

Commentary on The Many Reasons Why Not to Commit Suicide: The Case of “Maggie”

Unifying Psychotherapy in Suicide Prevention

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ABSTRACT

Youth and young adults are facing an unprecedented mental health crisis, where part of the solution is providing flexible and effective psychotherapy. In this case study commentary, we review the case of Maggie, a young adult in the United States dealing with suicidal ideation, symptoms from a traumatic sexual assault, and internalized shame. Using his version of a Unified Psychotherapy model, Gregg Henriques explains and details how to use the Unified Theory of Knowledge (UTOK) with particular emphasis on his mindfulness-and acceptance-based technique called CALM-MO. We comment on both the use of his treatment model and on how Maggie’s suicidal ideation was treated. Here, we found promise in Henriques’ UTOK model as a comprehensive framework for case conceptualization, although we worried about its accessibility to new clinicians. As well, we discuss how Henriques’ resource-focused framework was advantageous to treating Maggie’s suicidality, although he may have found additional benefit from updating his risk management practices to be more collaborative and humanistic. Ultimately, we believe the case of Maggie offers a timely exemplar of who is at the heart of our mental health crisis, while offering a comprehensive and unified psychotherapeutic approach for treatment consideration.

Keywords: Unified Psychotherapy; Unified Theory of Knowledge; Suicide Risk Assessment; Suicide Prevention; Case Conceptualization; Case Study; Clinical Case Study

INTRODUCTION

The mental health crisis, according to the Center for Addiction and Mental Health, has three important realities: (a) the total number of patients is rising, (b) diagnosis upon admission is wide-ranging and complex, and (c) youth aged 15-24 are highly vulnerable (CAMH, 2023). Although suicide rates in countries that provided economic relief dropped during the pandemic

(McIntyre et al., 2021), youth were not spared from this benefit. Across 18 countries, there was a modest increase of emergency room visits for suicidal ideation in youth during the pandemic (Madigan et al., 2023), contributing to a 60% increase in suicide deaths since 2011 (Curtin & Garnett, 2023). Partly explaining this rise in psychological distress is the recent sociopolitical disorganization, which asks clinicians to determine whether they are treating a sick person or a sick society (Aftab & Druss, 2023). The added complexity of contemporary mental health presentations and the high demand of service for youth and young adults is pushing clinicians to psychotherapy treatments that are flexible while remaining effective.

It is thereby timely to read Gregg Henriques' (2023) case study of "Maggie," which discusses a case prototypical of the mental health crisis and offers conceptual solutions. Henriques reported on his treatment of a young adult dealing with a complex presentation of depressive- and trauma-related symptoms using his unified psychotherapy (UP) approach, the Unified Theory of Knowledge (UTOK). UP theories like UTOK draw from the diversity of approaches, processes, techniques, and research findings in psychology by providing an evolving, comprehensive, and holistic framework for psychotherapy treatment (Marquis et al., 2021). Said simply, UP offers clients and clinicians a very broad compendium of knowledge in psychology to make sense of their issues and find interventions that fit with their conceptualization of change.

We were also pleased that Henriques focused on suicidality in this case study. Suicide treatment is, for most clinicians, the most stressful clinical activity in our profession (Kleespies et al., 1993); and it takes a disproportionate amount of time, is laden with litigious fears, and routinely causes death anxiety (Dubue & Hanson, 2020; Roush et al., 2018). As well, it is highly prevalent in youth and young adults (Curtin & Garnett, 2023), places an extreme burden on our health (Arakelyan et al., 2023) and economic systems (Kinchin & Doran, 2017), and can lead to lifelong disability in those surviving the loss (Mitchell et al., 2005; Tal Young et al., 2012). Not to mention, the field of suicide prevention has changed significantly in the last 15 years, where best practices have shifted from risk prediction to therapeutic assessment (Hawton et al., 2022; Sommers-Flanagan & Shaw, 2017). Case studies that contend with these realities, such as Henriques', offer us the opportunity to better understand, and thereby attend, to suicidal clients.

In this commentary, we focus on two discussion points: (a) the use of UTOK in conceptualizing Maggie, and (b) the suicide-specific conceptualization and treatment of Maggie.

