TEACHING STRATEGIES FOR SUICIDE PREVENTION FOR TEACHERS, TRAINERS, AND SELF-DIRECTED LEARNERS

Samuel Knapp, Ed.D., ABPP

Educational strategies vary considerably depending on the context and audience. An entire semester graduate course on suicide prevention in a doctoral psychology program, for example, would differ considerably from a shorter segment in a psychopathology course or from a 6-hour continuing education class for licensed mental health professionals.

This document contains

1. General Points to Consider.
2. Potential Books to Assign.
3. Cramer's Competencies.
4. Suicide Concept Map.
5. Bloom/Krathwohl Taxonomy.
6. A Sample Problem-Solving Vignette.
7. Top Quotations from Noted Suicidologists.
8. Some Evaluation Instruments.
9. References and Resources.

GENERAL POINTS TO CONSIDER

1. Audiences may vary in their past instruction on suicide. Some new students may have had almost no instruction, while advanced students may have already had some training and or experience treating suicidal patients.

2. Use core competencies (such as Cramer, 2013; Cramer, 2023) to guide learning goals. There are other classifications of core competencies, but the differences appear to be more in how the competencies are classified and less in the content. Also, the concept map can help students conceptualize what they need to learn.

3. Teacher effectiveness ratings are highest when teachers establish learning objectives, solicit dialogue with participants, and use case examples.

4. As a general rule, participants tend to learn more from continuing education programs where lectures are brief and integrated with other activities and if the instructional time is longer (Buttars et al., 2021).

   It may be helpful to start by discussing attitudes toward suicide, including asking students to think about their past experiences (e.g., Did someone in your family die from suicide?

Did a patient attempt suicide? How does it feel to talk to a suicidal patient?)

6. It may also be helpful to discuss one's emotions or fears when treating suicidal patients, such as asking questions: What is it like to talk to a suicidal patient? What are your fears? How do you manage your fears?

7. Students may need to unlearn thoughts about suicides, such as a preference for medications, hospitalizations, or no-suicide contracts. They may also tend to be over-controlling (paternalistic), often a fear-driven approach. Instead, they must learn to listen, explain, collaborate, and ask. Finally, they need to appreciate the unpredictability of suicide. About half of suicides occur among low-risk groups or those who did not report suicidal thoughts the last time they were asked.

   It has been said that the most challenging thing about learning is unlearning.

8. Problem-solving exercises may be helpful, such as the *layered vignette* approach in which students are given some information and then asked, "What do you know?" and "What do you need to know?" followed by more information and then asking the same two questions, followed by being given the last bit of information about the case. See the case example below.

9. First-person accounts are helpful. I have included references to Hom et al. (2017) and Hom et al. (2020) as examples of getting patient and survivor feedback. However, there are many other first-person accounts from many sources, such as the Quinnett Award winners (first-person accounts from survivors) from the American Association of Suicidology. The Suicide and Stuff podcasts on YouTube often include interviews with survivors.

10. I found that the Top Quotations could be a starting point for effective discussions on attitudes toward suicide and the role of the psychotherapist.

11. Reflection is "a critical comparison of information with existing knowledge (in the context of an educational experience), which clarifies meaning, creates new understanding, and results in a changed perspective" (Ratelle et al., 2017, p. 162).

    a. Commitment to change is a process by which learners identify the changes they expect to make due to the educational program. The number of CTCs identified correlates with more learner reflection (Ratelle et al., 2017).

    b. Commitment to change exercises are more effective if they are more specific (e.g., "I will employ lethal means counseling with my suicidal patients" as opposed to "I will do better at intervening with my suicidal patients") if participants identify their level of commitment, and if the statements occur close to the learning event, and if participants receive reminders (Neimeyer & Taylor, 2019).

POTENTIAL BOOKS TO ASSIGN

The books chosen would depend on the goals of the instruction. If the goal is to get general information about suicide prevention, then I would recommend either.

When it is darkest (O'Connor, 2021)

> A well-written book by the noted British suicidologist combines personal experiences with scientific data to describe his understanding and approach to suicide prevention.

Rethinking suicide (Bryan, 2021)

> Also, a well-written book by the noted suicidologist Craig Bryan describes the complexities of suicide research, including some of its limitations and research issues. Nevertheless, it has practical implications, and readers do not get lost in the weeds of research issues as they are described in terms of their practical applications for healthcare professionals.

Helping the suicidal person (Freedenthal, 2018).

> An easy-to-read and down-to-earth book on suicide prevention that covers the major topics in treating suicidal patients.

