A TEACHING TEST ON SUICIDE:
TEST QUESTIONS ON EVALUATING AND TREATING SUICIDAL PATIENTS
Version 4.0

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INTRODUCTION

This document contains 250 questions about evaluating and treating suicidal patients, including sources for each question and commentary. Teachers or supervisors can use this test to assess the extent to which learners have mastered information related to suicide. Others can use this test as a self-directed educational tool. Participants may also benefit from the Annotated Glossary and the Notes on Teaching Suicide by the same author (contact Samuelknapp52@yahoo.com).

The content is informed by Cramer et al.'s (2013; 2024) 10 core competence areas in suicide prevention, although the author created all the test questions. The 10 areas are: (1) attitudes and reactions to suicidal patients and suicide-related topics, (2) developing a collaborative stance with suicidal patients, (3) knowing and eliciting evidence-based and culturally-informed risk and protective factors, (4) focusing on the current suicidal interest and plans of the patients, (5) determining risk,[1] (6) developing collaboratively and evidence-supported treatment plans, (7) notifying or involving other persons if helpful, (8) documenting risk, treatment plan formulation, and clinical decision-making, (9) knowing laws concerning suicide, and (10) engaging in appropriate self-care.

Commentary on Test Questions

References were given for the test questions. Often, a question could have more supporting references than the one cited. Several of the questions (such as the optimal use of screening instruments or psychological tests as an aid in estimating the risk of suicide) are based on interpretations of the data, although some authorities may disagree. The author sought to identify such interpretive differences in the commentary preceding each section. Important words are italicized. These and other terms are further defined in the suicide glossary by the same author. Some questions included footnotes to explain the rationale for the test question or how it was phrased.

Each section includes a brief introductory commentary on the implications of the test questions for practitioners. All the true/false questions are phrased so that the answer is true,

[1] The original wording was "levels of risk," however, I changed the wording to reflect problems with the levels of risk methodology.

although teachers can modify them. Some of the test questions could fit into more than one category. For example, questions dealing with rates of suicide among ethnic groups could have also been placed in the section on suicide and diverse populations. Questions concerning psychotherapist attitudes could have been placed in the section on psychotherapy, and so on.

Here are several caveats for this test.

- This test focuses on evaluation and treatment. It excludes many important areas in the study of suicide, including population-wide prevention, postvention with suicide survivors, and so on.

- The emphasis is on general principles of suicide prevention. Those working with specialized populations, such as adolescents, older adults, veterans, or patients from historically marginalized communities, will need more information than found in this test.

- This test was designed for health care practitioners. It only briefly covers cutting-edge developments, such as machine learning or just-in-time interventions, because the research is insufficient to recommend their applicability to the day-to-day work with suicidal patients.

- Educators will likely supplement or modify the questions herein to fit their specific training needs or perspectives on suicide.

- This test covers factual knowledge, although actual competence requires skills and attitudes in addition to factual knowledge. Competence is best developed when professionals receive external feedback from educators, supervisors (for students), peers, or mentors (for practicing professionals).

- Some of the concepts are asked more than once using different questions. This allows teachers to select the questions they think are best.

- The knowledge base about suicide and the principles of suicide prevention is evolving. Psychotherapists must ensure that they continually keep up to date with these changes.

- Two of the questions dealing with legal issues are based on laws in Pennsylvania, where the author once held a psychology license. Participants may need to modify those questions to reflect the laws of their states, territories, or provinces

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BASIC INFORMATION

Effective psychotherapists understand basic information about suicide, including the frequency of its risk across the population, including age, region of the country, race, gender, and

other factors. This section includes questions on suicide clusters, contagions, and survivor grief reactions.

1. Which of the following is TRUE about suicide in the United States?

a. Almost 49,000 Americans died from suicide in 2023.
b. There are more than twice as many suicides as homicides.
c. Suicide rates are highest for those aged 75 or older.
d. All the above.

2. In 2023, suicide was the 11th leading cause of death in the United States.[2]

TRUE FALSE

3. The age-adjusted suicide rate in the United States increased by _____ from 2001 to 2021.

a. 3%.
b. 35%.
c. 10%.
d. 80%.

4. Suicidal ideation is higher than average among persons who

a. Graduated from college.
b. Have incomes near or below the poverty line.
c. Are married.
d. All the above.

5. The frequency of suicidal ideation across the United States varies according to

a. Age.
b. Gender.
c. Region of the country.
d. All the above.

6. Suicides are more common in which part of the United States?

a. Pacific Northwest.
b. Midwest.
c. California.
d. Mountain and Southern States.

7. Although women are more likely to attempt suicide than men, men in the United States are approximately ____ as women to die from suicide.

a. Less likely.
b. 4 times more likely.
c. As likely as.
d. 12 times as likely as.

[2] Over recent years, suicide is usually the 10th or 11th leading cause of death within the United States. Asking the question about its rank in one recent year avoids ambiguity because the rankings may vary from year to year In 2021, suicide was moved out of the top 10 causes for mortality because COVID—which was not listed as a cause of death before 2020, entered the top 10 reasons for mortality (Ahmed et al., 2022).

8. In 2023, the one-year frequency of suicidal ideation in the United States was[3]

a. 5.5% for men and 5.5% for women.
b. 19% for men and 5.5% for women.
c. 5.5% for men and 19% for women.
d. 19% for men and 19% for women.

9. Americans of this ethnic group have the lowest risk of dying from suicide[4]

a. Native American or Alaska Native.
b. Black or African American.
e. Hispanic.
c. White Non-Hispanic.
d. Asian American.
f. Hawaiian or Pacific Islander.

10. Americans of this ethnic group have the highest risk of dying from suicide

a. Native American or Alaska Native.
b. Black or African American.
e. Hispanic.
c. White Non-Hispanic.
d. Asian American.
f. Hawaiian or Pacific Islander.

11. Among Americans who had suicidal thoughts in the last year, approximately_____ will attempt suicide in the next 10 years. [5]

a. LT 1%. b. 13%. c. 60%. d. 80%.

12. Psychologists who die from suicide are more likely to be

a. Unmarried.
b. Living in the Mountain or Southern States.
c. Male.
d. All the above.

13. The most frequent method <u>of suicide attempts</u> in the United States is by

a. Hanging.
b. Firearms.
c. Self-poisoning (including overdoses).
d. None of the above.

[3] For Question 8, students should not be expected to know the exact percentage of Americans who had one-year suicidal ideation because that figure will change from year to year and vary slightly according to different studies. For example, Han et al. (2014) found 3.5% for men and 3.9% for women. Nonetheless, informed students should be able to infer the correct answer if they know the general frequency of suicidal ideation in the population and know that the difference in suicidal ideation between women and men is not very large.

[4] Questions 9 and 10 use the CDC descriptors for ethnic groups in the United States, except that the CDC refers to Native Americans as American Indians.

[5] In question 11, one would not expect students to know the exact percentages. However, well-informed students may infer the right answer because the other options (LT 1%, 60%, and 80%) are so extreme.

14. The most frequent method of suicide in the United States is by

a. Hanging.
b. Firearms.
c. Self-poisoning (including overdoses).
d. None of the above.

15. Suicide rates are higher in the ____ areas of the United States.

a. Rural
b. Urban
c. Suburban
d. Oceanic

16. *Suicide clusters* refer to an elevated rate of suicide in a specific location and time, which is greater than one would expect by chance.

TRUE FALSE

17. *Social contagion* of suicide refers to the idea that

a. Being exposed to suicidal behaviors can increase the likelihood that individuals will attempt suicide themselves.
b. Sexually transmitted diseases are spread through social contact.
c. Social media has been a very positive factor in the recent sharp reduction in suicide rates.
d. Suicides are influenced almost exclusively by an individual's genetic makeup, and social factors have little influence.

18. What is TRUE about suicide?

a. An average of 1 to 2 persons will experience profound grief at their deaths.
b. When teenagers die from suicide, their friends rarely grieve for them.
c. Those who had a loved one who died from suicide have a worse quality of life after the suicide than if the loved one had died from natural causes or an accident.
d. All the above.

19. Some of the common stereotypes are that persons with suicidal thoughts are

a. Weak.
b. Immoral.
c. Selfish.
d. All the above.

PSYCHOTHERAPISTS AND SUICIDE

This section includes general information about burnout and psychotherapist stress, but also information specific to working with suicidal patients. Psychotherapists may fear that their patients may die from suicide, that they would be blamed for that death, and face legal consequences (Conrad et al., 2021). Some otherwise highly competent psychotherapists can deliver less-than-optimal services because of their fears. Treating suicidal patients can indeed be stressful and evoke

many difficult emotions, and the reality is that some patients will die from suicide. Nonetheless, effective psychotherapists strive to understand and manage their emotional reactions to suicidal patients. Knapp and Schur (2019) suggested that psychotherapists adopt an attitude of *concerned alertness* and avoid the extremes of being either dismissive or alarmist. *Dismissive* psychologists do not take the risk of suicide seriously enough. *Alarmis*t psychologists may overreact and promote counterproductive, overly controlling strategies (Joiner, 2010).

20. One of the professional events most feared by psychologists, according to Pope and Tabachnick (1993), is that they will have a patient die from suicide.

TRUE FALSE

21. A study in the UK found that _____ of all suicides occurred among those who were currently receiving mental health services.

a. LT 1%. b. 27%. c. 85%. d. 90%.[6]

22. Sometimes, compassionate psychotherapists, delivering high-quality and evidence-supported services, will have a patient die from suicide.

TRUE FALSE

23. One of Dr. Smith's patients died by suicide. If Dr. Smith reacts like most other psychotherapists, she is likely to

a. Lose her license to practice.
b. Need to consider retiring.
c. Experience serious emotional distress.
d. All the above.

24. According to Jobes, the obligation of a psychotherapist is to

a. Prevent all suicides
b. Assume all responsibility for the patient's wellbeing
c. Compassionately deliver high-quality services.
d. All the above

25. Working with suicidal patients can be difficult if patients

a. Engage in therapy-interfering behavior.
b. Engage in "suicidal blackmail" or threatening suicide unless the psychotherapists meet their unreasonable demands.
c. Elicit countertransference hate.
d. All the above.

[6] Once again students should be able to infer the correct answer because the other options are so extreme.

26. Psychotherapists who have had a patient die from suicide can reduce their emotional burden if they

a. Can identify or recognize their feelings.
b. Receive social support.
c. Do not assume that they alone are responsible for a death by suicide.
d. All the above.

27. According to Maslach's theory of *burnout*, burnout consists of all of these components EXCEPT

a. Emotional exhaustion.
b. Depersonalization.
c. Fear of the unknown.
d. Demoralization.

28. When treating suicidal patients, it is optimal for psychotherapists to

a. Treat suicidal patients with a relaxed attitude, remembering that most of them threaten suicide only to get attention.
b. Become hypervigilant and take every precaution to prevent suicide, whether the patient wants to cooperate or not.
c. Adopt a compassionate, concerned, and alert attitude, emphasizing a good relationship with the patients and allowing them to tell their stories in their own words.
d. Always refer every suicidal patient to a psychiatrist who can determine whether the patient is faking or not.

29. Psychotherapists who report high levels of personal well-being tend to

a. Come from cultures of honor.
b. Have a "lone wolf" attitude.
c. Have strong social networks.
d. Constantly demand perfection from themselves

30. Which of the following schemas can predispose psychologists to professional burnout?

a. Excessive self-sacrifice
b. A and B.
c. Unrelenting high standards.
d. None of the above.

THEORIES OF SUICIDE

Theories are helpful because they can explain large amounts of data and guide future research directions. Psychotherapists can use a theory to guide their assessments and formulate intervention targets. They can also use their theory to give patients a framework to understand how they came to consider suicide as an option and how they can improve their lives. Two of the most respected theories are the *interpersonal theory of suicide* (Thomas Joiner) and the *integrated*

motivational-volitional theory (Rory O'Connor), which are both *ideation-to-action theories* that postulate that suicide requires both the desire for death and the capability of killing oneself. Other psychologists may prefer hopelessness theory, escape theory, the three-step theory, narrative crisis theory, or another theory. Here, instructors may want to add questions more suited to their orientations.

31. According to the *stress-diathesis model*, suicidal behavior is a consequence of

a. Only stressors such as financial problems or loss of a relationship.
b. Only predisposing factors such as one's life history or genetic makeup.
c. The interaction between stressors and predisposing factors.
d. Internalized anger.

32. According to *ideation-to-action* theories of suicide, suicide attempts are the result of

a. The desire for suicide alone.
b. The capability of suicide alone.
c. Both the desire for suicide and the capability of suicide.
d. None of the above.

33. Within the ideation-to-action framework, factors related to suicide could include

a. Perceived burdensomeness.
b. Acquired capability for suicide.
c. Thwarted belongingness.
d. All the above.

34. Within the ideation-to-action framework, the *capability* for suicide (or the acquired capability for suicide) could be influenced by

a. Past experiences.
b. Access to lethal means.
c. One's disposition or genetic makeup.
d. All the above.

35. According to the integrated motivational volitional theory of suicide, patients may develop the personality traits or beliefs that predispose them to suicidal thoughts during the

a. *Premotivational* stage.
b. *Volitional* stage.
c. *Motivational* stage.
d. Integrated stage.

36. According to the integrated motivational-volitional theory of suicide, patients may develop suicidal thoughts during the

a. Premotivational stage.
b. Volitional stage.
c. Motivational stage.
d. Integrated stage.

37. According to the integrated motivational-volitional theory of suicide, patients may develop the capability for suicide during the

a. Premotivational stage.
b. Volitional stage.
c. Motivational stage.
d. Integrated stage.

38. According to the integrated motivational-volitional theory of suicide, _____is a central component of suicide.

a. Anxiety sensitivity.
b. Auditory hallucinations.
c. Entrapment.
d. The failure to commit.

ASSESSMENT

The rule of thumb is to ask all patients seeking mental health services if they have thoughts of suicide, and this is best done through both a written and a verbal question (see question 41), followed by a narrative assessment in which the psychotherapist encourages the patients to tell their stories at their own pace with minimal interruptions (Bryan & Rudd, 2018). Psychotherapists can use these assessments to identify their patients' needs, establish a baseline to measure future improvements (or deterioration), and develop an effective intervention. The first question in this section (Question 39) is especially important, not so much for learners to know the term but to understand the concept that patients may have many different pathways to a suicide attempt. Often, patients go on a gradual sequence from ideas to plans to actions. However, this sequence is not uniform, and every patient has a unique trajectory and timeline. Some patients appear to jump directly from ideation to attempt, while other patients will have the suicidal attempt come on them suddenly, sometimes within minutes.