THE USE OF UTOK IN CONCEPTUALIZING MAGGIE

In UTOK, clinicians are asked to incorporate the metaphysics that binds ontology, epistemology, and cosmology as a way of conceptualizing the totality of influences that inform human functioning. This includes eight key ideas which cover topics such as the hierarchy of knowledge, how we justify behaviour, how we are influenced by relationships, and other salient

psychological concepts. Although UTOK in its entirety is not detailed in this case study, many of its fundamental systems (e.g., Character Adaptation System Theory and the Triple Negative Neurotic Loop) are described in depth. Here, we comment on the use of UTOK in conceptualizing Maggie, specifically: (a) the utility of CALM-MO, and (b) the connection between UTOK and practice.

The Utility of CALM-MO

CALM-MO, the central technique in this case study, stands for curiosity, acceptance, loving compassion, motivated, and modus operandi or meta-cognitive observer. The influence of Acceptance Commitment Therapy (ACT; Hayes et al., 2012) and interpersonal neurobiology are evident, as CALM-MO is used to help clients better understand their experience, mindfully attend to their consciousness, and do so with self-compassion, all of which informs how to act towards valued ends.

In the case study of Maggie, CALM-MO is introduced in the third phase of treatment with the clinical intent of reducing her anxiety and breaking her self-critical thought patterns. Henriques used an example of a conflict between Maggie and her father as a way of further describing the technique, its benefits (i.e., being able to think about thinking), and its risks (i.e., revealing unacknowledged fears).

We believe that some of the best therapeutic interventions are the ones clients can easily recall, in part due to experiential learning during session and because of the simplicity of the intervention. CALM-MO is both things, and it shows as Maggie seemingly and easily recalled CALM-MO to mitigate a neurotic anxious spiral after a difficult interaction with her father. It is a useful heuristic with strong theoretical support.

We would have liked to see more discussion and examples of how CALM-MO was taught to Maggie. In the case study, the emphasis was more about the results of using CALM-MO rather than how it was brought up and taught in session. Getting this account from the clinician's perspective may help bolster our ability to learn and use this technique with our own clients.

Our biggest concern, however, is the utility of CALM-MO as a technique that, in and of itself, needed to be developed. As Henriques described, CALM-MO is borne from ACT and Interpersonal Neurobiology, both of which have similar techniques and acronyms. ACT, for example, has the hexaflex (Hayes et al., 2012) which is core to the treatment and the "Four As" of Acceptance (acknowledge, allow, accommodate, and appreciate; R. Harris, 2021), and Interpersonal Neurobiology has the Wheel of Awareness (D. J. Siegel, 2021). Both theories have comparable heuristics that do not require clients nor clinicians an additional acronym to learn. As well, both ACT and Interpersonal Neurobiology have effectiveness data (Fumero et al., 2020; Öst, 2014), which is fundamental to our ability to act as scientist-practitioners and practice

evidence-based psychotherapy. In the spirit of unification, we believe our efforts may be better spent identifying commonalities among psychotherapies instead of re-tooling already described techniques.

The Connection between UTOK and Practice

Throughout the case study, we looked for examples of how the UTOK model was applied to Maggie's conceptualization and treatment, with a specific interest in its pragmatism. We found multiple instances where some of UTOK's eight key ideas came up. For example, CALM-MO was the main treatment in the third phase; the Justification Systems Theory was used to help explain Maggie's inner critic in the fifth phase, and the Influence Matrix informed the conceptualization of Maggie's relational value and security in the second phase.

Although we were glad to see UTOK ideas applied, we felt there were many shortcomings that prevented us from fully understanding the utility of UTOK in case conceptualization and treatment. The most notable is that, despite the explanation of UTOK and its concepts, there was little of that language in the final conceptualization at the end of the paper. The conceptualization, which used the Well-Being Screen and Check-up System (WBCU), provided a detailed description of Maggie's functioning, health, emotions, relationships, and identity/coping. Although there were references to the neurotic loop and internal CRITIC in the lattermost section, we noted there was a sudden disconnect from the UTOK model and the actual case.

As well, we are mindful about the pragmatism of UTOK in case conceptualization and treatment. The treatment plan described Henriques' priority to develop a quality therapeutic relationship, a shared conceptualization of Maggie's distress that offers her hope for recovery, and the use of CALM-MO to reduce her inner CRITIC. We felt that the richness of the UTOK model was not on display in this conceptualization and, as a result, we had difficulties making sense of how concepts such as metaphysical understanding, the Character Adaptation System Theory, or even more broadly the Tree of Knowledge System were integrated into Maggie's treatment. This is especially important, given UTOK is complex and there are many acronyms and systems to learn. For example, in the UTOK outline section, readers are asked to learn about the unification pathways, metaphysics, the Tree of Knowledge System, Behavioral Investment Theory, Justification Systems Theory, the Influence Matrix, the Character Adaptation System Theory (CAST), its three contexts of development and its five systems of character, the triple negative neurotic loop, their exacerbating factors and the inner CRITIC, shame-based depression, and how the CAST connects to the Core Change Principles in Therapy. This is a lot of novelty for many clinicians, and we fear this is a significant barrier to understanding UTOK, especially when we have not seen it fully applied to a case.