Building a Therapeutic Alliance with the Suicidal Patient (Michel & Jobes, 2011).

> An important milestone book in the treatment of suicidal patients focusing on respect, understanding, and empathy for suicidal patients.

Other excellent books describe specific interventions, such as:

Managing suicidal risk (Jobes, 2023).

> Describes the highly effective collaborative assessment and management of suicide program.

The Suicide Crisis (Galynker, 2017)

> Describes the well-researched suicide crisis state and the narrative approach to suicide prevention.

Brief Cognitive Therapy for Suicide Prevention (Bryan & Rudd, 2018).

> Describes the highly effective brief cognitive therapy program for suicide prevention.

CRAMER'S COMPETENCIES

1. Understand and manage your attitude and reactions toward suicidal patients and suicide-related topics.

2. Develop and maintain a collaborative, empathic stance toward the client.

3. Know, elicit, and assess evidence-based and culturally informed risk and protective factors.

4. Elicit information on the patient's suicidal ideation, current plan, and intent to die.

5. Determine the level of risk through a therapeutically informed process.

6. Develop and enact a collaborative, evidence-based treatment plan.

7. Notify and involve other persons if clinically indicated.

8. Document risk, treatment plan, and reasoning for clinical decisions.

9. Know the law concerning suicide.

10. Engage in debriefing and self-care.

Cramer (2013; 2023)

SUICIDE CONCEPT MAP (PREVENTION DISPLAY)

SUICIDAL STATES

Vulnerabilities
- income, minority stress, trauma, thinking patterns isolation

Protective Factors
- Social contact, resilience, Religion, reasons for living

Culture
- Social Meanings, Idioms of distress
- Culture-specific life events

Suicidal Behavior
- Thoughts (Duration, recency, Frequency, etc.), plans preparations and past attempts

Demographics
- Age, sexual orientation, , Ethnicity, gender, Other, intersectionality

Ideation to action theories
- Interpersonal
- Integrated motivational/volitional
- Three step (3ST)

Fluid Vulnerability Theory

Cultural Theory of Suicide

Suicidal Mode and Suicidal Belief System
- Perceived burdensomeness, entrapment wish to die thoughts

Suicide Crisis State/Acute Suicidal Affective Disorder

Barriers to treatment or disclosures: Stigma, fear of coercion, shame, etc.

PATIENT
SERVICE PROVIDER

ASSESSMENT	MANAGEMENT	TREATMENT
Facilitate disclosures Interviewing style Treatment planning	Safety plans Lethal means counseling Monitoring	Evidence-based practices: CBT, DBT, CAMS, ASSIST, OTHERS Medications, hospitals
Law	Provider Factors	Transtheoretical factors
Risk Management Ethical Principles	Training (core competence) Attitudes (humility, mindfulness, etc.)	Emotional regulation, Soothing, Thinking style
	Experience in delivering services Self-care	Build social networks, Role of concerned others

Patient reports concerning their subjective experience in treatment.
Postvention when a patient dies.
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INTERVENTIONS

BLOOM AND KRATHWOHL'S TAXONOMY

According to Bloom's taxonomy of learning (1956) and as modified by Krathwohl (2002), learning can take place from basic knowledge (memorization) up through creativity. Objective tests primarily measure knowledge, comprehension, and analysis. However, some data suggests that high scores on questions in the lower levels predict performance on higher levels (Verenna et al., 2018). The tables below analyze two concepts, psychotherapist burnout and safety plans, from Bloom/Krathwohl's taxonomy.

Example of Bloom and Krathwohl's Taxonomy Applied to Suicide Prevention

	Definition	**Verbs**	**Example**
Knowledge (remember)	recall of basic facts	identify, define, memorize, name	Burnout is an emotional state sometimes experienced by healthcare professionals characterized by fatigue, depersonalization, and demoralization.
Comprehen-sion (understand)	ability to expand upon, summarize, or grasp the meaning of facts	describe, explain, expand, summarize	Psychotherapists who feel fatigued have difficulty putting their best effort into their work. Those who feel depersonalized have trouble showing empathy toward their patients, and those who feel demoralized do not feel pride in their work.
Application (apply)	ability to use the information in a specific situation	apply, employ, operate, put to use	Dr. Lopez currently has several patients with suicidal thoughts in her caseload, and she is beginning to feel burned out. Excessive fear of or worry over having a patient die from suicide may contribute to her feelings of burnout.
Analysis (analyze)	break down the material into its parts	diagram, examine, separate, take apart	The three components of burnout (fatigue, depersonalization, and demoralization) are separate but may interact with each other and may coexist with depression or anxiety.
Evaluation (evaluate)	understand the value of the material in a situation	Conclude, criticize, interpret, recommend	Burnout is related to poor patient outcomes. Therefore, psychotherapists should take steps to reduce burnout in themselves and others.
Creating (create)	Reorganizing elements in a new way. Generating new patterns or arrangements of the ideas.	put together, create. reorganize, restructure	Being aware of the risk of burnout, a psychotherapist can consider their life circumstances and personality and develop a program that reduces stress at work as much as possible by cultivating supportive social networks and reflecting on their expectations and goals for themselves.