39. As it applies to suicidal patients, the terms *equifinality* or *indeterminacy* mean that

a. All suicides can be prevented.
b. Evidence-based practices get the best results.
c. Suicide attempts may have different causes or follow different trajectories from thoughts to actions.
d. None of the above.

INTERVIEWING PATIENTS

Usually, psychotherapists can learn if their patients have suicidal thoughts by asking them. However, many patients (maybe one-fifth to one-half; Obegi, 2021) with suicidal thoughts will not disclose them. However, psychotherapists can take steps to increase the likelihood that their patients will disclose their suicidal thoughts more fully.

40. Many patients who died from suicide had an appointment with a healthcare professional shortly before they died. [7]

TRUE FALSE

41. Which of the following are (is) TRUE?

a. Some patients will acknowledge suicidal thoughts in response to a question on a written form but deny them in an in-person interview.
b. Some patients will acknowledge suicidal thoughts in an in-person interview but deny them in response to a question on a written form.
c. Both a and b.
d. None of the above.

42. Asking patients about suicide does NOT make them suicidal.

TRUE FALSE

43. According to the *narrative* approach to assessing suicidal patients, psychotherapists will

a. Allow patients to tell their own stories in their own words.
b. Prioritize open-ended questions.
c. Rarely interrupt patients.
d. All the above.

44. Blanchard and Farber (2020) found that about ___ of patients consistently denied suicidal thoughts even when those thoughts were present. [8]

a. 90%. b. 88%. c. 21%. d. LT 1%.

45. Suicidal patients commonly deny suicidal ideation because they

a. Feel shame at having such thoughts.
b. Resent being asked this question.
c. Have a narcissistic personality disorder.
d. All the above.

46. A patient denied suicidal thoughts because she thought that admitting to suicidal thoughts was a sign of weakness and cowardice. This denial of suicidal thoughts is most likely caused by

[7] The number reported across studies varies from 75% (Luoma et al., 2002) to 44% (Stene-Larsen & Reneflot, 2019), depending on the time frame used and how professionalism was defined. We are less interested in the exact number and more interested in having students understand that many opportunities to help suicidal persons were lost.

[8] The frequencies of non-disclosure vary considerably (Obegi, 2021). Nonetheless, well-informed students should be able to infer the correct answer because the other options are so extreme.

a. Self-stigma.
b. Reverse perfectionism.
c. Anxiety sensitivity.
d. Negative urgency.

47. Psychologists can help suicidal patients who deny or minimize their suicidal thoughts to open up by doing all the following EXCEPT

a. Encouraging self-compassion.
b. Arguing with their patients.
c. Normalizing suicidal thoughts.
d. Reinforcing or praising patients who make difficult self-disclosures.

48. Patients are more likely to deny suicidal thoughts when interviewers use negatively worded questions.

TRUE FALSE

49. Which is an example of a negatively worded question about suicide?

a. Are you thinking of suicide?
b. Have you had any thoughts of suicide recently?
c. No thoughts of suicide, right?
d. All the above.

50. When asking patients about suicide, it is important to

a. Phrase questions in a manner that reduces embarrassment.
b. Try to get information about past suicide attempts, if any.
c. Keep a good relationship and rapport with the patients.
d. All the above.

51. A state or attitude that occurs when individuals apply the social stigmas about a specific group to themselves

a. Embarrassment.
b. Cognitive constriction.
c. Internalized stigma.
d. The Dunning-Krueger effect.

52. Patients who have an *internalized stigma* (also called *self-stigma*) often

a. Keep their suicidality secret.
b. Have an increased risk of a suicide attempt.
c. Avoid mental health treatment.
d. All the above.

53. Patients with serious suicidal thoughts who refuse to get help are engaging in

a. Subliminal denials.
b. Reaction formation.
c. Help negation.
d. Insecure attachment disorders.

FACTORS RELATED TO SUICIDE

Many factors have a statistical correlation with suicidal ideation or suicide attempts. However, these correlations tend to be low. Instead of looking for only one factor that motivates the desire for suicide, it is often optimal to look at how many factors interact with each other for each patient. So, for example, a patient with a chronic medical condition may understandably experience distress from this condition. However, if the chronic medical condition is combined with loneliness, a sense that one is a burden on others, and access to lethal weapons, then the risk of developing suicidal thoughts is higher. Knapp (2020) categorized the risk factors as either *baseline* (*static*) or *changing* (*dynamic*). Although Bryan and Rudd (2018) used the term baseline factors, they did not use the term dynamic factors. Instead, they broke them down into activity events, symptoms, suicide-specific beliefs, and problems with impulse control. Although it is still worth looking for these factors correlated with suicides, clinicians must ensure that they view these factors in the context of their patients' experiences, recognizing that risk can vary over time. Group data can only take a clinician so far. It is necessary to look at the patient's unique life experiences and perspectives.

54. When assessing suicidal risk, psychotherapists should consider

a. Static (fixed) factors such as the patient's age or personal history.
b. Dynamic (changing) factors, such as the patient's current workplace.
c. Protective factors such as life-protecting religious beliefs.
d. All the above.

55. Which is TRUE about fixed (baseline or static) factors?

a. Members of some demographic groups never die from suicide.
b. They include the patient's history, including the history of being exposed to violence.
c. Members of some demographic groups are always immune from suicide.
d. All the above.

56. Risk factors that never change are called

a. Static or baseline factors.
b. Dynamic or changing factors.
c. Residual factors.
d. Warning signs.

57. An example of a baseline (static) factor when assessing suicide risk is

a. The patient's perception of pain.
b. A current sense of entrapment.
c. Childhood history.
d. Perceived burdensomeness.

58. Risk factors that can change are called

a. Static or baseline factors.
b. Dynamic or changing factors.
c. Residual factors.
d. Warning signs.

59. An example of a changing (dynamic) factor for estimating the risk of suicide is

a. Highest educational level.
b. A current sense of entrapment.
c. Birth date.
d. Childhood experiences.

60. Factors that could increase the risk of suicidal ideation include

a. Relationship problems.
b. Self-hatred.
c. Poor physical health.
d. All the above.

61. *Moral injury* occurs when an individual

a. Has injured people who are known for their high standards of morality.
b. Violates one or more of their deeply held moral beliefs.
c. Sees injuries to moral people regardless of who caused the injury.
d. Has been injured while doing something moral.

62. People who engage in *nonsuicidal self-injury*

a. Almost always go on to attempt suicide.
b. Very seldom go on to attempt suicide.
c. Have a rate of suicidal attempts higher than rates found in the general public.
d. Have extraordinarily high self-esteem.

63. Patients who attempt suicide have, on average, lower levels of *distress tolerance,* which refers to the ability to

a. Tolerate positive emotions.
b. Tolerate negative emotions.
c. Experience both positive and negative emotions at the same time.
d. Identify when they have a negative emotion.

64. Which person is likely to have the HIGHEST risk of having suicidal ideation?

a. A young mother with small children.
b. A happily married man.
c. An older man who recently lost his wife and has few friends.
d. An unmarried woman with lots of friends and good relationships with her family.

65. Galynker (2017) estimated that ____ of persons who died from suicide had a mental illness.

a. 20%.
b. 90%.
c. 50%.
d. 99%.

66. People have an elevated risk of suicide if they experience *loneliness*, defined as a state in which one

a. Has few contacts with other people.
b. Feels a gap between one's desired quantity or quality of social interaction and the actual quantity or quality of one's social interactions.
c. Lives alone.
d. Is either a widow or a widower.

67. Some of the consequences of loneliness include

a. An increase in all-cause mortality.
b. A decrease in life satisfaction.
c. An increased risk of suicide.
d. All the above.

68. Patients with serious and chronic illnesses often have sequelae associated with suicide, such as

a. Social isolation.
b. Financial instability.
c. A sense that they are a burden to others.
d. All the above.

69. The best predictor of suicide risk among persons with physical illnesses would be

a. Whether it was pulmonary or cardiac-related.
b. The impact of the illness on their activities of daily living.
c. The age of the patient.
d. The gender of the patient.

70. Factors that increase the risk of suicide among persons with disabilities could include

a. Perceived burdensomeness.
b. The presence of several co-morbid disabilities.
c. Minority stress.
d. All the above.

71. Post-traumatic stress disorder often involves elements related to overarousal, including

a. Insomnia.
b. Hypervigilance.
c. Irritability.
d. All the above.

72. The *polytrauma triad*, which increases the risk of suicide, includes

a. PTSD.
b. Head trauma.
c. Chronic pain.
d. all the above.

73. Patients who have thoughts of suicide often have difficulties sleeping.

TRUE FALSE

74. Averse experiences or events in childhood may increase the risk of suicide if they lead to

a. Poor executive functioning.
b. Maladaptive responses to life circumstances.
c. Mistrust of others.
d. All the above.

75. Patients have an elevated risk of suicide if they have [9]

a. More than one psychiatric diagnosis.
b. A bipolar disorder.
c. A pattern of misusing alcohol or other drugs.
d. All the above.

76. Painful and provocative events increase a person's capability for suicide. An example of a painful or provocative event with the potential to increase one's capability for suicide would be

a. Having a routine teeth cleaning at a dental appointment.
b. Feeling provoked during a discussion of politics.
c. Experiencing physical abuse as a child.
d. Getting tired after a strenuous physical workout.

77. Some drug overdoses recorded by coroners as accidental may have been intentional.[10]

TRUE FALSE

78. Which of the following is TRUE about suicide risk?

a. Patients with comorbid diagnoses have a higher risk of suicide than patients with only one diagnosis.
b. Patients who abuse alcohol have an elevated risk of suicide.
c. Some persons who attempt suicide do not have a disorder listed in the DSM.
d. All the above.

79. A style of thinking characterized by thinking about one's problems in an intrusive manner that is difficult to disengage from is called

a. Negative urgency.
b. Ruminations.
c. Other-prescribed perfectionism.
d. Thwarted belongingness.

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[9] Any mental illness increases the risk of suicide somewhat, although most studies find especially elevated risks for bipolar disorders, substance misuse disorders, and in patients who have comorbid psychiatric disorders.

[10] The frequency is unknown and perhaps unknowable. However, this fact has two important implications. First, the demographics of who dies from suicide may be skewed because Black Americans have high rates of deaths listed as drug overdoses, many of which may actually have been suicides. Second, psychotherapists should be aware that patients with a background of nonfatal accidental overdoses may have actually been trying to kill themselves or at least showing indifference as to whether they lived or not.

80. *Socially prescribed perfectionism* is correlated with suicide. Socially prescribed perfectionism is defined as the belief that

a. I cannot make mistakes.
b. Others expect me to be perfect.
c. I should always strive to do my best.
d. I should expect others to be perfect.

81. *Protective factors*, or factors that reduce the risk of suicide, could include

a. Working as a police officer or in protective services.
b. Having close friends.
c. Being a protective male.
d. All the above.

82. Positive mental health (high levels of happiness and life satisfaction) reduces the risk of suicidal behavior.

TRUE FALSE

83. Resilience is the

a. Ability to recover from or to adjust to adverse life events or stressors.
b. Insensitivity toward pain.
c. The feeling of compassion for others.
d. The lack of fear or anxiety when faced with stressful events.

84. Which is TRUE about the relationship of suicide to religion

a. For many people, religion is a protective factor against a suicide attempt.
b. The social connections associated with participation in a religious group may reduce the risk of a suicide attempt.
c. Some very religious people may still have a high risk of suicide.
d. All the above

85. Even patients with great psychological pain will refrain from attempting suicide if they have strong *reasons for living*. The reasons for living that could inhibit a suicide attempt include

a. A commitment to family members.
b. A belief that suicide is morally wrong.
c. A desire to live out one's religious values.
d. All the above.

86. Dr. Garcia wants to do a comprehensive evaluation of his patient's risk of suicide. To do that, Dr. Garcia needs to ask her patient about

a. Recent upsetting life events, such as those that disrupt important social relationships.
b. Her physical health.
c. Whether she can identify reasons for living.
d. All the above.

SCREENING OR PSYCHOLOGICAL TESTS

Scholars disagree on when a screening instrument or test has sufficiently strong psychometric properties to recommend it. A screening "usually consists of a short list of questions that, if answered in the affirmative, indicate that a more thorough evaluation should be conducted" (Silverman & Berman, 2014, p. 421). These instruments lack sufficient psychometric strengths to be used by themselves to determine the risk of suicide for any one patient. Some are high on sensitivity (ability to detect suicidal patients), and others are high on specificity (ability to exclude those who are not suicidal), but none are consistently high in both. No one test stands out as noticeably better than the others (Gutierrez et al., 2021).

The general belief is that psychotherapists can supplement their clinical impressions with screening measures or tests. Bongar et al. (2017) stated that such assessments are "vital to the continued appraisal of suicidal thoughts and behaviors" (p. 118). However, Quinlan et al. (2018) took a minority position and argued that "no scales perform sufficiently well so as to be recommended for routine clinical use" (p. 1). So, the answer to question 74 reflects my (and others') interpretation that tests serve to supplement interviews. Nonetheless, research on screening instruments is ongoing, and recommendations regarding screening instruments or psychological tests may change over time. Some of the more widely used instruments are the AsQ, Beck Hopelessness Scale, Columbia Self-Rating Scale, Patient Health Questionnaire-9 (PHQ-9), Scale of Suicide Intent, and the Suicide Behaviors Questionnaire. The AsQ and Columbia are in the public domain.

Some scholars developed "levels of risk" to categorize patients according to the risk of suicide, and this was one of the 10 core competencies identified by Cramer et al. (2013; 2024). According to these risk criteria, a psychotherapist could rate a patient's risk as high, moderate, low, or a combination of risk levels, and then recommend a level or type of care based on that rating. A patient at the highest level of risk could, for example, receive a recommendation to go to a hospital, and a patient at the next lower level of risk could receive a recommendation for intensive outpatient treatment, and so on. The advantage of these levels of risk is that they provide a semi-standardized and reasoned approach to risk, and they avoid an overly simplistic dichotomy of suicide risk as either "present" or "not present." Nonetheless, if used at all, they must be used with sufficient caveats; some competent professionals may prefer not to use them (see question 91).

87. The ability of a psychological test or screening instrument to accurately identify individuals who have a specific disorder is called its

a. Reliability.
b. *Sensitivity.*
c. *Specificity.*
d. Validity.

