section C (*Clinician Outcome Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS
OTHER: _____

ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE

THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
OTHER: _____

THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS
MORBIDITY OTHER: _____

ABSTRACTION: WNL NOTABLY CONCRETE
OTHER: _____

SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
OTHER: _____

MEMORY: GROSSLY INTACT
OTHER: _____

REALITY TESTING: WNL
OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____
_____

Axis II _____
_____

Axis III _____

Axis IV _____

Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ❑ **No Significant Risk**
- ❑ **Mild**
- ❑ **Moderate**
- ❑ **Severe**
- ❑ **Extreme**

Explanation:_____
_____
_____
_____

CASE NOTES (diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date):

_____
_____
_____
_____
_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____ _____

Clinician Signature Date Supervisor Signature Date