

Implementing an evidence-based approach to working with suicidal inpatients

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In this article, the authors describe the implementation of a new approach to working with suicidal patients in an inpatient psychiatric facility. The Collaborative Assessment and Management of Suicidality (CAMS) has been under development for almost two decades, but has rarely been implemented or studied in an inpatient setting. Here the authors describe the context for this project, the nature of the CAMS intervention in this setting, the structure for the research aspect of the project, and some of the implementation issues that have arisen as the project has unfolded. The authors conclude that a solid foundation has been laid for an initiative that will both enhance assessment and treatment of at-risk patients and contribute to a body of knowledge that is currently lacking in evidence for interventions with suicidal patients. (Bulletin of the Menninger Clinic, 73[4], 339-354)

Although hospitals are generally considered safe havens for suicidal individuals, they are not risk-free. To the contrary, patients can and do kill themselves while hospitalized. It is estimated that 4%-7% of the 32,000 suicides in the United States each year occur in inpatient psychiatric settings (Wolfersdorf, 2000). Moreover, despite the fact that significant improvement typically occurs during hospitalization (see Latini et al., this issue), the weeks following discharge from psychiatric inpatient services constitute one of the highest risk periods for psychiatric patients (Deisenhammer, Huber,

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Kemmler, Weiss, & Hinterhuber, 2007; Kan, Ho, Dong, & Dunn, 2007). Thus, accurate risk assessment and effective treatments for at-risk patients are imperative.

Ironically, although psychiatric illness is a well-known risk factor for suicide (Tanney, 1992), remarkably little research exists describing treatments that effectively reduce suicide risk (Comtois & Linehan, 2006). Indeed, it is not an overstatement to say that, from the standpoint of suicide prevention, most suicidal patients are treated with unproven therapies. This is especially true with respect to inpatient treatment; for example, a review of the literature on treatment of suicidal individuals (Linehan, 2000) listed only two outcome studies of inpatient treatments for suicidal individuals. This is a serious gap in the literature, because suicide risk is especially high for patients whose psychopathology is severe enough to require hospitalization (Bostwick & Pankratz, 2000; Nordentoft & Mortensen, 2007).

The purposes of this article are threefold: (1) to describe a structured, suicide-specific therapeutic framework adapted for use in a psychiatric hospital, (2) to describe implementation of this framework in this setting, and (3) consistent with the thrust of Allen et al. (this issue) and Sharp et al. (this issue), to illustrate a clinical research program that both facilitates a research-informed treatment environment and contributes to the clinical knowledge base.

Although many treatments have been studied for psychiatric disorders, therapies that have been proven effective in reducing symptoms of those disorders have not generally been shown effective in reducing suicidal behavior (Linehan, 2000; Slee, Spinhoven, Garnefski, & Arensman, 2008). However, recent years have seen the introduction of new therapies designed specifically to reduce suicide risk. For example, Linehan and associates (2006) tested a therapy designed specifically for suicidal patients with borderline personality disorder and found the treatment (Dialectical Behavior Therapy [DBT]) superior to treatment as usual by community experts. This was a dismantling study, results of which indicated that “the efficacy of DBT cannot reasonably be attributed solely to general factors associated with receiving expert psychotherapy” (p. 763).

Similarly, in a test of Beck's cognitive model of suicidality (Wenzel, Brown, & Beck, 2008), Brown and associates (2005) used community therapists to implement a brief, structured cognitive therapy designed to develop alternate coping behaviors in patients with recent, severe suicide attempts. The comparison group was treated with usual care, which was enhanced with tracking and referral services. Brown et al. found a 50% reduced risk for future suicide attempts in the cognitive therapy condition compared to enhanced usual care.

In addition to therapies specifically tailored to the vulnerabilities of suicidal patients, Jobes (2006) has introduced a therapeutic framework that serves both as a means of assessing risk in suicidal patients and as a platform for developing the kind of therapeutic relationship thought to be essential to working effectively with patients who may have low motivation for accepting help (Ellis, 2004). This system, the Collaborative Assessment and Management of Suicidality (CAMS), provides a method for therapists to join with the patient in a collaborative endeavor to explore the degree of risk for self-harm and to develop a plan for ensuring the patient's safety. Studies to date (e.g., Jobes, Kahn-Greene, Greene, & Goeke-Morey, 2009; Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005) have indicated great promise for this approach, including evidence that patients resolve suicidal ideation relatively quickly and more effectively in comparison to conventional interventions.