88. The ability of a psychological test or screening instrument to accurately identify individuals who do NOT have a specific disorder is called its

a. Reliability.
b. Sensitivity.
c. Specificity.
d. Validity.

89. A generalization about screening or brief tests of suicidal thoughts is that

a. They are almost all high on sensitivity but low on specificity.
b. They are almost all high on specificity but low on sensitivity.
c. None are consistently high on both sensitivity and specificity.
d. Specificity and sensitivity are almost perfectly correlated.

90. When using screening instruments or brief tests of suicidal ideation, psychologists are advised that

a. They can rely almost exclusively on them for estimating the risk of a suicide.
b. These tests have no usefulness at all in estimating the risk of suicide.
c. The tests can be used, in conjunction with interview data, other data, and the clinician's judgment, to evaluate the risk of a suicide attempt.
d. The PH-9 is by far the best screening instrument to use.

91. Psychotherapists need to use caution when categorizing patients into "levels of risk" because

a. Even patients at low levels of risk may die from suicide.
b. A low level of risk may give the psychotherapist a false sense of security.
c. The patient's actual level of risk may fluctuate.
d. All the above.

92. Psychotherapists need to use caution when categorizing patients into "levels of risk" because

a. Such formulae may lead to confirmation bias.
b. Risk is dynamic and not static.
c. These formulae contain many false positives and false negatives.
d. All the above.

93. Psychotherapists need to use caution when categorizing patients into "levels of risk" because

a. Categorical labels do not convey the threats or protective factors unique to the patient.
b. The interrater reliability of these formulae is moderate.
c. The actual risk may vary over time.
d. All the above.

94. Some patients reported that they went directly into a suicide attempt without having any suicidal thoughts precede their actions.

TRUE FALSE

SUICIDAL THOUGHTS, BEHAVIORS, AND FEELINGS

95. The term *suicidal mode* refers to the

a. Method (or mode) that patients use to attempt suicide.
b. The psychological state (thoughts, feelings, behaviors, and motivations) that propel a patient to attempt suicide.
c. The patient's crisis intervention plan.
d. Whether the treatment is done as an inpatient or outpatient.

96. Which of the following is NOT true about suicidal thoughts? Suicidal thoughts

a. Fluctuate rapidly over time.
b. May vary in intensity.
c. Are highly similar in their frequency and character.
d. Vary in their duration.

97. Which of the following is (are) TRUE, according to Paashaus et al. (2021)? [11]

a. 36% of attempters acted within 5 minutes of the suicidal urge.
b. 44% of attempters acted within 10 minutes of the suicidal urge.
c. 75 % of attempters acted within 3 hours of the suicidal urge.
d. All the above.

98. A general rule is that suicidal plans with greater specificity and detail indicate

a. A lower risk of attempting suicide.
b. No risk of suicide.
c. A higher risk of attempting suicide.
d. None of the above.

99. When a patient has had several suicide attempts, it is desirable for psychotherapists to ask

a. Only about the first attempt.
b. About their worst and their latest attempt.
c. Only about their latest attempt.
d. Only about their worst attempt.

100. Joiner et al. (2013) defined the *worst suicide attempt* as the one [12]

a. With the most lethal means used.
b. That gets people the most upset.
c. The patient calls it the worst attempt.
d. None of the above.

101. Anything that is empirically related to the risk of suicide, regardless of time frame, is called a

a. Warning sign.
b. Risk factor.
c. Dynamic factor.
d. Static factor.

---

[11] Knowing the exact figures is less important than knowing that suicidal thoughts can come on rapidly.

[12] See Joiner et al. (2003) on how the patient's rating of their own worst suicide attempt is a predictor for a future suicide attempt. This has implications for how psychotherapists interview their patients about past suicide attempts.

102. Anything that indicates a heightened short-term risk of suicide for an individual is called a

a. Warning sign.
b. Risk factor.
c. Dynamic factor.
d. Static factor.

103. The *fluid vulnerability theory* of suicide holds that suicidal behavior occurs as a result of

b. Only baseline factors such as sex, trauma history, or psychiatric history.
b. Only acute factors such as emotional distress, hopelessness, or somatic symptoms.
c. An interaction between baseline and acute factors.
d. Only adverse childhood events.

104. *Thwarted belongingness* refers to the

a. The sense that one is a burden to others, and they would be better off if one were dead.
b. The disappointment over the lack of social acceptance by a valued group.
c. The anger that occurs from the loss of religious faith.
d. All the above.

105. *Perceived burdensomeness* refers to

a. The sense that one is a burden to others, and they would be better off if one were dead.
b. The burden of having an accurate perception of life.
c. The anger that occurs from a loss of religious faith.
d. All the above.

106. A patient said that she believed that she was a burden to others and that others would be better off if she were dead. This statement best reflects the psychological state of

a. Thwarted belongingness.
b. Insecure attachment.
c. Perceived burdensomeness.
d. The Dunning-Krueger effect.

107. A patient said that she wished to die but did not intend to kill herself. This statement best reflects

a. A wish-to-die or passive suicide statement.
b. Insecure attachment.
c. Perceived burdensomeness.
d. The Dunning-Krueger effect.

108. The rates of suicide attempts among those reporting *passive suicidal thoughts*

a. Are twice as high as those who have active suicidal thoughts.
b. Are twice as low as those who have active suicidal thoughts.
c. Are about the same as those who have active suicidal thoughts.

109. Patients who feel *entrapment* [13]

a. Are in emotional pain that they consider unbearable.
b. Have extreme hopelessness.
c. See no end to the pain.
d. All the above.

110. A strong desire to immediately end a situation that seems intolerable

a. Negative urgency.
b. Thwarted belongingness.
c. Overarousal.
d. Perceived burdensomeness.

111. Symptoms commonly found in an acute suicidal crisis state could include[14]

a. Social withdrawal, thwarted belongingness, or perceived burdensomeness.
b. Excessive joy and false euphoria.
c. Ringing in the ears accompanied by back pains.
d. All the above.

112. Problems of overarousal may manifest themselves through

a. Agitation.
b. Nightmares.
c. PTSD symptoms.
d. All the above.

113. Compared to those who have suicide ideation alone, those with suicidal ideation who go on to attempt suicide are more likely to

a. Have had a family member or friend die from suicide.
b. Score higher on scales of acquired capability for suicide.
c. Score higher on measures of impulsivity.
d. All the above.

114. Studies of those with a history of suicidal thoughts revealed that they commonly experienced

a. A desire to be the focus of attention.
b. A desire to punish people whom they were mad at.
c. A feeling of loneliness and lack of social connection.
d. A feeling of pride in one's ethnic heritage.

MANAGEMENT OF SUICIDAL RISK

The older model of suicide prevention focused on treating the patient's mental illness with the expectation that the suicidal behavior was secondary to the mental illness and would then

[13] Entrapment is a key feature of the Integrated Motivational Volitional Model of suicide of O'Connor (2021) and also Galynker's (2017) Narrative Crisis Model of suicide.

[14] The two most researched descriptions of the psychological states immediately preceding a suicide attempt are the acute suicidal affective disturbance (Rogers et al., 2018) and the suicide crisis states (Galynker, 2017). To their credit, they are collaborating to help clarify these different but overlapping descriptions of this state.

dissipate. However, more contemporary and effective models also focus on the suicidal behavior itself. Older models also focused on controlling patients to keep them from attempting suicide, either through hospitalizations or pressuring them to sign “no suicide” contracts. Old practices die hard, and I still hear of situations where it appears that hospitalizations were overused or where psychotherapists still use the debunked practice of using no-suicide contracts (one recent study of mental health clinicians found that 43% of them still use no-suicide contracts (Labouliere et al., 2021). Fortunately, more effective interventions, such as *collaboratively developed safety plans* or collaboratively implemented *lethal means counseling*, can substantially reduce the risk of a suicide attempt. Such interventions could include Stanley and Brown’s (2012) safety plan intervention, Bryan et al.’s (2017) Crisis Response Plan, or Jobes’ Collaborative Assessment and Management of Suicide (2023). Lethal means counseling could be part of the safety plan or a stand-alone intervention.

115. Suicide management strategies refer to activities that

a. Address the patient’s underlying mental illness.
b. Allow for a more detailed assessment of the patient.
c. Reduce the patient’s short-term risk of suicide.
d. Rely heavily on psychometrically sound suicide assessment instruments.

116. Good suicide management strategies include

a. Recommending psychiatric hospitalizations at the slightest hint of self-harm.
b. Using a pre-written no-suicide contract.
c. Using a collaboratively developed safety plan.
d. All the above.

117. Psychotherapists can monitor their patients’ suicidal ideation by

a. Asking patients about their suicidal thoughts.
b. Giving patients brief screening instruments that measure suicidal ideation.
c. Asking for the input of relatives or others in the patient’s natural social network.
d. All the above.

118. The potential harm(s) from an involuntary psychiatric hospitalization is (are) that it may

a. Disrupt the treatment relationship.
b. Humiliate or embarrass the patient.
c. Disrupt the patient’s job or social support system.
d. All the above.

119. No suicide contracts are ____ imposed and tell patients what they cannot do, while collaboratively developed safety plans are _____ generated and tell patients what they can do to reduce their emotional pain. [15]

a. Externally, externally.
b. Externally, internally.
c. Internally, internally.
d. Internally, externally.

120. Problems with no-suicide contracts are that

a. No evidence exists that they prevent suicides.
b. Patients may perceive that their psychotherapists are more interested in reducing their personal liability than in helping them.
c. Psychotherapists sometimes pressure patients to sign them.
d. All the above.

121. Patients who received a collaborative assessment and intervention tended to have treatment outcomes

a. Worse than those without collaborative assessments and interventions.
b. The same as those without collaborative assessments and interventions.
c. Better than those without collaborative assessments and interventions.

122. Which of the following are (is an) element(s) in most collaboratively developed safety plans?

a. Reasons for living.
b. Distracting activities.
c. Warning signs.
d. All the above.

123. An emotional crisis could occur by the accumulation of several small events or stressors (similar to a flood caused by several small rainstorms) or by one large event or stressor (similar to a flood caused by a major rainstorm)

TRUE FALSE

124. Which of the distracting activities below would an effective psychotherapist be MOST likely to recommend to a patient trying to interrupt suicidal thoughts[16]

a. Going bowling with a friend.
b. Using alcohol or recreational drugs.
c. Watching a television show alone.
d. Going out to a restaurant by oneself.

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[15] Despite the lack of evidence of their effectiveness and the problems associated with them, we still encounter professionals who use no-suicide contracts. Many students who have worked in agencies may have been taught that these no-suicide contracts are the standard of care.

[16] Patients are the experts on what helps them the most. Watching television and going to a restaurant may be valuable in distracting patients because they involve visual and audio stimulation, taste, and movement, respectively. However, option a is generally preferred because it is a social, motor, and sensory activity.

125. According to the meta-analysis by Nuij et al. (2021), *collaboratively developed safety plan-type interventions* reduce suicide attempts by an average of[17]

a. 189%. b. 43%. c. 3%. d. LT 2%.

126. Restricting easy access to firearms can reduce the risk of death for suicidal patients who plan to kill themselves with firearms

TRUE FALSE

127. Patients' self-ratings of the likelihood that they will die from suicide help predict later suicide attempts.

TRUE FALSE

128. Firearms account for approximately ___ percent of all attempts and approximately ___ percent of all suicides.[18]

a. 10 and 20.
b. 5 and 50.
c. 20 and 20.
d. None of the above.

129. Decedents who died by firearms had a prior history of fewer previous suicide attempts compared to suicide decedents who died by other means (i.e., those who died by using a firearm in a suicide attempt were more likely to die on their first attempt).

TRUE FALSE

130. Psychotherapists will be better able to get patients to cooperate with *means safety* recommendations if they

a. Threaten to call the police.
b. Use motivational interviewing strategies.
c. Try to make their patients feel guilty.
d. All the above.

131. When counseling patients about firearm safety, psychologists

a. May want to use the word firearms, not guns.
b. Should expect that some patients will fear that their psychotherapist will try to take their firearms away.
c. Should emphasize voluntary and temporary measures.
d. All the above.

[17] Well-informed students may infer the correct answer even if they are unfamiliar with the study referenced.

[18] The question uses the qualifier "approximately" because different scholars have slightly different.

132. It is helpful to remove firearms from the homes or to create obstacles to the easy access of firearms by suicidal patients who are thinking of shooting themselves, because it is unlikely that they will use another way to kill themselves.

TRUE FALSE

133. Deaths by drug overdoses can be reduced if

a. Patients get rid of expired, unused, or unnecessary medications.
b. Physicians limit their prescription of drugs to non-lethal doses.
c. Naloxone kits are available for patients who are prescribed or who abuse opioids.
d. All the above.

134. It is indicated to send patients to emergency rooms if they[19]

a. Have physical concerns that need immediate attention.
b. Only need a friendly person to talk to.
c. Need an expert evaluation by an ER physician who understands suicide very well and has enough time to do a thorough evaluation in a quiet environment.
d. All the above.

SUICIDE RISK WITH SPECIAL GROUPS

Psychotherapists who work with special groups need to learn the unique suicide risks and interventions for these groups. The author selected three such groups, although this section could be expanded substantially to include veterans, survivors of PTSD, those with brain damage, healthcare professionals, first responders, and so on.

OLDER ADULTS

135. Suicide among older adults is higher when the older adult

a. Reports high rates of anxiety or depression.
b. Has fewer people to depend on.
c. Suffers from physical limitations.
d. All the above.

136. Physical limitations may be especially problematic among older adults and increase the risk of suicide if they lead to

[19] Sometimes learners report that they have access to a local ER physician or department which is particularly adept and helpful with suicidal patients. Therefore, the options other than the correct one are considered absurd. Unfortunately, some inadequately trained psychotherapists routinely refer their suicidal patients to emergency rooms under the mistaken belief that this ensures that they will necessarily receive a good quality evaluation or that they have shifted legal obligations elsewhere.

a. Social isolation.
b. Decrease in social contacts.
c. Loss of autonomy.
d. All the above.

137. A suicide in a nursing home or long-term facility is more likely to occur when an older adult

a. Has had a significant interpersonal loss, such as the death of a loved one.
b. Has recently surrendered a lethal weapon.
c. Is recently married.
d. Has a close relationship with an adult child.