Second Example of Bloom and Krathwohl's Taxonomy Applied to Suicide Prevention

	Definition	**Verbs**	**Example**
Knowledge (remember)	recall of basic facts	identify, define, memorize, name	Psychologists can use collaboratively developed safety plans to reduce the risk that a patient will attempt suicide.
Comprehen-sion (understand)	ability to expand upon, summarize, or grasp the meaning of facts	describe, explain, expand, summarize	Safety plans will result in a brief written document that patients can take with them. The safety plans provide a means to reduce suicidal urges through distraction or activities or contacts that help patients change their attitudes.
Application (apply)	ability to use the information in a specific situation	apply, employ, operate, put to use	Dr. Lopez currently has a patient with suicidal thoughts in her caseload. She can present the idea of the collaboratively developed safety plan to her patient.
Analysis (analyze)	break down the material into its parts	diagram, examine, separate, take apart	Safety plans include reasons for living, personalized warning signs, distracting activities, supportive contacts, and professional contacts. Lethal means counseling can be part of the safety plan or conducted separately.
Evaluation (evaluate)	understand the value of the material in a situation	Conclude, criticize, interpret, recommend	A meta-analysis showed that safety plans reduced the rate of suicide attempts by approximately 43% (Nuij et al., 2020). Individual psychologists can ask patients to rate the usefulness of their safety plan on a scale of 1 to 10, thus allowing them the opportunity to modify the plan to make it more responsive to the patient's needs.
Creating (create)	Reorganizing elements in a new way. Generating new patterns or arrangements of the ideas.	put together, create. reorganize, restructure	Psychologists can modify the format or procedures when developing safety plans depending on their patients' needs. This could include decisions about whether or how to involve family members or friends in the development of plans, whether to include lethal means counseling in the plans or to have it as a separate activity, and so on.

A SAMPLE PROBLEM-SOLVING VIGNETTE

Your goal is to assess the risk and then develop an intervention.

Jane Doe is a 28-year-old unmarried white woman with a history of depression. She sought treatment from a psychiatrist four years ago, but she stated that she responded poorly to medications. She is seeking treatment for her suicidal thoughts and ongoing depression. She reported that she had no plans to kill herself.

Q: What do you know about the patient?
Q: What more information do you need to know?

Jane works as a veterinarian's assistant and says she likes her work and gets good reviews from her employers. She has good physical health, although sometimes she gets headaches. She sleeps poorly at night. Jane denies abusing alcohol, and she smokes marijuana occasionally. She reported that her relationship with her parents is strained because they disapproved of her boyfriend, whom she broke up with several weeks ago. He was physically and verbally abusive to her. The suicidal thoughts started to come while she was in the relationship. Jane has several close friends who encouraged her to get psychotherapy. A year ago, a close friend of hers died from suicide.

Q: What do you know about the patient?
Q: What more information do you need to know?

After a few sessions, Jane admitted that she did have a suicide plan, which included taking an overdose of medication. The suicidal thoughts fluctuate in duration, frequency, and intensity. Sometimes, they are quite upsetting to her. Jane continually referenced how stupid she has been in her relationships and said, "I never seem to be able to do anything right."

SUGGESTION: The additional information focuses on the self-reported facts of Jane's life. This is helpful information. However, a good evaluator wants to know Jane's reactions to these events, her thinking habits, and her emotional responses. Does she perceive that she is a burden to others? How painful are these experiences? Does she view the pain as intolerable? What are her protective factors? Does she feel strongly connected to another person, an idea, or a cause?

The last bit of information gets closer to the critical questions that must be answered. Does she believe that she will eventually die from suicide? What is the nature of the suicidal thoughts (recency, frequency, duration, intensity), and how strong were they at their worst point)? Does she have a suicidal plan? Has she identified the means to kill herself? Does she have access to the means to kill herself, etc.?

TOP QUOTATIONS FROM NOTED SUICIDOLOGISTS

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 focus on motivating patients by trying to understand 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 strivings are most effective when done in the context of 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).