The breadth of concepts, albeit welcomed as part of the unification process, may have also poorly affected Maggie's ability to share in her conceptualization. A main goal in the treatment plan was to develop a conceptualization of Maggie's distress, specifically with Maggie's input, and while we agree there was an agreed-upon conceptualization, we wonder if there was more room for collaboration. Part of the pragmatic beauty of unified theory is the flexibility in conceptualization. For example, if clients are experiencing anxious thoughts, there are cognitive, emotional, and behavioural routes that could explain its etiology and guide its treatment. Inviting clients into this collaborative space gives clinicians the simpler job of matching the psychotherapy approach to the client's theory of change. In this case study, we did not see a summary or explanation of the UTOK model to Maggie, rather, we saw explanations of specific components of UTOK (e.g., shame-based depression) without as much exploration into Maggie's own conceptualization of her distress. Although we recognize that she may have internalized a medicalized or biological understanding of depression (i.e., told to take medications and talk about feelings), sharing more of the UTOK model with Maggie and exploring what connected with her might have helped her feel more agentic in her treatment. Perhaps this is one of the challenges of applying the UTOK model; the breadth of knowledge comprised within the model may make it hard to summarize and share with clients, which invariably limits its application.

Similarly, we wonder if UTOK was sufficient for treating Maggie's symptoms. As noted, Maggie experienced a traumatic event that had followed her for years. This led to chronic and maladaptive avoidance that spiralled into this neurotic loop that plagued her ability to develop authentic relationships. In the second phase of treatment, we noted that exposure was used to help her face this memory and avoidance pattern, yet, as the exposure began, we are mindful that some key trauma-informed interventions were missing. We did not see techniques such as incorporating the window of tolerance and grounding (Corrigan et al., 2011), which are typically explained prior to the exposure and used during. As well, we are concerned with the first reflection after Maggie reported on her sexual assault; "You did not tell anyone?" (Henriques, 2023, p. 206) we need for you to understand it a valid curiosity, but we fear it could come off as judgmental, which is a sensitive intervention given the systemic underreporting of sexual assault due to shame and not being believed (Johnson & Lewis, 2023). And although we agree that clients beginning to untangle their traumatic memories can decompensate, we wonder if more grounding, coping, and awareness of trauma theory may have helped Maggie stay within her window of tolerance. Although these concepts may be partly incorporated in UTOK, there may be room for more intentional representation of the trauma literature and its important practice considerations.

SUICIDE-SPECIFIC CONCEPTUALIZATION AND TREATMENT OF MAGGIE

As mentioned earlier, treating an acutely suicidal client is no simple task. Conducting suicide risk assessments take more time and resources, cause disproportionate stress in clinicians, and lead to feelings that nothing can be done (Ellis & Patel, 2012; Reeves & Mintz, 2001). As well, clinicians fear how they will cope if their client dies by suicide (Cureton & Clemens, 2015) and feel poorly trained in suicide prevention (Dubue, 2023). To mitigate these discordant feelings, clinicians will routinely use suicide risk assessments to rationalize autonomy-limiting interventions (Dubue & Hanson, 2020) or simply avoid suicidal clients altogether (McCabe et al., 2017). And yet, 97% of us will work with a suicidal client before the end of our training (Kleespies et al., 1993) and are assumed to be working with at least one suicidal client per month (Bruno, 1995). Treating a suicidal client is complex, stressful, and yet, very common (Maris, 2019).

In the case of Maggie's suicidality and her treatment, we will discuss the following: (a) the benefit of additional resources, (b) the role of hopefulness in case conceptualization, (c) the autonomy-restricting risk of hospitalization, and (d) the assessment and management of suicidality.

The Benefit of Additional Resources

A systematic concern with suicide treatment is the lack of resources, both at the individual and community-level. Clinicians in both public and private settings often have full case loads that do not permit extra clinical time for clients and, when they aim to refer out to community (e.g., hospitals, suicide-specific clinics), they are often met with long wait times that are contraindicated to the acute risk presentation. In fact, the development of a treatment plan is intimately related to the available clinician and community resources, where more resources (e.g., time, peer consultation, access to emergency services) decrease clinician stress and, presumably, increase client benefit (Regehr et al., 2021, 2022).