138. Which dementia patient has the highest risk of dying from suicide?

a. An adult with early-onset dementia who recently received their diagnosis.
b. An older adult who lives in a nursing home.
c. An adult who has dementia and a co-morbid medical condition.
d. There is no data on which adults with dementia have a higher risk of dying from suicide

ADOLESCENTS

139. Which of the following is (are) TRUE from the 2023 Youth Behavioral Survey?[20]

a. Approximately 21% of high school youth thought of suicide in the last year.
b. Approximately 9.5% of high school youth attempted suicide in the last year.
c. Approximately 28.5% of high school youth reported poor mental health.
d. All the above.

140. According to Czyz et al. (2016), youth who predicted that they would eventually die of suicide were more likely to attempt suicide in the future.

TRUE FALSE

141. When talking to parents about the suicidal risks to their children, Jobes (2023)

a. Focuses on assuring the parents that their children will be safe.
b. Recommends sugarcoating the issue to reduce parental distress.
c. Candidly speaks to parents about the very real risk that their child may die from suicide.
d. Points out to parents that children rarely die from suicide.

142. When assessing suicide risk, psychotherapists should consider whether the adolescent has

a. Parents who are nonempathic.
b. Been the victim of physical violence.
c. Been exposed to bullying in school.
d. All the above.

[20] Again, we are less concerned about exact percentages and more that students understand the general trends.

143. Examples of adverse events in childhood linked to an increased risk of suicide include

a. Parental psychopathology.
b. Child abuse or neglect.
c. Loss of a parent to death or divorce.
d. All the above.

144. Those who engage in *non-suicidal self-injury* (NSSI) may be more likely to go on to have suicidal thoughts or attempts, especially if they[21]

a. Engage in the NSSI more frequently.
b. Have a more extended history of NSSI.
c. Use multiple methods of self-harm.
d. All the above.

145. Which is TRUE about non-suicidal self-injury?

a. Most people who engage in NSSI do not go on to attempt suicide.
b. Patients often engage in NSSI to manage unpleasant emotions.
c. Those who engage in NSSI do not expect it to result in their deaths.
d. All the above.

SUICIDE AND DIVERSE POPULATIONS

146. According to Chu's *cultural theory of suicide*, psychotherapists can enhance their evaluations of suicide among racial and ethnic minority patients by considering

a. *Cultural messages about suicide.*
b. *Culture-unique life events.*
c. *Cultural idioms of distress.*
d. All the above.

147. A patient who belonged to a religious group with a strong prohibition against suicide denied suicidal ideation yet wished that "The Lord would take me away." This statement reflects a

a. Cultural message about suicide.
b. Culture-unique life event.
c. Cultural idiom of distress.
d. All the above.

148. A Black patient with suicidal ideation got worse following an incident where he received rough treatment from a police officer during a routine traffic stop. This is an example of a

a. Cultural message about suicide.
b. Culture-unique life event.
c. Cultural idiom of distress.
d. All the above.

149. A patient recently reported that she was seeing images of her deceased loved ones coming to visit her at night. If this is a normative experience in her culture, then it would be considered a

a. Cultural message about suicide.
b. Culture-unique life event.
c. Cultural idiom of distress.
d. All the above.

[21] Issues concerning non-suicidal self-injury and suicide are likely to occur frequently among adults as well.

150. Persons who identify as gay, lesbian, or bisexual have an elevated risk of suicide.

TRUE FALSE

151. The risk of suicide among those who identify as gay, lesbian, or bisexual is reduced if they have strong social or family support.

TRUE FALSE

152. *Intersectionality* refers to the cumulative impact of multiple identities, such as race, gender, age, or socioeconomic status.

TRUE FALSE

153. *Minority stress theory* holds that

a. Dealing with minorities can be stressful for persons from the majority culture.
b. Stressors associated with being a member of a minority, such as discrimination or harassment, can cause stress and impair one's health.
c. A minority of Americans experience high levels of stress.
d. A majority of the stress that Americans feel comes from a minority of causes.

TREATMENTS

The two goals of psychotherapy with suicidal patients are to keep them alive and to help them construct lives worth living. Good interventions with suicidal patients are based on what is known about good interventions in general, with added features to address the unique challenges found with suicidal patients. Psychotherapists should refer patients for medications when it is clinically indicated. However, they should not overvalue the role of medications in reducing suicide attempts in the short term.

Interventions with suicidal patients have historically emphasized controlling patients, sometimes through shaming or threatening them. Research shows, however, that the most effective treatments focus on developing culturally sensitive, personalized treatments that mobilize the patient's inner motivations for health.

INFORMATION ON EFFECTIVE PSYCHOTHERAPY IN GENERAL

Good psychotherapy with suicidal patients shares many features with good psychotherapy in general.

154. Psychotherapists' effectiveness appears UNRELATED to their ____.

a. Age. b. Gender. c. Years of experience. d. All the above.

155. According to Wampold et al. (2017), the effectiveness of psychotherapy appears to improve when psychotherapists

a. Form good relationships with patients.
b. Monitor outcomes.
c. Show healthy self-doubt (humility).
d. All the above.

156. According to Kraus et al (2011), some psychotherapists who had good outcomes with many conditions had poor outcomes with suicidal patients.

TRUE FALSE

157. Patients tend to get better outcomes when psychotherapists accommodate reasonable patient preferences.

TRUE FALSE

158. According to the American Psychological Association, evidence-based practice involves

a. Evidence on the effectiveness of treatment.
b. Clinical judgment.
c. Accommodating patient needs and reasonable patient preferences.
d. All the above.

159. Routinely gathering information about how well patients progress in treatment tends to improve treatment outcomes.[22]

TRUE FALSE

160. *Mindfulness* could be defined as

a. A non-judgmental attention to one's immediate experience.
b. Practicing a skill over and over until you get it right.
c. Focusing one's own concerns, e.g., "minding one's own business."
d. Focusing on the role of the mind, as opposed to the role of the body, in promoting self-actualization.

161. Psychotherapists who collaborate with their patients

a. Work together to identify treatment goals.
b. Listen carefully to the concerns raised by patients.
c. Make reasonable accommodations to the patient's wishes on how to conduct psychotherapy
d. All the above.

[22] The data on routine outpatient monitoring with standardized instruments shows a trend toward modest improvement in outcomes (De Jong et al., 2021). However, the question is worded to allow for the monitoring to include other modalities, such as structured questions at the end of the session or feedback from family members.

162. According to the APA Ethics Code, informed consent must include

a. The opportunity for patients to ask questions.
b. Information on the use of information (limits of confidentiality)
c. The nature and expected course of psychotherapy.
d. All the above.

163. Informed consent procedures with suicidal patients ideally include

a. What the psychotherapist expects of patients in treatment.
b. An expectation that the patient will cooperate with treatment.
c. Transparency about risks.
d. All the above.

164. Which of the following is NOT true about informed consent?

a. Patients should have the chance to ask questions.
b. Informed consent should be revisited throughout treatment as needed.
c. Informed consent is a one-time event that only occurs before treatment begins.
d. Informed consent is designed to respect patients' right to make decisions.

165. Psychologists can show *respect for patient autonomy* in psychotherapy by

a. Listening carefully to their concerns.
b. Asking for feedback.
c. Collaborating with them in treatment.
d. All the above.

166. Psychotherapists with poor mental health, as measured by burnout scales, tend to get poorer outcomes than those with good mental health.

TRUE FALSE

INTERVENTIONS WITH SUICIDAL PATIENTS

One very important treatment goal is to help reduce suicides, although it is also important to help patients create lives worth living. Therefore, suicidal ideation, even in the absence of an immediate threat to the life of a patient, is a legitimate goal of treatment because it reflects much emotional pain and suffering (Jobes & Joiner, 2019).

Some scholars are pessimistic about the ability of interventions to reduce the risk of suicide (e.g., Fox et al., 2020), although Kleiman et al. (2022) believe that they may be overly pessimistic. I favor Kleiman et al.'s perspective. There is much about suicide prevention that we do not know, and some highly competent psychotherapists delivering good quality care will still have patients die from suicide. Nonetheless, these same psychotherapists will save many lives and help patients create lives worth living.

Extensively researched effective interventions include Acceptance and Commitment Therapy, Cognitive-Behavior Therapy, Collaborative Assessment and Management of Suicide, and Dialectical Behavior Therapy. Evidence is also strong for mentalization therapy, attachment therapy, social problem-solving therapy, and assisted suicide planning therapy. Safety-type planning interventions and lethal means counseling also appear to reduce the risk of a suicide attempt. However, several other treatments have at least one study attesting to their effectiveness with suicidal patients. My opinion is that students should be aware of the strong outcomes data for the three big interventions, but this does not mean they cannot use the other interventions effectively. I would rather have a practitioner implement an intervention with modest evidence well than implement an intervention with stronger evidence poorly.

Our understanding of what helps suicidal patients has improved in recent years because of a series of studies looking at patients' reactions to or opinions about the treatment that they have received (e.g., Hom et al., 2020).

167. Studies of mental health professionals show that a substantial minority still engage in clinically contraindicated or ineffective strategies when working with suicidal patients.

TRUE FALSE

168. A policy of refusing to treat any suicide patient may, paradoxically, increase suicidal risk because many patients without suicidal thoughts are reluctant to reveal them; thus, psychotherapists will be treating suicidal patients, but they just do not know about it.

TRUE FALSE

169. According to Jobes (2023), the realistic aspirations of the treating psychotherapist is to

a. Prevent a suicide.
b. Provide the best possible clinical care.
c. Ensure the patient is happy.
d. All the above.

170. Three common ways to deal with suicide are psychiatric hospitalizations, medications, and no suicide contracts. However, evidence shows that[23]

a. Patients recently discharged from psychiatric hospitals have high rates of suicide attempts.
b. No-suicide contracts do not prevent suicides.
c. Except for bipolar disorder and perhaps schizophrenia, the evidence for the effectiveness.
of medications by themselves in reducing suicide attempts in the short term is weak.
d. All the above.

171. Some of the activities promoted by the *Zero-Suicide Initiative include*

a. Screening patients for suicidal thoughts and referring them to appropriate services if needed.

[23] Readers may note the qualification to the option 3 in the medications concerning the impact of medications by themselves. Of course medications may be one component of an overall effective plan.

b. Getting medications for all suicidal patients.
c. Prioritizing hospital-based treatments for suicidal patients.
d. Widely sharing confidential information about suicidal patients without asking permission.

172. One example of social support that could help racial or ethnic minority patients with suicidal thoughts is to participate in activities that support ethnic pride.

TRUE FALSE

173. In the context of treating suicidal patients, *validation* means that the psychotherapist

a. Strives to understand the circumstances and experiences leading patients to consider suicide.
b. Agrees with the patient's decision to kill themselves.
c. Argues with their patient's decision to kill themselves
d. All the above.

174. Cognitively based suicide interventions may include

a. Looking at cognitive distortions that feed suicidal desires.
b. Creating a strong therapeutic alliance.
c. Respecting and promoting patient autonomy.
d. All the above.

175. Trauma-informed care is relevant to the treatment of suicidal patients because

a. Many suicidal patients have experienced traumas.
b. Surviving a suicide attempt may be traumatic.
c. Some interventions, such as those involving forced treatment, may be traumatic.
d. All the above.

176. Some of the elements of trauma-informed treatment include

a. Creating an environment of physical and emotional safety.
b. Empowering patients and ensuring they have choices.
c. Being transparent and trustworthy in communicating with patients.
d. All the above.

177. Effective treatments for suicidal patients commonly

a. Connect them to a faith community, whether they want to be connected or not.
b. Empower them by teaching skills they can apply in their lives.
c. Help them to overcome their underdeveloped reaction formations.
d. All the above.

178. Effective treatments for suicidal patients commonly

a. Teach patients valuable skills to reduce their suicidal thoughts.
b. Encourage patients to adhere to treatment protocols.
c. Help patients to identify emerging crises and take steps to resolve them.
d. All the above.

179. The treatments that have been empirically validated to reduce suicidal behavior include

a. Dream reduction therapy.
b. The Collaborative Assessment and Management of Suicide.
c. Z-therapy.
d. All the above.

180. Dialectical behavior therapy has been especially effective in reducing the risk of suicide in patients who have

a. Childhood autism.
b. Borderline personality disorder.
c. Late-onset dementia
d. All the above

181. Treatments for insomnia could include

a. Cognitive behavior therapy for insomnia (CBT-I).
b. Anti-depressants.
c. Imaginal Rehearsal Therapy for nightmares.
d. All the above.

182. The frontline treatment(s) for nightmares is (are)

a. Formally induced mentalization therapy.
b. Imaginal rehearsal therapy, especially if enhanced by CBT.
c. Dream Reduction Therapy (DRT).
d. All the above.

183. When it comes to issues of trauma or past abuse, it is advised that psychotherapists[24]

a. Delve into those issues as early as the first session.
b. Help patients to recreate the original emotions associated with the trauma.
c. Deal with trauma-related issues later in treatment when patients feel more stable.
d. None of the above.

184. Psychologists can help patients develop better social support by

a. Teaching them social skills.
b. Addressing maladaptive thoughts about social relationships.
c. Creating opportunities for them to socialize with others.

[24] To my knowledge this is clinical lore that makes intuitive sense, although I know no data on it.

d. All the above.

185. One goal of cognitive behavior therapy may be to help patients overcome *cognitive rigidity*, which is

a. A failure to consider every conceivable possible options when faced with a problem.
b. A tendency to fixate on only one possible solution to a problem.
c. A tendency to feel uncontrolled emotional arousal when a solution to a problem cannot be found easily.
d. All of these could be facets or dimensions of cognitive rigidity.

186. It can be beneficial to involve family members or close friends in psychotherapy to

a. Help monitor patients.
b. Provide background information.
c. Assist patients with the day-to-day management of their feelings.
d. All the above.

187. When it comes to involving family members or close friends in psychotherapy, psychotherapists should

a. Always accept the patient's decisions about involving significant others without question.
b. Make their own decisions about involving a family member regardless of the patient's wishes.
c. Rely heavily on the patient's decisions and only override them in extreme circumstances, such as when the risk of a suicide attempt is imminent, and there are no other ways to prevent it.
d. Accept the patient's decisions about involving friends, but not about involving family members.

188. Group psychotherapy with suicidal patients

a. Often leads to suicide contagion (an increased risk of suicide for participants).
b. Appears to be effective in reducing suicide-related behaviors.
c. Has been studied extensively.
d. All the above

189. Which of the following is TRUE about peer support groups for suicidal persons?

a. They can vary considerably in size, leadership composition, and location.
b. Evidence suggests that peer support groups can be helpful for persons with mental illnesses.
c. The data on the effectiveness of peer support groups for suicidal persons is very limited.
d. All the above

LIVED EXPERIENCE

190. When asked about how their treatment experiences could be improved, suicidal persons with lived experiences most frequently commented on the importance of

a. Getting into a hospital right away.
b. Having caring and compassionate providers.
c. Getting the right dose of medication.
d. Having ECT.