These and other studies have contributed to a growing body of evidence indicating that outpatient therapies specifically targeting cognitive vulnerabilities and suicidal behaviors are effective and produce benefits superior to conventional therapies (Ellis, 2006). However, the picture regarding inpatient treatment is less clear. In the aforementioned review, Comtois and Linehan (2006), concluded that "while inpatient treatment is the standard of care, it [per se] has never been found efficacious in a clinical trial" p. 166). On the other hand, there is some evidence that specific therapies delivered in inpatient settings may be beneficial. For example, Bohus et al. (2004) tested DBT in an inpatient setting with 31 patients over a period of 3 months and found substantial benefit compared to a usual treatment group. However, the behavior of interest in this study was nonsuicidal self-injury, so the question of reduction in

ideation and behavior associated with a wish to die still awaits study.

Background

Because ensuring patient safety is its first obligation, the psychiatric hospital must continually seek more effective ways to assess for suicide risk and intervene in such a way that risk of self-inflicted injury or death is minimized. Like most psychiatric hospitals, The Menninger Clinic through the years has relied on the clinical judgment of its clinicians to routinely assess suicide risk by inquiring about suicidal ideation and behavior upon admission and as indicated throughout the hospital stay. However, except for broad parameters such as asking about the presence of planning or a history of prior attempts, such assessment has not been standardized to any significant extent. The same can be said for treatment of suicidal patients: The nature and focus of therapeutic interventions has varied considerably among individual clinicians and among treatment programs within the hospital.

In 2006, the Suicide Prevention Resource Center began providing training for select professionals in a new training package, *Assessing and Managing Suicide Risk* (Suicide Prevention Resource Center, 2006), which for the first time focused on core competencies as identified by expert consensus. The Menninger Clinic's participation in this training enabled the organization to begin a process of implementing a more standardized, evidence-based approach to suicide risk assessment and intervention. Training based on this system was made mandatory for all clinical staff and made available in a self-paced format via DVD. Shortly thereafter, the Clinic initiated a consultative relationship with David Jobes, creator of CAMS (Jobes, 2006), who conducted educational sessions and demonstration interviews over a series of visits. The following year, the first author, a research clinician with expertise in clinical suicidology, was recruited to direct a research program on effective assessment and intervention with suicidal patients. The effort described herein is the first step in the development of this program.

CAMS—Collaborative Assessment and Management of Suicidality

The development of CAMS began about 20 years ago with the creation of the Suicide Status Form (SSF), a multipurpose clinical instrument designed to assess suicide risk and promote treatment planning (Jobes, Jacoby, Cimboric, & Husted, 1997). Derived from an integration of various theories of suicidal behavior, the SSF assesses the patient's subjective experience of various forms of negative emotion (see below), current wish to live and wish to die, reasons for living and dying, subjective judgment of probability of eventually dying by suicide, and a question about the "one thing" that would cause him or her to no longer be suicidal. The SSF also provides for collection of other information needed for a thorough assessment of suicide risk (e.g., mental status exam), as well as for problem identification and treatment planning, especially safety planning. Finally, an alternate (tracking) form of the SSF allows the clinician to follow the patient session-by-session on a number of these variables.

The SSF is a multifaceted instrument, but at its core are five items asking for subjective ratings (1-5) of negative states: psychological pain, stress, agitation, hopelessness, and self-hate. This set of variables, the "SS Core Assessment," has shown good validity and reliability with both suicidal outpatients (Jobes et al., 1997) and inpatients (Conrad et al., 2009). The first three variables are based on Shneidman's (1993) cubic model of psychic pain that lies at the heart of his formulation of the suicidal experience. *Pain* (dubbed "psychache" by Shneidman) refers to the psychological suffering caused by unfulfilled psychological needs. When the clinician asks, "Where does it hurt?" it is this domain of hurt, anguish, sorrow, etc., that he or she seeks to understand. *Press* (stress) refers to force or pressure felt by the individual due to demands from his or her environment, whether internal or external. Interpersonal conflict, work pressures, financial and legal problems, and internal demands (including command hallucinations) all fall under this heading. *Perturbation* is the upset or agitation, the sense of urgency and need to take action that the individual feels to do something to gain relief. It can be considered the energy that fuels the move from unbearable pain to action to eliminate that pain.