SOME EVALUATION INSTRUMENTS

Here are some common evaluation measures for suicide training with professionals or professional students. None of them are widely researched. Often, they measure the student's perception of how much they have mastered the identified educational goal. The SCAF, for example, takes Cramer's ten core competencies and phrases them in the form of questions. As such, they may help obtain feedback from the students or participants on how well they thought the course's objectives were met. The SIRI-2 measures mastery of content, but the content is more appropriate for students early in their training.

Suicide Competency Assessment Form (SCAF)

Cramer, R., Johnson, S. M., Rausch, E. M., & McLaughlin, J. (2013). Suicide risk assessment training for psychology doctoral programs: Core competencies and a framework for training. *Training and Education in Professional Psychology, 7*(1), 1-11.

Cramer, R. J., Ireland, J. L., Long, M. M., Hartley, V., & Lamis, D. A. (2020). Initial validation of the Suicide Competency Assessment Form among behavioral health staff in the National Health Service Trust. *Archives of Suicide Research, 24*, S136-S149. http://doi.org.10.1080/138811118.2019.1577194

Sample items:

"Know and manage your attitude and reactions toward suicide."
"Maintain a collaborative, empathic stance toward the patient."

10 items rated on a 4-point Likert-type scale from "incapability to perform the task" to "advanced competency."

The Competency Assessment Instrument for Suicide Risk (CAI-S).

Hung, E. K., Binder, R. L., Fordwood, S. R., Hall, S. E., Cramer, R. J., & McNiel, D. E. (2012). A method for evaluating competence in assessment and management of suicide risk. *Academic Psychiatry, 36* (1), 23-28.

Sample items:

"Displays rapport with patients."
"Obtains a history relevant to risk of suicide."

30 items in which respondents rate on a scale of 1 to 4 from "task not done" to "advanced."

Confidence in Suicide Risk Assessment, Formulation, and Safety Planning Scale

Sandford, D. M., Kirtley, O. J., Thwaites, R. Dagnan, D., & O'Connor, R. (2021). Adapting a measure of confidence in assessing, formulating, and managing suicide risk. *Crisis*, http://dx.doi.org/10.1027/0227-5910/a000830

Sample items

"Use your clinical skills to gather suicide risk information from patients."
"Identify relevant perpetuating factors."

13 items rated on a 5-point Likert scale from "not confident" to "highly confident."

Suicide Confidence Inventory

Graham, R. D., Rudd, M. D., & Bryan, C. J. (2011). Primary care providers' views regarding assessing and treating suicidal patients. *Suicide and Life-Threatening Behavior, 41*, 614-623.

Sample items

"I am confident with the responsibility of treating suicidal clients."
"I feel confident to treat a client in an acute suicidal crisis."

11 items rated on a 5-point Likert scale from "strongly disagree" to "strongly agree."

Suicide Intervention Response Inventory (SIRI-2)

Neimeyer, R. A., & Bonnelle, K. (1997). Suicide intervention response inventory : A revision and validation. *Death Studies, 21* (1), 59-81.

Sample item

"I decided to call in tonight because I feel like I might do something to myself. . . I've been thinking about suicide."

Helper A "You say you're suicidal, but what is it that's really bothering you."
Helper B "Can you tell me more about your suicidal feelings?"

2 potential caregiver responses for 24 statements that a person at risk of suicide might make.

REFERENCES AND RESOURCES

Barcaccia, B., Baiocco, R., Pozza, A., Pallini, S., Mancini, F., & Salvati, M. (2019). The more you judge the worse you feel. A judgmental attitude towards 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.

Bloom, B. (1956). *Taxonomy of educational objectives: The classification of educational goals*. Longman, Green. Subsequent scholars have modified the educational objectives while retaining the basic format. See, for example, Krathwohl (2002).

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

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

Buttars, E. M., Taylor J. M., & Neimeyer, G. J. (2021). Continuing education in professional psychology: Exploring the transition from learning to practice. *Professional Psychology: Research and Practice, 52*(6), 627-634. http://doi.org/10.1037/pro0000398

Cramer, R. J., Ireland, J. L., Long, M. M., Hartley, V., & Lamis, D. A. (2020). Initial validation of the Suicide Competency Assessment Form among behavioral health staff in the National Health Service Trust. *Archives of Suicide Research, 24*, S136-S149. http://doi.org.10.1080/138811118.2019.1577194

Cramer, R. J., Johnson, S. M., Rausch, E. M., McLaughlin, J., & Conroy, M. A. (2013). Suicide risk assessment training for psychology doctoral programs: Core competencies and a framework for training. *Training and Education in Professional Psychology, 7*, 1-11. http://doi.org/10.1037/a0031836

Cramer, R. J., Hawgood, J., Kaniuka, A. R., Brooks, B., & Baker, J. C. (2023, September 25). Updated Suicide Prevention Core Competencies for Mental Health Professionals: Implications for Training, Research, and Practice. *Clinical Psychology: Science and Practice*. Advance online publication. https://dx.doi.org/10.1037/cps0000172

Freedenthal, S. (2018). *Helping the suicidal person*. Routledge.