191. Persons with lived experience in treatment for suicide found the following elements of their treatment to be important.

a. A good informed consent process
b. Providers who would listen to them.
c. Concrete skills and activities, such as developing a safety plan.
d. All the above.

192. Some patients who attempted suicide claimed that their attempt was influenced by a sense of being devalued by their health care professionals.

TRUE FALSE

MEDICATIONS

193. Empirical evidence shows that medication for the treatment of Major Depressive Disorder does NOT usually reduce the risk of suicide immediately after the medication is started.

TRUE FALSE

194. Evidence suggests that lithium may reduce suicidal acts in patients with manic-depressive (bipolar) disorder.

TRUE FALSE

195. Evidence suggests that anti-psychotics, such as Clozaril, may reduce suicide risk for some patients.

TRUE FALSE

196. Nonadherence to medication recommendations is a major cause of treatment failure for medications.

TRUE FALSE

197. Adherence can be influenced by

a. Lack of belief in the efficacy of the treatment.
b. Lack of understanding of how or why to take the medication.
c. Practical issues, such as a lack of money to purchase medications.
d. All the above.

198. Psychologists can reduce non-adherence to treatment by

a. Clearly explaining the reasons for the intervention.
b. Eliciting questions or concerns that patients may have.
c. Involving patients in important decisions, as much as feasible.
d. All the above.

199. Adherence to medications is higher if

a. Patients understand why the drug was prescribed
b. The patient is given reminders such as a digital alarm
c. Listen carefully to the patient's concerns and questions and address them respectfully.
d. All the above.

200. According to Hom et al. about ____ of patients reported problems or complications with the medication prescribed

a. LT 1%
b. 44%
c. 5%
d. 95%

201. Some studies suggest that ketamine may be effective in reducing suicidal ideation in persons with treatment-resistant depression; however, current research has yet to adequately address

a. The impact of ketamine on suicidal behaviors as well as suicidal ideation.
b. Whether it can be effective as a solo treatment or only as an adjunctive treatment.
c. Long-term side effects
d. All the above.

HOSPITALS

202. Some of the harmful effects of a psychiatric hospitalization are

a. Even brief hospitalizations can disrupt the lives of patients in terms of work, childcare, etc.
b, Patients may be exposed to frightening behavior from other patients.
c. It is expensive.
d. All the above.

203. Which of the following are TRUE about psychiatric hospitalizations for the treatment of suicide

a. Appeared especially helpful for patients who have never attempted suicide.
b. The treatment outcomes for suicidal patients are mixed.
c. Hospitalizations always reduce the risk of suicide for patients.
d. All the above.

204. Which is TRUE about the risk of suicide following a psychiatric hospitalization?

a. The first week and the first month are times of elevated risk for a suicide attempt.
b. Suicide rates are extraordinarily low following discharge from a psychiatric hospital.
c. Suicide rates are low in the first month following a discharge, but higher one year later.
d. Suicide rates are low in the first week following discharge and then gradually increase over the next year.

205. Hom et al. (2020) found that ___ of those with lived experience as a suicidal patient in a psychiatric hospital found it to be helpful and ____ found it to be negative.

a.	40%	27%	c. 90%	10%
b.	27%	40%	d. 10%	90%

TREATMENT (EMOTIONS)

206. *Affect regulation* can be defined as

a. A positive feeling that arises when one regulates their feelings
b. A deep affection for regulatory activities.
c. The process by which individuals influence their emotions
d. All the above

207. Activities that can help promote affect regulation include

a.	Mindfulness training.	c. Relaxation exercises
b.	Sleep hygiene.	d. All the above

208. *Emotional dysregulation* refers to

a. The inability to regulate one's emotional or affective states.
b. A set of beliefs and strategies regarding emotions.
c. The ability to understand the emotions of others.
d. Thoughts, feelings, and behaviors.

209. Judgmental attitudes toward one's emotions can increase dysphoria

TRUE FALSE

210. *Emotional schema* refers to

a. The inability to regulate one's emotional or affective states.
b. A set of beliefs and strategies regarding emotions.
c. The ability to understand the emotions of others.
d. Thoughts, feelings, and behaviors.

211.___Emotions, behaviors, or thoughts that make it seem that suicide is the only option — a. *agitation*

212.___The extent to which an individual fears anxiety — b. *aggression*

213.___An intense desire to escape a very unpleasant situation — c. *irritability*

214.___Cognitive and motor hyperactivity characterized by inappropriate behavior — d. *entrapment*

215.___The intent to harm someone who does not wish to be harmed — e. *anxiety sensitivity*

216.___The tendency toward negative emotions such as anger — f. *negative urgency*

217. ____ is likely to prompt an individual to repair or make amends for their past mistakes whereas ____ is likely to prompt an individual to withdraw

a. Anger, irritability.
b. Guilt, shame.
c. Irritability, anger.
d. Shame, guilt.

Match the Researchers and Their Theories

218. ___Thomas Joiner. — a. Suicide crisis state

219. ___David Klonsky. — b. Cultural model of suicide

220. ___Rory O'Connor. — c. Integrated motivational volitional model

221. ___Joyce Chu. — d. Three-step model of suicide

222. ___Igor Galynker. — e. Interpersonal/psychological theory of suicide

Match the researchers and their interventions.

223. ___David Jobes. — a. Safety plan-type interventions

224. ___Marsha Linehan. — b. Cognitive therapy for suicide

225. ___David Rudd and Craig Bryan.

226. ___Barbara Stanley & Greg Brown.

c. Dialectical behavior therapy

d. Collaborative assessment and management of suicide

TREATMENT INNOVATIONS

Research is continuing into ways to assess and prevent suicides. Participants may have heard of some of the interventions below. Although promising, none of them has reached the point where they can be used routinely in clinical care.

227. Just-in-time-adaptive interventions would monitor a patient for signs of suicidal distress (such as through a digital device or a smartphone) and offer interventions or options when such suicidal distress arises. Evidence for just-in-time adaptive interventions

a. Is so robust that it is now considered the standard of care.
b. Is sufficiently robust that it is considered a feasible option for suicidal patients.
c. Has yet to be gathered or confirmed sufficiently to recommend it for routine practice.
d. Shows it is a failure and should never be used under any circumstances.

228. The questions about AI when used to predict a suicide concern

a. The group upon which the data was normed.
b. It assumes the information it received was accurate.
c. Aggregate or average data need to account for individual variability
d. All the above

229. The goal of precision medicine is to

a. Understand which patient factors influence treatment outcomes and modify the treatment accordingly.
b. Tell practitioners precisely what to do in all cases.
c. Completely eliminate any possibility of a suicide attempt.
d. All the above.

230. Implicit tests of suicidality could include

a. Analysis of vocal characteristics.
b. Implicit associations tests.
c. Analysis of verbal patterns.
d. All the above.

231. Ecological momentary assessment has been used to study suicidal ideation. In ecological momentary assessment, researchers study

a. The impact of the ecological movement on public health.
b. How a person’s ecology changes from moment to moment as a result of being assessed.

c. Experiences based on sampling in the real world.
d. All the above.

232. Studies with digital (e.g., web or mobile app, online learning modules) interventions for suicide showed that digital interventions

a. Patients always had lower suicidal ideation compared to wait-list controls.
b. Patients always had more suicide ideation compared to patients in usual treatment.
c. Modalities varied considerably in their effectiveness.
d. Digital-based interventions did not work well with adolescents.

LEGAL LIABILITY AND RISK MANAGEMENT

Risk Management strategies are designed to minimize the likelihood of treatment failures and to reduce the legal risks to psychotherapists. Older risk management ideas focused on defensive and legalistic practices that created distance between psychotherapists and their patients. The newer model of risk management focuses on patient well-being. According to therapeutic risk management (Simon, 2011) and individualized risk management models (Knapp, 2013), good risk management strategies focus on overarching ethical principles and improving patient well-being. Psychotherapists who want to avoid disciplinary complaints will focus on doing what is best for their patients.

233. The goal of therapeutic risk management, compared to traditional risk management, could be conceived as shifting the focus away from psychotherapist self-protection and onto promoting patient well-being.

TRUE FALSE

234. A psychotherapist was worried that one of her patients was not progressing adequately. Which step(s) could she take to help improve the likelihood of a positive outcome for this patient?[25]

a. Consult with another professional.
b. Ask the patient for feedback on how psychotherapy works for them and what, if anything, should be changed.
c. Gather data on patient progress.
d. All the above

235. When documenting services, psychotherapists should ensure that they

a. Explain what they mean by the words “suicide gesture” if they use that term.
b. Document conversations about suicidal thoughts.
c. Be transparent in their documentation, including why they did or did not make certain choices
d. All the above.

[25] Based on the Harris-Younggren risk management strategies (or quality enhancement strategies; Knapp et al.,2013).

236. The best risk management strategy is to provide and document good treatment.

TRUE FALSE

237. A false risk management principle is one that

a. Reduces the risk of false malpractice claims.
b. Protects psychotherapists from false claims.
c. Does not promote patient wellbeing or uphold an ethical principle.
d. None of the above.

238. Malpractice can occur if psychotherapists

a. Deviated from accepted standards of care.
b. Failed to prevent a suicide.
c. Failed to do everything even remotely possible to prevent a suicide attempt.
d. Did not get the patient to sign a no-suicide contract.

239. The standard of care refers to

a. The best treatment possible.
b. The highest level of care that anyone could expect.
c. What a reasonable professional would have done under similar circumstances.
d. all the above

240. Courts determine the standard of care by relying on the testimony of experts whose opinion is informed by

a. Their personal opinion alone, regardless of what the research says.
b. Only testimony of suicide survivors.
c. Learned texts and peer-reviewed empirical studies.
d. All the above.

241. In Pennsylvania, psychologists may disclose confidential information about a suicidal patient without that patient's consent if it is necessary to prevent a suicide attempt.

TRUE FALSE

242. In Pennsylvania, a patient may be involuntarily hospitalized if they

a. Attempted suicide in the last 30 days.
b. Have taken a step toward the implementation of a suicide attempt, such as purchasing a firearm and threatening to use it to kill themselves.
c. Have a serious mental illness.
d. Have c and either a or b.

SOCIAL DETERMINANTS OF SUICIDE

Although suicides may occur among any individual regardless of their demographics or position in society, suicides are far more common among those who have less access to social goods or who have been marginalized because of religious, racial, or ethnic reasons. As citizens concerned about public health, psychologists should have an interest in improving public well-being by addressing the social determinants of suicide. An awareness of the social determinants of suicide may help psychotherapists become more understanding and compassionate.

243. Social determinants of health refer to the daily living conditions that affect people's health.

TRUE FALSE

244. Deaths of despair are deaths caused by

a. Suicides.
b. Cirrhosis of the liver.
c. Drug overdoses.
d. All the above.

245. *Social death* occurs when a person

a. Lacks a social identity.
b. Does not participate in society in a meaningful way.
c. Lacks social connections.
d. All the above.

246. Society-wide safety nets, such as increasing the minimum wage, can reduce rates of suicide.

TRUE FALSE

247. Suicide rates are highest in American counties with

a. Fewer health care professionals.
b. High rates of poverty.
c. Social Isolation.[26]
d. All the above

248. Democracies tend to have lower rates of suicide than authoritarian governments.

TRUE FALSE

249. The social determinants of suicide include a personal history of

a. Averse childhood events
b. Intimate partner violence
c. Incarceration
d. All the above

[26] The research I found referred to social capital—connectedness involving trust and norms of reciprocity. It overlaps so highly with loneliness that I think loneliness is an acceptable option but I used loneliness instead of social capital because some students might now know what social capital refers to.

250. Unwarranted police stops, based on discriminatory policies, are associated with an increased risk of suicide among targeted groups.

TRUE FALSE

ANSWER SHEET

1.	A	B	C	D			26.	A	B	C	D
2.	TRUE		FALSE				27.	A	B	C	D
3.	A	B	C	D			28.	A	B	C	D
4.	A	B	C	D			29.	A	B	C	D
5.	A	B	C	D			30.	A	B	C	D
6.	A	B	C	D			31.	A	B	C	D
7.	A	B	C	D			32.	A	B	C	D
8.	A	B	C	D			33.	A	B	C	D
9.	A	B	C	D	E	F	34.	A	B	C	D
10.	A	B	C	D	E	F	35.	A	B	C	D
11.	A	B	C	D			36.	A	B	C	D
12.	A	B	C	D			37.	A	B	C	D
13.	A	B	C	D			38.	A	B	C	D
14.	A	B	C	D			39.	A	B	C	D
15.	A	B	C	D			40.	TRUE		FALSE	
16.	TRUE		FALSE				41.	A	B	C	D
17.	A	B	C	D			42.	TRUE		FALSE	
18.	A	B	C	D			43.	A	B	C	D
19.	A	B	C	D			44.	A	B	C	D
20.	TRUE		FALSE				45.	A	B	C	D
21.	A	B	C	D			46.	A	B	C	D
22.	TRUE		FALSE				47.	A	B	C	D
23.	A	B	C	D			48.	TRUE		FALSE	
24.	A	B	C	D			49.	A	B	C	D
25.	A	B	C	D			50.	A	B	C	D

51. A B C D
52. A B C D
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54. A B C D
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73. TRUE FALSE74. TRUE FALSE
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103. A B C D
104. A B C D
105. A B C D
106. A B C D
107. A B C D
108. A B C
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118. A B C D
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120. A B C D
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122. A B C D
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124 A B C D
125. A B C D
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128. A B C D
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167. TRUE FALSE
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170. A B C D
171. A B C D
172. TRUE FALSE
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181 A B C D
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186. A B C D
187 A B C D
188. A B C D
189. A B C D
190. A B C D
191. A B C D
192. TRUE FALSE
193. TRUE FALSE
194. TRUE FALSE
195. TRUE FALSE
196. TRUE FALSE
197. A B C D
198. A B C D
199. A B C D
200. A B C D
201. A B C D
202. A B C D
203. A B C D
204. A B C D
205. A B C D
206. A B C D
207. A B C D
208. A B C D
209. TRUE FALSE
210. A B C D
211. A B C D E F
212. A B C D E F
213. A B C D E F
214. A B C D E F
215. A B C D E F
216. A B C D E F
217. A B C D
218. A B C D
219. A B C D E
220. A B C D E
221. A B C D E
222. A B C D E
223. A B C D
224. A B C D
225. A B C D
226. A B C D
227. A B C D
228. A B C D
229. A B C D
230. A B C D
231. A B C D
232. A B C D
233. TRUE FALSE
234. A B C D
235. A B C D
236. TRUE FALSE
237. A B C D
238. A B C D
239. A B C D
240. A B C D
241. TRUE FALSE
242. A B C D
243. TRUE FALSE
244. A B C D
245. A B C D
246. TRUE FALSE
247. A B C D
248. TRUE FALSE

249. A B C D 250. TRUE FALSE

TOP 12 QUESTIONS

The author believes these are some of the most important concepts to learn (as reflected in the questions).