Beyond Shneidman's cubic model, the SSF also obtains ratings of the patient's sense of hopelessness and self-hate. Derived from Beck's pioneering work, *hopelessness* refers to the individual's predictions about his or her suffering continuing and the prospect of failure to obtain relief, regardless of effort. This is essentially a cognitive characteristic (a prediction or set of predictions about the future), although closely associated with the emotional experience of despair. It has been shown to be a potent predictor of suicidal behavior (Beck, Brown, & Steer, 1989) and is appropriately a key focus in the treatment of suicidal individuals. Finally, an SSF item on *self-hate* taps into psychodynamic theorizing about suicide as an attack on the self, as well as Baumeister's work (1990) conceptualizing suicide as an escape from the pain of self-loathing and awareness of one's failures. Hopelessness and self-hate are significant additions to Shneidman's cubic model; whereas pain, stress, and perturbation are chiefly dimensions of an individual's crisis, hopelessness and self-hate carry with them implications for long-term vulnerability to suicide.

In addition to integral use of the SSF, CAMS is built upon an explicit philosophy of treatment that eschews a traditional healer-patient perspective and emphasizes collaborative and complementary efforts by both parties to develop a shared understanding of the patient's suicidal thoughts and behaviors, as well as possible directions for therapy (e.g., expansion and elaboration of reasons for living). By design, CAMS can serve as a platform for treatment from essentially any therapeutic orientation; it is distinguished by its specific focus on suicidality as the priority subject matter, with the focus of therapy shifting only when suicidal ideation has been reliably resolved (operationalized as three successive sessions with patient report of no suicidal thoughts or urges).

Although CAMS began as an approach to assessing risk in suicidal patients and a framework for treatment planning and documentation, the question arises as to whether it constitutes a treatment unto itself. It certainly contains many of the characteristics of a treatment, including an explicitly articulated philosophy and a clear focus (suicidal behavior). Moreover, the content of the SSF (in particular the five aspects of cognitive-emotional functioning described above) can serve as a major (if not sole) focus for therapy

sessions, leading quickly to core issues having to do with self, inner experience, interpersonal relationships, and one's place in the world. On the other hand, CAMS does not specify what change strategies should be used, whether insight development or cognitive restructuring. Indeed, CAMS is compatible with essentially any approach to treatment aimed at reducing psychological distress associated with suicidality. Functioning as such a "platform," it serves the important function of keeping the focus on the patient's survival and pointing toward important psychological issues associated with the emotional pain that might endanger that survival.

It is important to note that although a CAMS-based approach involves a sharp focus on suicidal phenomena, it is not accurate to construe it as a process narrowly focused on "talking about suicide." To the contrary, talking early in treatment about reasons for living (for example), or beginning a session with an assessment of self-hate, leads very naturally to identification and exploration of key, literally life-and-death, issues. For example, when a retired, depressed male patient with a recent suicide attempt was asked the question from the SSF about the "one thing" that would help him no longer feel suicidal, he replied, "To feel like my life has a purpose." This statement led to much therapeutic work on his views of what constitutes a meaningful life and problem-solving regarding ways to enrich his life postretirement and compensate for the loss of his highly productive career.

On the other hand, CAMS also offers structure for providing safety measures for use in future crises and alternative, nonsuicidal coping strategies. The safety plan (offered as an alternative to the conventional no-suicide contract) is a prominent example. In outpatient usage of CAMS, safety planning often occurs during the initial session, as therapist and patient develop a specific plan to keep the patient safe, including specifying whom to call in a crisis and safeguarding the patient's environment by removing firearms or other possible means of self-harm. At Menninger, because safety measures are implemented by the nursing service at admission, CAMS safety planning is shifted to a later stage of therapy as part of the discharge planning process. However, the general thrust is much the same, anticipating what sorts of "triggers" might result in a return of suicidal ideation and creating a series of possible

coping responses, tapping into both internal resources and external resources.