It was therefore a very welcomed sight to see Henriques utilize an array of administrative and emotional resources to attend to Maggie's distress. For example, Henriques was able to immediately respond to the consultation call from his doctoral student, leave his seminar, and be with Maggie within 10 minutes. This hasty response may be rare in other healthcare settings that are not prepared to work with acute suicidality, and we applaud this as a standard of care. Further, Henriques was able to immediately respond to a panicked text message, shepherd Maggie through her hospitalization, visit her multiple times at the hospital, book multiple emergency and lengthier (e.g., "we spent two hours together") sessions, and follow her until she felt ready for discharge. As well, there were multiple moments throughout the case study where Henriques noted the importance of personally connecting to Maggie. Forming a therapeutic

alliance with a chronically suicidal client is typically more difficult than with other clients (Dubue, 2023; Dubue & Hanson, 2020), and Henriques displayed a commitment to forming this relationship, even when Maggie tried to distance herself. This dedication, and the generous use of personal and community resources, may partly explain the strength of the therapeutic relationship and her successful treatment outcome.

The Role of Hopefulness in Case Conceptualization

An integral part of contemporary suicide treatment is the development of a collaborative and hopeful conceptualization. To briefly summarize decades of literature in a sentence, suicide prevention has been moving away from medicalizing suicide as its own disease, to where it is now understood as a symptom of psychosocial issues, for example, interpersonal stress (Fawcett & O'Reilly, 2022; Sommers-Flanagan & Shaw, 2017). The landmark model that prizes this understanding is the Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2012), which posits these psychosocial issues as drivers of suicidal ideation (such as general hopelessness and financial concerns), which are idiosyncratic and the focus of treatment.

Henriques applies this philosophy early in the treatment. He explains to Maggie her distress as a shame-based depression, describing its etiology and offering a pathway to feeling better: “We need for you to understand it, understand what drives it, and work through the unfinished emotional business that gave rise to it” (p. 205). Importantly, he follows up this conceptualization with a hope intervention, asking if Maggie is willing to “give this a chance,” which is central to CAMS treatment (Swift et al., 2021) and remoralization (Connor & Walton, 2011). This hope-focused conceptualization appears integral to Maggie’s recovery; for most suicidal clients, the reasons for dying are not because they wish to die, but rather to end an excruciating and seemingly inescapable pain. Here, Henriques offers an escape that is not self-harm, death, or a lifelong use of psychotropics. Rather, he offers her a chance to build a life worth living.

Although we applaud this early hope-focused intervention, we continue to wonder about the room for more collaborative conceptualization. As written, Henriques offered a description of shame-based depression as the singular conceptualization of Maggie’s distress, suggesting this is, in fact, what is happening to her. Offering just one conceptualization and treating it as a truth is somewhat antithetical to the UP philosophy, which we believe Henriques also recognized later in his formal case conceptualization. At the end of the paper, Henriques enumerates multiple other etiologies for Maggie’s depressive symptoms, including high relational insecurity, avoidance of traumatic memories, a transient identity, and anhedonic behaviors. Part of good suicide prevention means collaboratively developing the client’s conceptualization, which in this case, could have looked like Henriques asking Maggie which of these etiologies best fits her own explanation for why she engages in self-harm. Ultimately, being collaborative with suicidal

clients increases the likelihood they will find another way to escape their pain (Swift et al., 2021).

The Autonomy-Restricting Risk of Hospitalization

A watershed moment in Maggie's treatment occurred during her hospitalization, an intervention that often risks more harm than good. In deciding to hospitalize a client for suicidal ideation, clinicians must decide if restricting the client's autonomy is worth the price of their short-term guaranteed safety. For most clients, this process is not worth it. Fifty percent of suicidal clients reported treatment was "very unhelpful" to "somewhat unhelpful" (Aboussouan et al., 2022) and feel invalidated because of the autonomy-restrictive milieu (Large, Sharma, et al., 2011; Ward-Ciesielski & Rizvi, 2020), which harms the therapeutic alliance (Hom et al., 2019; M. Siegel, 1979) and leads to less help-seeking behaviour (Jones et al., 2021). Indeed, hospitalization can paradoxically increase suicide risk (K. M. Harris & Goh, 2017; Large et al., 2014; Ward-Ciesielski & Rizvi, 2020), which is why 70% of clients with suicidal ideation conceal their thoughts because they fear hospitalization (Blanchard & Farber, 2020).