24. Jobes on the obligations of psychotherapists

28. Concerned alertness is the optimal attitude to have toward suicidal patients

39. Multiple pathways to suicide

43. The narrative model of assessment is an effective way to interview suicidal patients

54. Multiple factors to consider in determining the risk of suicide.

125. The efficacy of safety plans

146. Chu’s cultural model of suicide

158. APA definition of evidence-based practice

165. Showing respect for patient autonomy is an essential part of effective treatments

166. The importance of psychotherapists' self-care in patient outcomes

230. Quality enhancement procedures include consultation and seeking patient input

236. The best risk management strategy is to promote patient well-being.

TOP QUOTATIONS FROM NOTED SUICIDOGISTS

In my readings, I have come across comments that strike me as especially succinct and helpful in understanding the psychotherapist's role with suicidal patients. Teachers can use these quotations to highlight specific points, integrate them within the presentation of the core competencies, or use them as a basis for discussion.

The Nature of Suicide

Suicide is a very difficult problem, and suicidal patients may represent the saddest, most damaged, and most desperate people a psychologist would ever encounter. Galynker's quotation highlights the importance of alienation and loss of social connection.

Suicides are an example of a "wicked problem," meaning they "have a high level of complexity, making them especially tricky to solve" (Bryan, 2021, p. 6)

"Suicide may be conceptualized as the ultimate phase of alienation from the world when all connections to everything a person loves in it—people, achievements, aspirations, or possessions—become irrevocably lost in one final action (Galynker, 2017, p. 96).

The Role of the Psychotherapist

Those working with suicidal patients will have the pleasure and pride of saving lives, but many will experience the tragedy of losing a patient to suicide. We need to retain our humility: we can only do the best we can, and we cannot save all lives. This attitude is realistic and protects psychotherapists from the harm caused by unwarranted "altruistic perfectionism" (e.g., I alone am responsible for saving the life of this patient).

"There are two types of psychiatrists—those who have had patients die from suicide and those who will" (Simon, 2011, p. 177).

"While we cannot guarantee a nonfatal outcome, we can nevertheless provide the *best possible clinical care* to every patient, including those with suicidal thoughts" (Jobes, 2023, p. 60, italics in original).

Working With (Not On or Against) Patients

Effective psychotherapists motivate patients by understanding their needs, preferences, and goals. Externally imposed interventions, such as unwanted hospitalizations, should be reserved for the

rarest of circumstances and only when other less intrusive interventions have failed and the threat to a patient's life is imminent. The quotes below show how psychotherapists can promote patient self-efficacy and help them buy into treatment.

"I would rather not debate with you whether you can kill yourself. Instead, I would propose that we consider a proven treatment that is designed to decrease your suffering and help save your life. The clinical treatment research shows that most people who are suicidal respond quickly to this treatment. . . So why not give it a try (Jobes, 2023, p. 7).

"We cannot stop people from taking their lives through coercion, intimidation, or even involuntary commitment (Jobes, 2023, p. 8).

"In the narrative assessment, the clinician invites the patient to "tell the story" of his or her suicidal crisis in the patient's own words" (Bryan & Rudd, 2018, p. 63).

"Listen, explain, involve, ask" (Knapp, 2022- the original was listen, explain, involve, evaluate)

"A safety plan is someone else's plan, it is not your plan" (O'Connor, 2021, p. 198).

Self-Awareness for Psychotherapists

Psychotherapists should strive for excellence, but such striving is most effective when grounded in self-compassion**.**

"The more you judge, the worse you feel" (Baccacia et al., 2019, p. 33).

"Love yourself as a person, doubt yourself as a therapist" (Nissen-Lie et al., 2015, p. 48).

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Bryan, C. J. (2021). *Rethinking suicide*.

SUICIDAL THOUGHTS, BEHAVIORS, AND FEELINGS

Question 95

Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention*. Guilford.

Questions 96 and 97

Paashaus, L., Forkmann, T., Glaesmer, H., Juckel, G., Rath, D., Schönfelder, A., & Teismann, T. (2021). From decision to action: Suicide history and time between decision to die and actual suicide attempt. *Clinical Psychology and Psychotherapy, 28*(6), 11427–1434. http://doi.org/10.100s/cpp.2580

Question 98

Chu, C., Klein, K. M., Buchman-Schmitt, J. M., Hom, M. A., Hagan, C. R., & Joiner, T. E. (2015). Routinized assessment of suicide risk in clinical practice: An empirically informed update. *Journal of Clinical Psychology, 71*(12), 1186–1200. http://doi.org/10.1002/jclp.22210

Questions 99 and 100

Joiner, T. E., Steer, R. A., Brown, G., Beck, A. T., Petit, J. W., & Rudd, M. D. (2003). Worst-point suicidal plan: A dimension of suicidality predictive of past suicide attempts and eventual death by suicide. *Behaviour Rsearch and Therapy, 41*(12), 1469–1480. http://doi.org/10.1016/s0005-7967(03)0070-6

Moscardini, E. H., Aboussouan, A. B., Bryan, C. J., & Tucker, R. P. (2020). Suicide-specific cognitions, attentional fixation, and worst-point suicidal ideation. *Suicide and Life-Threatening Behavior, 50*(4), 899–908. http://doi.org/10.1111/sltb.12628

Questions 101 and 102

Tucker, R. P., Crowley, K. J., Davidson, C. L., & Gutierrez, P. M. (2015). Risk factors, warning signs, and drivers of suicide: What are they, how do they differ, and why does it matter? *Suicide and Life-Threatening Behavior, 45*(6), 679–689. http://doi.org/10.1111/sltb.12161

Question 103

Bryan, C. J. & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention*. Guilford.

Questions 104-106

Chu, C., Buchman-Schmitt, J. M., Stanley, I. H., Hom, M. A., Tucker, R. P., Hagan, C. R., Rogers, M. L., Podlogar, M. C., Chiurliza, B., Ringer, F. B., Michaels, M. S., Patros, C. H. G., & Joiner, T. E. (2017). The

interpersonal theory of suicide: A systematic review and meta-analysis of a decade of cross-national research. *Psychological Bulletin, 143*(12), 1313–1345. http://doi.org/10.1037/bul0000123

Questions 107-108

Baca-Garcia, E., Perez-Rodriguez, M. M., Oquendo, M. A., Keyes, M. A., Hasin, D. S., Grant, B. F., & Blanco, C. (2011b). Estimating risk for suicide attempt: Are we asking the right questions? Passive suicidal ideation as a marker for suicidal behavior. *Journal of Affective Disorders, 134*, 327–334. http://doi.org/10.1016/j.jad.2011.06.026

Question 109

Galynker, I. (2017). *The suicide crisis state*. Guilford.

Question 110

O'Connor, R. (2021). *When it is darkest*. Vermillion.

Question 111

Rogers, M. L., & Joiner, T. E. (2018). Life-time acute suicidal affective disturbance symptoms account for the link between suicide-specific rumination and lifetime past suicide attempts. *Journal of Affective Disorders, 235*, 428–433. http://doi.org/10.1016/j.jad.2018.04.023

Question 112

Ribeiro, J. D., Silva, C., & Joiner, T. E. (2014). Overarousal interacts with a sense of fearlessness about death to predict suicide risk in a sample of clinical outpatients. *Psychiatry Research, 218*, 106–112. http://doi.org/10.1016/j.psychres.2014.03.036.

Question 113

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Dhinga, K., Boduszek, D., & O'Connor, R. C. (2015). Differentiating suicide attempters from suicide ideators using the Integrated Motivational Volitional model of suicide behaviour. *Journal of Affective Disorders, 186*, 211–218. https://doi.org/10.1016/j.jad.2015.07.007

Weatherall, K., Cleare, S., Eschle, S., Ferguson, E., O'Connor, D. B., O'Carroll, R. E., & O'Connor, R. C. (2018). From ideation to action: Differentiating those who think about suicide and those who attempt suicide in a national study of young adults. *Journal of Affective Disorders, 241*, 475–483. https://doi.org/10.1016/j.jad.2018.02.074

Question 114

Shamsaei, F., Yaghmaei, S., & Haghighi, M. (2020). Exploring the lived experience of the suicide attempt survivors: A phenomenological approach. *International Journal of Qualitative Studies on Health and Well-being. 15.* https://doi.org/10,1080/17482631.2020.1745478

Søndergaard, R., Buss, N., Berring, L.L., Anderson, C. B., Grundahl, M., Stjernegaard, K., & Hybholt, L. 2022). Living with suicidal thoughts: A scoping review. *Scandinavian Journal of Caring Science, 37*, 60–78. https://doi.org/10.111/scs.13137

MANAGEMENT OF SUICIDAL RISK

Questions 115-118

Many people have made these statements. I am just including one source below:

Knapp, S. (2020). *Suicide prevention: A scientifically and ethically informed approach*. American Psychological Association.

Questions 119 and 120

Rudd, M. D., Mandrusiak, M., & Joiner, T. E. (2006). The case against no-suicide contracts: The commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology, 62*(2), 243–251. http://doi.org/10.1002/jclp.20227

Knapp, S. (2023). The essentials of creating effective safety-plan-type interventions for suicidal patients. *Practice Innovations*, *8*(1), 131–140. http://doi.org/10.1037/pri0000205

Question 121

Lohani, M., Bryan, C. J., Elsey, J. S., Dutton, S., Findley, S. P., Langenecker, S. A.,West, K., & Baker, J. C. (2024). Collaboration matters: A randomized controlled trial of patient-clinician collaboration in suicide risk assessment and intervention. *Journal of Affective Disorders, 360*, 387–393. https://doi.org10.1016/j.jad.2024.06.004

Question 122

Bryan, C. J., & Rudd, M. D. (2018). *Brief Cognitive behavior therapy for suicide prevention*. Guilford.

Question 123

Selby, E. A., Anestis, M. D., & Joiner, T. E. (2008). Understanding the relationship between emotional and behavioral dysregulation: Emotional cascades. *Behaviour Research and Therapy, 4*(5), 593-611. http://doi.org/10.1016/j.brat.2008.02.002

Questions 124

There are several good sources that describe the steps in safety-planning-type interventions. Here is one source.

Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention*. Guilford.

The idea of using multiple senses to distract people or interrupt ruminations is probably found in many sources.

Question 125

Nuij, C., van Ballegooijen, W., de Beurs, D., Juniar, D., Erlangsen, A., Portzky, G., O'Connor, R. C., Smit, J. H., Kerkhof, A., & Riper, H. (2021). Safety planning-type interventions for suicide prevention: meta-analysis. *British Journal of Psychiatry, 219*(2), 419–426. http://doi.org/10.1192/bjp.2021.50

Question 126

Houtsma, C., Butterworth, S. E., & Anestis, M.D. (2018). Firearm suicide: Pathways to risk and methods of prevention. *Current Opinion in Psychology, 22*, 7–11. http://doi.org/10.1016/j.copsyc.2017.07.002

Question 127

Peterson, J., Skeem, J.S., & Manchak, S. (2011). If you want to know, consider asking: How likely is it that patients will hurt themselves in the future? *Psychological Assessment, 23*(2), 626–634. http://doi.org/10.1037/a0022971

Question 128

Anestis, M. D. (2016). Prior suicide attempts are less common in suicide decedents who died by firearms relative to those who died by other means. *Journal of Affective Disorders, 189*, 106-109. http://doi.org/10.1016/j.jad.2015.09.007

Question 129

Hoyt, T., Holliday, R., Simonetti, J. A., & Monteith L. L. (2021). Firearm lethal means safety with military personnel and veterans: Overcoming barriers using a collaborative approach. *Professional Psychology: Research and Practice, 52*(4), 387–395. http://doi.org:10.1037/pro0000372

Questions 130-131

Pallin, R., Siry, B., Azrael, D., Knoepke, C. E., Matlock, D. D., Clement, A., Ranney, M. L., Wintemute, G. J., & Betz, M. E. (2019). "Hey, let me hold your guns for a while": A qualitative study of messaging for firearm suicide prevention. *Behavior Science and the Law, 3*(3), 259–269. http://doi.org:10.1002/bsl.2393

Question 132

See, for example, *Statement of the American Association of Suicidology Regarding the Role of Firearms in Suicide and the Importance of Means Safety Counseling in Preventing Suicide Deaths.* 2018 retrieved from https://suicidology.org/wp-content/uploads/2019/07/FirearmStatementFinal.pdf

There is a history of means restriction efforts, such as reducing access to human toxic pesticides in Sri Lanka, or detoxification of domestic gas in the United Kingdom, which led to very substantial reductions in suicide rates in those countries. Within the United States, means safety efforts focus on gun safety, or access to medication.

Question 133

Carpenter, J. E., Lee, T., Greene, E., & Holovac, E. (2021). A stepwise approach for preventing suicide by lethal poisoning. *Federal Practitioner, 38*(2), 62–67. http://doi.org/10.12788/fp.0087

Question 134

This is a personal opinion, and I may be reacting to some psychotherapists who saw nothing wrong with routinely referring suicidal patients to the emergency room instead of doing a suicidal assessment themselves. I would prefer much more selective criteria for referring to emergency rooms.