CAMS also makes use of the “Hope Kit.” Introduced by Beck, Brown, and colleagues (Brown et al., 2005), this consists of a collection, often in a shoebox, of items that remind the patient of what matters most in his or her life and what gives him or her hope. These may include photographs of friends and loved ones, recordings of songs that the patient finds encouraging, notes from key psychotherapy sessions, and anything else that in the patient’s eyes represents a reason for living or way to cope with adversity. The Hope Kit is also a powerful teaching device, in that it illustrates the process by which reasons for living and other positive beliefs and memories often become unavailable when one is depressed and suicidal, but can become accessible through prompts of various kinds, such as meaningful objects.

Purpose and Objectives

The CAMS initiative is being implemented at The Menninger Clinic with four purposes in mind. First, consistent with the agenda set forth elsewhere in this issue (Allen et al., Sharp et al.), we seek to systematically examine the impact of treatment provided to Menninger patients (in this case, suicidal patients) in hopes of achieving increasingly positive outcomes. In the process, we are examining issues of implementation, including adjustments required for inpatient use, acceptability to patients and staff, and therapist adherence to the protocol. Second is to move more in the direction of an approach with suicidal patients that meets established criteria as an empirically supported treatment (EST; Chambless & Hollon, 1998). In an era of increasing prominence for these treatments, the current standard of care for suicidal individuals (treatment as usual for the underlying disorder) increasingly appears inadequate (Jobes, Rudd, Overholser, & Joiner, 2008). The highest risk situations in mental health practice--indeed, one of the few situations we face that is literally life-and-death--calls for the highest standards in what is considered appropriate treatment.

CAMS certainly shows promise as such a treatment. However, most extant research on the effectiveness of CAMS has been

conducted with outpatients. Thus, our third purpose is to extend CAMS outcome research to the inpatient environment. This environment, the severity of impairment among the patients, and the limited time frame for intervention constitute a new level of challenge for this intervention. Our fourth purpose, related to the third, is to contribute to the outcome research literature and thereby help advance the knowledge and skills of all mental health providers. Indeed, we anticipate that the “exportability” of this intervention to other inpatient care providers will be significant.

The Research Process

The research aspect of the initiative is conceptualized in three phases: (1) an initial case series for implementation and field testing, (2) a preliminary (open) effectiveness trial (comparison with treatment as usual), and (3) a larger randomized controlled trial. These phases correspond roughly to Rounsaville, Carroll, and Onken’s (2001) steps in treatment development: feasibility testing, “tinkered” pilot testing, and efficacy testing

Although not yet meeting criteria to qualify as an empirically supported treatment (Chambless & Hollon, 1998), CAMS has a substantial research foundation and a sufficient base of clinical experience such that we are not approaching this as a test of an experimental treatment (indeed, it can be said that the research base for CAMS is already stronger than that for usual treatment). Rather, the initiative is viewed as an opportunity to look systematically at the implementation of a new and promising approach to treating our suicidal patients.

Study participants, like virtually all patients at The Menninger Clinic, present with severe Axis I and Axis II disorders and extensive histories of biological and psychosocial treatments that have fallen short of desired outcomes. The most common diagnoses are recurrent mood disorders (unipolar and bipolar), generalized anxiety disorder, posttraumatic stress disorder, substance abuse disorders, and personality disorders (typically Cluster B or C). Suicidal ideation and/or behavior are present in roughly half of Menninger patients at admission. Hopelessness is among the most common presenting complaints, with patients understandably pessimistic

about recovering from their psychiatric conditions and returning to normal daily functioning.

In the current phase, no randomization procedure is in place. Patients meeting the following criteria are included in the study: (1) assignment to a therapist (psychologist or clinical social worker) who has been trained in CAMS and who has completed the fidelity check procedure, (2) suicide attempt within 6 months of admission or history of multiple attempts, (3) significant current suicidal ideation, as indicated by psychiatric evaluation, score greater than 0 on the “suicide” item of the BDI-II, and/or self-report during the initial individual therapy session, (4) agreement to terms of informed consent, and (5) lack of contraindications as per the treatment team. With the exception of the SSF, data collection is integrated within the existing computer-administered system used at Menninger for ongoing assessment of therapeutic progress (see Allen et al., this issue).