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

Graham, R. D., Rudd, M. D., & Bryan, C. J. (2011). Primary care providers' views regarding assessing and treating suicidal patients. *Suicide and Life-Threatening Behavior, 41*, 614-623.

Hom, M., Albury, E. A., Gomez, M. M., Christensen, K., 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. http://doi.org:10.1037/pro0000265

Hom, M.A., Stanley, I. H., Podlogar, M. E., & Joiner, T. E. (2017). "Are you having thoughts of suicide?" Examining experiences with disclosing and denying suicidal ideation. *Journal of Clinical Psychology, 73*(10), 1382-1392. http://doi.org/10.1002/jclp.22440

Hung, E. K., Binder, R. L., Fordwood, S. R., Hall, S. E., Cramer, R. J., & McNiel, D. E. (2012). A method for evaluating competence in assessment and management of suicide risk. *Academic Psychiatry, 36* (1), 23-28.

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

Joiner, T. E. (2010). *Myths about suicide*. Harvard University Press.

Joiner, T. E., Van Orden, K. A., Witte, T. K., & Rudd, M. D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients.* American Psychological Association.

Knapp, S. (in press). Listen, explain, collaborate, evaluate: Why promoting autonomy helps suicidal patients. *Ethics and Behavior*. http://doi.org/10.1080/10508422.2022.215338

Knapp, S., & Fingerhut, R. (2023). *Practical ethics for psychologists: A positive approach*. American Psychological Association.

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.

Krathwohl, D. R. (2002). A revision of Bloom's taxonomy: An overview. *Theory into Practice, 41*(4), 212-218. http://doi.org/10.1027/515430421tip4104-2

McAleavey, A. A., Xiao, H., Bernecker, S. L., Brunet, H., Morrison, N. R., Stein, M., & 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.

Michel, K., & Jobes, D. A. (Eds.) (2011). Building a therapeutic alliance with the suicidal patient. American Psychological Association.

Neimeyer, G. J. & Taylor, J. M. (2019). Advancing the assessment of professional learning, self-care, and competence. *Professional Psychology: Research and Practice, 50*(2), 95-105. http://doi.org/10.1037/pro0000225

Neimeyer, R. A., & Bonnelle, K. (1997). Suicide intervention response inventory : A revision and validation. *Death Studies, 21* (1), 59-81.

Nissen-Lie, H. A., Rønnestad, M. H., Høglend, P. A., Havik, O. E., Solbakken, O. A., Stiles, T. C., & Monsen, J. T. (2017). Love yourself as a person, doubt yourself as a therapist? *Clinical Psychology & Psychotherapy*, *24*(1), 48–60. https://doi.org/10.1002/cpp.1977

Norcross, J., & Cooper, M. (2021). *Personalizing psychotherapy: Assessing and accommodating patient preferences*. American Psychological Association. https://doi.org/10.1037/0000221-000

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

Ratelle, J. T., Wittich, C. M., Yu, R. C., Newman, J. S., Jenkins, S. M., & Beckman, T. H. (2017). Relationship between reflection and behavior change in CME. *Journal of Continuing Education in the Health Professions, 37*, 161-167. http://doi.org/10.1097/CEH000000000000162

Sandford, D. M., Kirtley, O. J., Thwaites, R. Dagnan, D., & O'Connor, R. (2021). Adapting a measure of confidence in assessing, formulating, and managing suicide risk. *Crisis*, http://dx.doi.org/10.1027/0227-5910/a000830

Simon, R. (2011). *Preventing patient suicide: Clinical assessment and management*. American Psychiatric Association Press.

Stanley, B., & Brown, G. K. (2012). Safety planning interventions: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*, 256-264. http://doi.org/ 10.1016/j.cbpra.2011.01.001

Verenna, A. M. A., Noble, K. A., Pearson, H. E., & Miller, S. M. (2018). Role of comprehension on performance at higher levels of Bloom's taxonomy: Findings from assessments of healthcare professional students. *Anatomical Sciences Education, 11,* 433-444.