SUICIDAL RISK WITH SPECIAL GROUPS

OLDER ADULTS

Question 135

Erlangsen, A., Banks, E., Joshy, G., Calear, A. L., Welsh, J., Batterham, P. J., Conwell, Y., & Salvador-Carulla, L. (2021). Physical, mental, and social wellbeing and their association with death by suicide and self-harm in older adults: A community-based cohort study. *International Journal of Geriatric Psychiatry, 36*(5), 647–656. http://doi.org/10.1002/gps.5463

Question 136

Fässberg, M. M., Cheung, G., Canetto, S. S., Erlangsen, A., Lapierre, S., Lindner, R., Draper, B., Gallo, J. J., Wong, C., Wu, J., Duberstein, P., & Waern, M. (2016). A systematic review of physical illness, functional disability, and suicidal behaviour among older adults. *Aging and Mental Health, 20*(2), 166–194. http://doi.org/10.1080/13607863.2015.1083945

Question 137-138

Reiss, N. S., & Tishler, C. L. (2008). Suicidality in nursing home residents: Part 1. Prevalence, risk factors, methods, assessment, and management. *Professional Psychology: Research and Practice, 39*(3), 264–270. http://doi.org/10.1037/0735-0728.393.264
Question 138

Schmutdrte, Y., Olfson, M., Maust, D. T., Xie, M., & Marcus, S. C. (2022). Suicide risk in the first year after dementia diagnosis in older adults. *Alzheimer's and Dementia, 18*(2), 262–271. http://doi.org/10.1002/alz.12390

ADOLESCENTS

Question 139

Verlenden, J. V., Fodeman, A., Wilkins, N., Jones, S. E., Moore, S., Cornett, K., Sims, V., Saelee, R., & Brener, N. D. (2024). Mental health and suicide risk among high school students and protective factors—Youth Behavior Survey, United States, 2023. *Morbidity and Mortality Weekly, 73*(4), 79–86. https://doi.org/10.15585/mmwr.su7304a9

Question 140

Czyz, E. K., Horwitz, A. G., & King, C. A. (2016). Self-rated expectations of suicidal behavior predict future suicide attempts among adolescent and young adult psychiatric emergency patients. *Depression and Anxiety, 3*(6), 512-519. http://doi.org/10.002/da.22514

Question 141

Jobes, D. (2023). *Managing suicidal risk: A collaborative approach* (3rd ed.). Guilford.

Question 142

Badr, H., E.-S. (2017). Suicidal behaviors among adolescents - The role of school and home environment. *Crisis, 38*(3), 168-176. http://doi.org/10.1027/0227-5910/a000426

Question 143

Björkenstam, C., Kosidou, K., & Björkenstam, E. (2017). Childhood adversity and risk of suicide: Cohort study of 548721 adolescents and young adults in Sweden. *BMJ, 357*. http://doi.org/10.1136/bmj.j1334

Questions 144-145

Kiekens, G., Hasking, P., Boyes, M., Claes, L., Mortier, P., Auerbach, R. P., Cuijpers, P., Demyttenaere, K., Green, J. G., Kessler, R. C., Myin-Germeys, I. M., Nock, M. K., & Bruffaerts, R. (2018). The associations between non-suicidal self-injury and first onset suicidal thoughts and behaviors. *Journal of Affective Disorders, 239*, 171–179. http://doi.org/10.1016/j.jad.2018.06.033

DIVERSE POPULATIONS

Questions 146-149

Chu, J., Maruyama, B., Batchelder, H., Goldblum, P., Bongar, B., & Wickham, R. E. (2020). Cultural pathways for suicidal ideation and behaviors. *Cultural Diversity and Ethnic Minority Psychology, 26*(3), 367–377. http://doi.org/10.1037/cdp0000307

Question 150

Hottes, T. S., Bogaert, L., Rhodes, A. E., Brennan, D. J., & Gesink, D. (2016). Lifetime prevalence of suicide attempts among sexual minority adults by study sampling strategies: A systematic review and meta-analyses. *American Journal of Public Health, 106*(5), e1-e12. http://doi.org/10.2105/AJPH.2016.303088

Question 151

Standley, C. J., & Foster-Fishman, P. (2020). Intersectionality, social support, and youth suicidality: A socioecological approach to prevention. *Suicide and Life-Threatening Behavior, 51*(2), 203-211. http://doi.org/10.1111/sltb.12695

Question 152

Ferlatte, O., Salway, T., Hankivsky, O., Trussler, T., Oliffe, J. L., & Marchand, R. (2018). Recent suicide attempts across multiple social identities among gay and bisexual men: An intersectionality analysis. *Journal of Homosexuality, 65*(11), 1507-1526. http://doi.org/10.1080/00918369.2017.1377489

Question 153

Meyer, I. H. (2020). Rejection sensitivity and minority stress: A challenge for clinicians and interventionists. *Archives of Sexual Behavior, 49*(7), 2287-2289. http://doi.org/10.1007/s10508-019-01597-7

TREATMENTS

INFORMATION ON EFFECTIVE TREATMENTS IN GENERAL

Question 154

Buetler, L. E., Malik, M., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S., & Wong, E. (2004). Therapist variables. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 227–306). Wiley.

Question 155

Wampold, B. E., Baldwin, S. A., Holtforth, M. g., & Imel, Z. E. (2018). What characterizes effective psychotherapists? In L. G. Castonguay & C. E. Hill (Eds.). *How and why are some therapists better than others? Understanding therapist effects* (pp. 37-53). American Psychological Association.

This is an excellent chapter in an excellent book that looks at the commonalities among highly effective psychotherapists.

Question 156

Kraus, D. R., Castonguay, L., Boswell, J. F., Nordberg, S. S., & Hayes, J. A. (2011). Therapist effectiveness: Implications for accountability and patient care. *Psychotherapy Research, 21*(3), 267-276. http://doi.org/10.1080/10503307.2011.563249

Question 157

McAleavey, A. A., Xiao, H., Bernecker, S. L., Brunet, H., Morrison, N. R., Stein, M., Youn, S. J., Castonguay, L. G., Constantino, M. L. & Beutler, L. (2019). An updated list of principles of change that work. In L. G. Castonguay, M. L. Constantino, & L. E. Beutler (Eds.). *Principles of change: How psychotherapists implement research in practice* (pp. 13–37). Oxford University Press.

Question 158

American Psychological Association. (2021). *Professional Practice Guidelines for Evidence-Based Psychological Practice in Health Care.* Retrieved from http://www,apa.org/about/policy/
Evidence-based-psychological-practice-health-care.pdf

Question 159

McAleavey, A. A., Xiao, H., Bernecker, S. L., Brunet, H., Morrison, N. R., Stein, M., Youn, S. J., Castonguay, L. G., Constantino, M. L. & Beutler, L. (2019). An updated list of principles of change that work. In L. Castonguay, M. L. Constantino, & L. E. Beutler (Eds.). *Principles of change: How psychotherapists implement research in practice* (pp. 13–37). Oxford University Press.

Question 160

Epstein, R. (1999). Mindful practice. *Journal of the American Medical Association, 282*(9), 833-839. http://doi.org/10.1001/jama.282.9.833

Questions 161

Knapp, S. (2024). Listen, explain, involve, evaluate: How promoting autonomy benefits suicidal patients. *Ethics and Behavior,* 34(1),18–27. http://doi.org/10.1080/10580422.2022.215338

Questions 162-164

Knapp, S., & Fingerhut, R. (2024). *Practical ethics: A positive approach* (4th ed.). American Psychological Association.

Question 165

Knapp, S. (2024). Listen, explain, involve, evaluate: How promoting autonomy benefits suicidal patients. *Ethics and Behavior,* 34(1),18–27. http://doi.org/10.1080/10580422.2022.215338

Question 166

Delgadillo, J., Saxon, D., & Barkham, M. (2018). Associations between therapists' occupational burnout and their patients' depression and anxiety treatment outcomes. *Depression and Anxiety, 35*(9), 844-850. http://doi.org/10.1002/da.22766

PSYCHOTHERAPY WITH SUICIDAL PATIENTS

Question 167

Roush, J. F., Brown, S. L., Jahn, D. R., Mitchell, S. M., Taylor, N. J., Quinnett, P., & Ries, R. (2017). Mental health professionals' suicide risk assessment and management practices. *Crisis, 39*(1), 55–64. https://doi.org/10.1027/0227-5910/a000478

Rozek, D. C., Tyler, H., Fina, B. A., Baker, S. N., Moring, J. C., Smith, N. B., Baker, J. C., Bryan, A. O., Bryan, C. J., & Dondanville, K. A. (2023). Suicide intervention practices: What is being used by mental health clinicians and mental health allies? *Archives of Suicide Research, 27*(3), 1034–1046. https://doi.org/10.1080/13811118.2022.2106923

Question 168

Knapp, S., Gottlieb, M. C., & Handelsman, M. M. (2024). Rethinking policies of avoiding suicidal patients. *Professional Psychology: Research and Practice, 55*(6), 556–562. https://doi.org/10.1037/pro0000588.

Question 169

Jobes, D. (2023). *Managing suicidal risk: A collaborative approach* (3rd ed.). Guilford.

Question 170

Many people have made these points. Matthew Large and his colleagues have a series of articles on the limitations of psychiatric hospitalizations. Jobes and Rudd have written about the shortcomings of no-suicide contracts, and Maris and others have written about the shortcomings of psychiatric medications in reducing suicide.

Chung, D. T., Ryan C. J., Hadzi-Pavlovic, D., Singh, S. P., Stanton, C., & Large, M. M. (2017). Suicide rates after discharge from psychiatric facilities. *JAMA Psychiatry*, *74*(7), 694–702. http://doi.org/10.1001/jamapsychiatry.2017.1044

Jobes, D. (2023). *Managing suicidal risk: A collaborative approach* (3rd ed.). Guilford.

Maris, W. W. (2019). *Suicide: A comprehensive biopsychosocial perspective.* Guilford.

Ward-Ciesielski, E. F., & Rizvi, S. L. (2021). The potential iatrogenic effects of psychiatric hospitalizations for suicidal behavior: A critical review and recommendations for research. *Clinical psychology: Science and Practice, 28*(1), 60–71. http://doi.org/10.1111/cpsp.12332

Question 171

Brodsky, B. S., Spruch-Feiner, A., & Stanley, B. (2018). The Zero Suicide Model: Applying evidence-based suicide prevention practices to clinical care. *Frontiers in Psychology*. http://doi.org/10.3389/fpsyt.2018,00033

Question 172

Hollingsworth, D. W., & Polanco-Roman, L. (2022). Ethnic identity protects against feelings of defeat and entrapment on suicidal ideation in African American young adults. *Cultural Diversity and Ethnic Minority Psychology, 28*(2), 217–226. http://doi.org/10.1037/cdp0000523

Question 173

Schecher, M., & Goldblatt, M. J. (2011). Psychodynamic therapy and the therapeutic alliance: Validation, empathy, and genuine relatedness. In K. Michel & D. A. Jobes (Eds.). *Building a therapeutic alliance with the suicidal patient* (pp. 93–108). American Psychological Association.

Question 174

Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention*. Guilford.

Questions 175-176

Mirick, R. G., McCauley, J., & Bridger, J. (2023). Integrating trauma-informed principles into suicide prevention, intervention, and postvention. *Practice Innovations, 8*(4), 305–316. https://doi.org/10.1037/pri0000212

Substance Abuse and Mental Health Service Administration. (2014). *Trauma-informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series 57*. HHS Publications No. (SMA) 13-48901. Substance Abuse and Mental Health Services Administration, Rockville, MA.

Questions 177-178

Bryan, C. J., & Rozek, D. C. (2018). Suicide prevention in the military: A mechanistic perspective. *Current Opinions in Psychology, 22,* 27-32. http://doi.org/10.1016/j.copsyc.2017.07.022

Question 179

Calati, R., Courtet, P., & Lopez-Castroman, J. (2018). Refining suicide prevention: A narrative review on advances in psychotherapeutic tools. *General Psychiatry Research, 20*(2). http://doi.org/10.1007/s11920-018-0876-0

Question 180

Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., Neacsiu, A. D., McDavid, J., Comtois, K. A., & Murray-Gregory, A. M. (2015). Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: A randomized clinical trial and component analysis. *Journal of the American Medical Association, 72*(5), 475–482. http://doi.org/10.1001/jamapsychiatry,2014.3039

Questions 181-182

Krakow, B., & Zadra, A. (2010). Imaginal rehearsal therapy: Principles and practice. *Sleep Medicine Clinics, 5*(2), 289–298. http://doi.org/10.1016/j.jsmc.2010.01.004

Porras-Segovia, A., Pérez-Rodríguez, M. M., López-Estaban, P., Courtet, P., Barrigón, M. M. S., López-Castromán, J., Cervilla, J. A., & Baca-García, E. (2020). Contributions of sleep deprivation to suicidal behavior: A systematic review. *Sleep Medicine Review, 44*, 37–47. http://doi.org/10.1016/j.smrv.2018.12.005

Question 183

I have no source for this, or at least none that comes to conscious memory. At this point, I can only identify it as clinical lore.

Question 184

Masi, C. M., Chen, H.-Y., Hawkley, L. C., & Cacioppo, J. T. (2011). A meta-analysis of interventions to reduce loneliness. *Personality and Social Psychology Review, 15*(3), 219–266. http://doi.org/10.1177/1088868310377394

Question 185

Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavior therapy for suicide prevention*. Guilford.

Questions 186-187

Many authors advocate this, including.

Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavior therapy for suicide prevention*. Guilford.

Knapp, S. (2022). Involving concerned others in the treatment of suicidal patients. *Psychotherapy Bulletin, 57*(3), 27–31.

Petrick, M. L., Biullera, M., Kaplan, Y., Matarazzo, B., & Wortzel, H. (2015). Balancing patient care and confidentiality: Considerations in obtaining collateral information. *Journal of Psychiatric Practice, 21*(3), 220-2249988

Question 188

Chalker, S. A., Martinez-Ceren, C. S., Ehret, B. C., & Depp, C. A. (2022). Suicide-focused group therapy. *Crisis, 44*(6). http://doi.org/10.1027/0227-5910.1000892

Question 189

Schlichthorst, M., Ozols, I., Reifels, L., & Morgan, A. (2020). Lived experience peer support programs for suicide prevention: A systematic scoping review. *International Journal of Mental Health Systems*, 14. http://doi.org/10.1186/s13033-020-03396-1

Questions 190-191

Hom, M.A., Bauer, B. W., Stanley, I. H., Buffa, J. W., Stage, D. R. L., Capron, D. W., Schmidt, N. B., & Joiner, T. E. (2021). Suicide attempt survivors' recommendations for improving mental health treatment for attempt survivors. *Psychological Services, 18*(3), 365–376. https://doi.org/10.1037/ser0000415

Schembari, B. C., Jobes, D. A., & Horgan, R. J. (2016). Successful treatment of suicidal risk: What helped and what was internalized? *Crisis, 37*(3), 218–223. https://doi.org/10.1027/0227-5910/a000370

Question 192

Berg, S. H., Rørtveit, K., & Aase, K. (2017). Suicidal patients' experiences regarding their safety during psychiatric in-patient care: A systematic review of qualitative studies. *BMC Health Services Research, 17*. https://doi.org/10.1186/s12913-017-2023-8

Hed, S., Berg, A. I., Wiktorsson, S., Strand, J., Canetto, S. S., & Waern, M. (2024). Older adults make sense of their suicidal behaviors: A Swedish interview study. *Frontiers in Psychiatry, 15*. http://doi.org/10.3389/fpsyt.2024.1450683.