Because the treatment is not experimental and patients are not randomized, the consenting process focuses primarily on informing patients that assessment data from their treatment will be utilized for research purposes and that their privacy will not be compromised in the process. In addition, patients are informed that video recordings of some CAMS sessions may be sent off-site to allow fidelity checks to be performed. Information about procedures for protecting confidentiality are detailed in the consent form.

Study therapists consist of clinical psychologists and clinical social workers licensed and credentialed to practice at The Menninger Clinic. They were prepared to deliver CAMS by reading the CAMS treatment manual (Jobes, 2006), attending training provide by Dr. Jobes, and participating in an ongoing, weekly peer consultation meeting. Fidelity checks are performed at Dr. Jobes’s laboratory at Catholic University of America in Washington, DC. Following patient consent, video recordings are made and delivered via overnight mail, where they are assessed by doctoral students trained to rate therapy sessions for adherence to competency criteria developed for CAMS research. Menninger therapists are cleared for participation in the study when they have reached competency criteria.

The current research phase utilizes a case series design. Within-group comparisons will be made using repeated-measures statistics comparing pretreatment scores on outcome measures with scores at midtreatment and at end of treatment. Qualitative analysis also will be used to examine patients' responses to open-ended items on the SSF. Future randomized studies will make between-group comparisons utilizing multivariate inferential statistics to determine whether CAMS treatment confers any benefit beyond that of usual treatment and care.

Repeated measures (administered biweekly) are used to track patients' progress over the course of treatment. In addition to the measures completed by all Menninger patients (described by Allen et al., this issue), we are also using the Beck Hopelessness Scale (BHS) to measure hopelessness, a key mediator between depression and suicidality (Beck et al., 1989) and the Beck Scale for Suicidal Ideation (BSS; Beck, Brown, & Steer, 1997) to assess and track severity of suicidal thinking. In addition, in hopes of gaining insight into mechanisms of change, we are administering the Working Alliance Inventory (Horvath & Greenberg, 1989) and the Suicide Cognitions Scale (Rudd, Schmitz, McClenen, Joiner, & Elkins, 2008). Finally, as described above, the Suicide Status Form (SSF) is used as an integral part of the CAMS intervention (Jobes, 2006).

Implementation Process

The implementation process, briefly described above, has corresponded roughly to the process described by Jobes and associates (D.A. Jobes, Bryan, & Neal-Walden, 2009), who conceptualize clinical research projects as developing in five steps: (1) site identification, (2) consultation and training, (3) designation of a champion or process improvement committee, (4) introduction of routine use of assessment tools, and (5) identification of reinforcers for clinicians participating in research. While we have tried to remain attentive to the challenges of implementing clinical innovations in any setting (e.g., the cost-benefit ratio to overextended clinicians), we have also become aware of further complexities specific to the inpatient setting regarding matters as basic as whether CAMS will even be utilized.

In outpatient settings, where CAMS was originally developed, clinicians involved with a patient may work relatively independently. Thus, the decision to use CAMS with a suicidal patient often resides between the therapist and the patient. Most inpatient services function rather differently: The attending psychiatrist is legally and clinically responsible for all aspects of treatment, including safety. The patient's psychiatrist directs treatment and leads the treatment team, including rehabilitation specialists, psychologists, social workers, nurses, and other allied health professionals. Meanwhile, the nursing staff are legally and clinically responsible for ensuring safety and implementing the medical aspects of the patient's treatment as prescribed by the attending psychiatrist through the patient's treatment plan. The determination as to whether the CAMS approach is appropriate for a given patient is subject to the treatment team's recommendation, as well as the attending psychiatrist's approval, regardless of whether the patient meets the objective criteria for CAMS as a therapeutic intervention.

Furthermore, the hospital is also an important stakeholder in the risk management issues concerning all patients and has legal and procedural responsibilities as defined by its institutional policies, guidelines, accreditation standards, and regulatory requirements. Consequently, the institutional commitment is necessary and instrumental to the success of any new clinical practice that might be piloted in the hospital setting.

As noted earlier, implementation issues such as training and fidelity checks of CAMS therapists, criteria for patient inclusion into the study, and instruments and data collection have already been defined for the project; however, several clinical process issues remain to be defined or identified. For example, the nature and timing of handoff communication with the nursing staff/clinical team regarding the outcome of each CAMS session as well as how CAMS data are actually charted are clinical and risk management issues for both the staff and the hospital. As part of nursing's clinical responsibilities and practice, they are required to complete a standard "safety plan," with or without the patient's collaboration, when any patient has been identified as at risk of suicide or self-injury. This safety plan may or may not correspond to the safety plan developed in the context of CAMS sessions, and differences

between the two plans will need to be addressed in a collaboration among the patient, CAMS therapist, and the other members of the treatment team. These implementation issues, and likely others not yet identified, will need clarification and consensus with clinical staff about how they will be addressed in the context of an inpatient operation.

Discussion

It is obvious, but cannot be stressed enough, that it is impossible to help a patient who does not survive his or her illness. Patients with histories of psychiatric hospitalization die by suicide at rates far exceeding other groups (Bostwick & Pankratz, 2000). Astonishingly, one is hard-pressed to find a treatment with research support for effectiveness in reducing suicidal ideation and behavior, either during hospitalization or after discharge. Nor do we know what the “active ingredients” in such a treatment might be.

This is not for lack of knowledge about psychological vulnerabilities to suicide: Studies have consistently shown the roles that hopelessness, perfectionism, impaired problem-solving, perceived burdensomeness, acquired capability, and other characteristics play in the unfolding of the suicidal impulse (Ellis, 2006). Rather, it is the development, implementation, and testing of interventions that address these vulnerabilities that are lacking.

In this article, we have described an attempt to adapt such an intervention, Collaborative Assessment and Management of Suicidality, for use in a psychiatric hospital setting and to determine empirically whether it is (1) feasible and (2) effective. A future article will provide outcome data on the initial implementation effort and feasibility testing. However, it is possible at this point to reflect on process issues that set the stage and made this endeavor possible. It is not possible to attribute its initiation to any single incident or factor within the hospital. Rather, a combination of the mission and values of the institution, administrative leadership and support, and corresponding commitment of resources has been required.

Although some suicidal behavior by psychiatric patients is perhaps inevitable, through the lens of continuous quality improve-

ment, it is never considered acceptable or “par for the course.” Furthermore, liability risk in the context of suicidal behavior has never been greater. Thus, the motivation for moving the institution (and indeed the field) forward in this arena comes naturally. Menninger’s historical identity as not only a clinical facility but also an educational and research institution has been instrumental as well. Thus, “selling” administration on the appropriateness of the project has not been difficult (which is not to say that funding during the current economic difficulties hasn’t been an issue!).

Availability of outside consultation and support also has been essential. This has provided consistent guidance in the service of fidelity to a theoretical model and academic rigor, as well as the availability of an “outside eye” to provide perspective, fresh ideas, and encouragement in the context of challenging tasks. Indeed, collaboration, a cornerstone of CAMS, might be considered an essential ingredient in this implementation of CAMS as well.

Future directions call for increasing levels of rigor in assessing the effectiveness of CAMS in the inpatient environment. As noted above, we intend to proceed through stages similar to those described by Rounsaville et al. (2001), as we move from feasibility testing to open trial and, finally, to a randomized controlled trial. As we progress to higher levels of rigor, it is expected that the added expense will necessitate pursuit of external funding (funding thus far has been provided internally by the Menninger Foundation).

Ongoing data analysis and continued clinical experience with CAMS are expected to lead to further refinements in the intervention. We look forward to examining correlates of outcome to inform our efforts to place greater emphasis on the more beneficial components. From a practical perspective, feedback from study therapists is expected to lead to procedural refinements that increase utilization throughout the hospital. “Exportability” is also a major goal; the need for effective interventions for patients in acute care facilities with shorter lengths of stay is great. We expect that CAMS will be useful in these settings as well, although a variety of adjustments will likely be necessary. We look forward to examining outcome data to learn more about mechanisms and trajectory of change in order to better tailor the approach for various settings.

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