MEDICATIONS

Questions 193 to 196

Maris, W. W. (2019). *Suicide: A comprehensive biopsychosocial perspective. Guilford*.

Question 197-199

Alpert, J. S. (2014). Compliance/Adherence to physician-advised diagnostic and therapeutic strategies. *American Journal of Medicine, 127*(8), 685–686. https://doi.org/10.1016/j,amjmed.2014.03.010

Iuga, A. O., & McGuire, M. J. (2014). Adherence and health care costs. *Risk Management And Healthcare Policy, 7*, 35-44. https://doi.org/10.2147/RMHP.S19801.

Marcum, Z. A., Sevick, M. A., & Handler, S. M. (2013). Medication nonadherence: A diagnosable and treatable medical condition. *Journal of the American Medical Association, 309*(20), 2105–2106. https://doi.org/10.1001/jama.2013.4638.

Question 200

Hom, M., Albury, E. A., Christensen, K., Gomez, M. M., Stanley, I. H., Stage, D. R. L., & Joiner, T. E. (2020). Suicide attempt survivors' experiences with mental health care services: A mixed method study. *Professional Psychology: Research and Practice, 51*(2), 172–183. https://doi.org/10.1037/pro0000265

Question 201

Kang, M. J. Y., Kulcar, E., Chanrdrasena, R., Anjum, M.- R., Fairbairn, J., Hawken, E. R., & Vazquez, G. H. (2021). Subanesthetic ketamine infusions for suicide ideation in patients with bipolar and unipolar treatment refractory depression. *Psychiatry Research, 296.* http://doi.org/10.1016/j.psychres.2020.113645

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Question 203

Ross, E. L., Bossarte, R. M., Dobscha, S. K., Gildea, S. M., Hwang, I., Kennedy, C. J., Liu, H., Luedtke, A., Marx, B. P., Nock, M. K., Petukhova, M. V., Sampson, N. A., Zainai, N. H., Sverdrup, E., Wager, S., & Kessler, R. C. (2024). Estimated average treatment effect of psychiatric hospitalization in patients with suicidal behaviors: A precision treatment analysis. *JAMA Psychiatry, 81*(2), 135–143. https://doi.org/10.1001/jamapsychiatry.2023.3994

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Question 204

Chung, D., Hadzi-Pavlocvic, D., Wang, M., Swaraj. S., Olfson M., & Large, M. (2019). Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalization. *BMJ Open, 9*. https://doi.org/10.1136/bmjopen-2018-0023883

Question 205

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TREATMENT (EMOTIONS)

Question 206-207

Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavior therapy for suicide prevention*. Guilford.

Question 208

Heffer, T., & Willoughby, T. (2018). The role of emotion dysregulation: A longitudinal investigation of the interpersonal theory of suicide. *Psychiatry Research, 260*, 379–383. http://doi.org/10.1016/j.psychres.2017.11.075

Question 209

Barcaccia, B., Baiocco, R., Pozza, A., Pallini, S., Mancini, F., & Salvati, M. (2019). The more you judge the worse you feel. A judgmental attitude toward one's inner experience predicts depression and anxiety. *Personality and Individual Differences, 138,* 33–39. http://doi.org/10.1016/j.paid.2018.09.012

Question 210

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Question 211

Galynker, I. (2018). *The suicidal crisis:* Oxford.

Question 212

Stanley, I. H., Hom, M. A., Spencer-Thomas, S., & Joiner, T. E. (2017). Examining anxiety sensitivity as a mediator of the association between PTSD symptoms and suicide risk among women firefighters. *Journal of Anxiety Disorders, 50,* 94–102. http://doi.org/10.1016/j.janxdis.2017.06.003

Question 213

O'Connor, R. C. (2021). *When it is darkest*. Vermillion.

Question 214

Ribeiro, J. D., Bodell, L. P., Hames, J. L., Hagan, C. R., & Joiner, T. E. (2013). An empirically based approach to the assessment and management of suicidal behavior. *Journal of Psychotherapy Integration, 23*(3), 207-221. http://doi.org/10.1037/a0031416

Question 215

Toohey, M. J., & DiGiuseppe, R. (2017). Defining and measuring irritability: Construct clarification and differentiation. *Clinical Psychology Review, 53*, 93–108. http://doi.org/10.1016/j.cpr.2017.01.009

Although this article is about irritability, it also includes comments on aggression.

Question 216

Toohey, M. J., & DiGiuseppe, R. (2017). Defining and measuring irritability: Construct clarification and differentiation. *Clinical Psychology Review, 53*, 93–108. http://doi.org/10.1016/j.cpr.2017.01.009

Deveney, C., Stoddard, J., Evans, R., Chavez, G., Harney, M., & Wulff, R. A. (2019). On defining irritability and its relationship to affective traits and social interpretations. *Personality and Individual Differences, 144*, 61–67. http://doi.org/10.1016/j.paid.2019.02.031

The medical literature offers many different definitions of irritability depending on the context. The lay definition is used here.

Question 217

Tangney, J. P., Miller, R. S., Flicker, L., & Barlow, D. H. (1996). Are shame, guilt, and embarrassment distinct emotions? *Journal of Personality and Social Psychology, 70*(6),1256-1269. http://doi.org/10.1037/0022-3514.70.6.1256

Questions 218 to 226

Various sources.

Question 226

Bryan, C. J., Wastler, H., Allan, N., Khazem, L. R., & Rudd, M. D. (2022). Just-in-Time Adaptive Interventions (JITAIs) for suicide prevention: Tempering expectations. *Psychiatry, 85*(4), 341–346. https://doi.org/10.1080/00332747.2022.2132775

Question 227

Numerous sources have raised these issues.

Question 229

Kessler, R. C., Bossarte, R. M., Luedtke, A., Zaslavsky, A. M., & Zubizarreta, J. R. (2019). Machine learning methods for developing precision-treatment rules with observational data. *Behaviour Research and Therapy, 120*. https://doi.org/10.1016/j.brat.2019.103412

Question 230

Iyer, R., & Meyer, D. (2022). Detection of suicide risk using vocal characteristics: Systematic review. *JMIR Biomedical Engineering, 7*(2), https://doi.org/10.2196/42386

Moreno, M., Gutiérrez-Rojas, L., & Porras-Segovia, A. (2022). Implicit cognitive tests for the assessment of suicide risk: A systematic review. *Current Psychiatry Reports, 24* (2), 141–159. https://doi.org/10.1007/s11920-022-01316-5

Walker, A., Zirikly, A., Stockbridge, M., & Wilcox, H. C. (2024). A linguistic analysis of Instagram captions between adolescent suicide decedents and living controls. *Crisis, 45*(2), 136–143. https://doi.org/10.1027/0227-5910/a000928

Question 231

Question 232

Burr, S. K., Yu, M., Clark, D., Alonzo, D., Gearing, R. E. (2025). Digital interventions for suicide prevention. *Crisis, 46*(3), 178–186. https://doi.org/10.1027/0227-5910/a000996

RISK MANAGEMENT

Question 232

Espeland, K., Hjelmeland, H., & Knizek, B. L. (2021). A call for change from impersonal risk assessment to a relational approach: Professionals' reflections on the national guidelines for suicide prevention in mental health care in Norway. *International Journal of Qualitative Studies on Health and Well-Being, 16*. https://doi.org/10.1080/17482631.2020.1868737

Knapp, S. (2024). Laws, risk management, and ethical principles when working with suicidal patients. *Professional Psychology: Research and Practice, 55(*1), 1–10. https://doi.org/10.1037/pro0000554

Question 233-240

Knapp, S., Younggren, J., VandeCreek, L., Harris, E., & Martin, J. (2013). *Assessing and managing risk in psychological practice: An individualized approach* (2nd ed.). Rockville, MD: The Trust.

Questions 241-242

Knapp, S., Baturin, R., & Tepper, A. (2020). *Pennsylvania Law and Psychology* (8th ed.). Pennsylvania Psychological Association.

SOCIAL DETERMINANTS OF SUICIDE

Question 243-244

Rehder, K., Lusk, J., & Chen, J. I. (2021). Deaths of despair: Conceptual and clinical implications. *Cognitive and Behavioral Practice, 28*(1), 40–52. http://doi.org/10.1016/j.cbpra.2019.10.002

Question 245

Salhi, B.A., & Osborne, A. D. (2021). Incarceration and social death—Restoring humanity in the clinical encounter. *New England Journal of Medicine, 384*(3), 201–203. http://doi.org/10.1056/NEJMp2023874

Question 246

Gertner, A. K., Rotter, J. S., & Shafer, P. R. (2019). Association between state minimum wages and suicide rates in the U.S. *American Journal of Preventive Medicine, 56*(5), 648–654. http://doi.org/10.1016/j.amepre.2018.12.008.

Suicide attempts are most frequent among those who are unemployed, have less than a high school education, or lack health insurance.

Bommersbach, T. J., Rosenheck, R. A., & Rhee, T. G. (2022). National trends of mental health care among US adults who attempted suicide in the last 12 months. *JAMA Psychiatry*, *79*(3), 219–231. http://doi.org/10.1001/jamapsychiatry.2021.3958

Question 246

Greater socioeconomic deprivation and lower provider density:

Fontenella, C. A., Saman, D. M., Camp, J. V., Hiance-Steelesmith, D. L., Bridge, J. A., Sweeney, H. A., & Root, E. D. (2018). Mapping suicide mortality in Ohio: A spatial epidemiological analysis of suicide clusters and area-level correlates. *Preventive Medicine, 106*, 177-184. http://doi.org/10.1016/j.ypmed.2017.10.033

I am inferring that social isolation is correlated with social capital (connections between people and norms of reciprocity). Suicide rates are higher in counties where social capital is low.

Zhai, M., Kishan, R. P., & Showalter, D. (2022). Social capital and suicidal behaviors: Evidence from United States counties. *Journal of Behavioral and Experimental Economics*. 98. http://doi.org/10.1016/j.soced.2022.101856

Question 247

Holt-Lunstad, J., & Steptoe, A. (2022). Social isolation: an underappreciated determinant of physical health, *Current Opinion in Psychology*, *43*, 232–237. http://doi.org/20.1016/j.copsyc.2021.07.012

Question 248

Overall, the greater the extent to which democracies have policies that benefit the populace, the lower their suicide rates are than those of non-democracies. For example, Russia has far higher suicide rates than Western European democracies. Among democracies, the United States has a higher suicide rate, probably linked to the high rate of firearm ownership.

Question 249

Na, P. J., Shin, J., Kwak, H. R., Lee, J., Jester, D. J., Bandara, P., Kim, J. Y., Moutier, C. Y., Piertzak, R. H., Oquendo, M. A., & Jester, D. V. (2025). Social determinants of health and suicide-related outcomes: A review of meta-analyses. *JAMA Psychiatry, 82*(4), 337–346. https://doi.org/10.1001/jamapsychiatry.2024.4241

Question 250

English, D., Oshin, L. A., Lopez, F. G., Smith, J. C., Busby, D. R., & Anestis, M. D. (2024). Systematic white supremacy: U.S. state policy, policing, discrimination, and suicidality across race and sexual orientation. *Journal of Psychopathology and Clinical Science*, *133*(4), 321332. https://doi.org/10.1037/abn0000891

ANSWERS

1. D
2. TRUE
3. B
4. B
5. D
6. D
7. B
8. A
9. D
10. A
11.B
12. D
13. C
14. B
15. A
16. TRUE
17. A
18. C
19. D
20. TRUE
21. B
22. TRUE
23. C
24. C
25. D
26. D
27. C
28. C
29. C
30. B
31. C
32.C
33. D
34. D
35. A
36. C
37. B
38. C
39. C
40. TRUE
41. C
42. TRUE
43. D
44. C
45. A
46. A
47. B
48. TRUE
49. C
50. D
51. C
52. D
53. C
54. D
55. B
56. A
57. C
58. B
59. B
60. D
61. B
62. C
63. B
64, C
65. B
66. B
67. D
68. D
69. B
70. D
71. D
72. D

73. TRUE
74. D
75. D
76. C
77. TRUE
78. D
79. B
80. B
81. B
82. TRUE
83. A
84. D
85. D
86. D
87. B
88. C
89. C
90. C
91. D
92. D
93. D
94. TRUE
95. B
96. C
97. D
98. C
99. B
100. C
101. B
102. A
103. C
104. B
105. A
106. C
107. A
108. C
109. D
110. A
111. A
112. D
113. D
114. C
115. C
116. C
117. D
118. D
119. B
120. C
121. C
122. D
123. TRUE
124. A
125. B
126. TRUE
127. TRUE
128. B
129. TRUE
130. B
131. D
132. TRUE
133. D
134. A
135. D
136. D
137. A
138. A
139. D
140. TRUE
141. C
142. D
143. D
144. D
145. D
146. D
147. A
148. B
149. C
150. TRUE
151. TRUE
152. TRUE
153. B
154. D
155. D
156. TRUE
157. TRUE
158. D
159. TRUE
160. A
161. D
162. D
163. D
164. C
165. D
166. TRUE
167. TRUE
168. TRUE
169. B
170. D
171. A
172. TRUE
173. A
174. D
175. D
176. D
177. B
178. D
179. B
180. B
181. C
182. B
183. C
184. D
185. D
186. D
187. C
188. B
189. D
190. B
191. D
192. TRUE
193. TRUE
194. TRUE
195. TRUE
196. TRUE
197. D
198. D
199. D
200. B
201. D
202. D
203. B
204. A
205. A
206. C
207. D
208. A
209. TRUE
210. B
211. D
212. E
213. F
214. A
215. B
216. C
217. B
218. E
219. D
220. C
221. B
222. A
223. D
224. C
225. B
226. A
227. C
228. D
229. A
230. D
231. A
232. C
233. TRUE
234. D
235. D
236. TRUE
237. C
238. A
239. C
240. C
241. TRUE
242. D
243. TRUE
244. D
245. D
246.TRUE
247. D
248.TRUE
249. D
250. TRUE