Henriques demonstrates a good example of minimizing these harms by "guiding" the client through the hospitalization. First, Henriques reassured Maggie that her hospitalization experience would be different. It is clear Maggie had already been hospitalized previously and, without much surprise, had a negative experience. This reassurance might have lowered the barrier for Maggie to admit herself and ask others for help, which she fortunately did. Second, Henriques showed up to the hospital and shepherded her through the visits with her family and the landmark disclosure to her mother. This likely provided structure to what is often an unstructured and chaotic experience. Last, Henriques offered a conceptualization of Maggie's distress that resonated with Maggie's existential despair and the overwhelming threat of being so suicidal making self-admittance feel like the safest option. He said:

Listen, Maggie. I know you are in your blackest place right now. Right now, all you feel is the pain of everything you try to block and hide and deny. And, believe me, when the flood gates open up to these kinds of feelings, it sucks. And I am sorry you are feeling it. But we are safe. And if we listen to your feelings and if we relate to them in the right way, this will be healing (2023, p. 208).

Together, the reassurance, provision of structure, and empathic reflection may have greatly facilitated Maggie's major corrective experience with her mother and minimized the harms to the therapeutic alliance with Henriques.

However, there were moments during the hospitalization that worried us. Maggie, or anyone who is being hospitalized for suicidal ideation, are in deeply vulnerable positions (Ward-Ciesielski & Rizvi, 2020) and are compromised in their ability to provide informed consent. This is especially true for highly impactful decisions such as allowing their mental health clinician to

meet their mother and discuss their treatment. This was particularly worrisome, as Maggie did not provide this consent previously, when she was not under the duress of hospitalization. We would have liked to see a more intentional consent process to connecting with her mother, in co-developing a treatment plan with Maggie's best friend, and assessing Maggie's mother. Although the outcome appeared monumental to Maggie's recovery, we are concerned that these interventions were presented without a clear discussion of the risks and benefits, the difficulty to consent under duress, and the importance of supporting the right to privacy of the friend, mother, and Maggie.

The Assessment and Management of Suicidality

Although not a focal point of the case study, Henriques engaged in some sort of suicide risk assessment throughout the case, which was best described in the final conceptualization. Here, Henriques noted that Maggie presented with a high risk of suicidal ideation, where the first goal was to conduct a risk assessment that informed a risk-reducing treatment plan. This plan focused first on developing a shared goal of staying safe, developing a strong therapeutic alliance, identifying pathways to change, and engaging with experiential treatment.

This plan, overall, is consistent with contemporary suicide risk assessment and management best practices. Recently, suicidologists have aggregated 40-50 years of data which suggests that, despite our best efforts, clinicians are only slightly better than chance at predicting suicide risk (Chan et al., 2016; Franklin et al., 2017; Large et al., 2016; Large & Ryan, 2014). This understanding has led clinicians to focus more on prevention rather than prediction, emphasizing understanding of client's drivers of suicide (i.e., self-reported causes of their suicidality) and directly treating those drivers as the main mechanism of suicide prevention (Jobes & Chalker, 2019). Furthermore, suicide assessment and prevention is becoming increasingly humanistic, where the focus is on helping the client become their own suicidologist and for the clinician to foster hope and treat their anguish (Espeland et al., 2021; Foster et al., 2021; Hawton et al., 2022; Pashak et al., 2022; Rudd, 2021). UTOK appears congruent with this philosophy, as there was clearly more emphasis on understanding and treating the client's distress than predicting it.

It is, however, note-worthy that Maggie was deemed to be "high-risk," a classification that is unlikely to be accurate. The unpredictability of suicide is, in part, because it is a very rare event that comes on rather suddenly; suicide desire is only predictive of intent for around 2 to 3 hours (Coppersmith et al., 2023), and nearly half of clients who attempted suicide only thought about the act for 10 minutes or less (Deisenhammer et al., 2009). And, to date, there is no good evidence our clinical intuition is any better than formal risk assessment scales (Large, Smith, et al., 2011). The harms of risk misclassification are also high. Those falsely categorized as low-risk get limited access to treatment, which raises the problem of increasing maladaptive coping

(e.g., self-harm, substance misuse) (Sutherland, 2021); and those falsely deemed high-risk can be involuntarily hospitalized, a typically harmful intervention.

Although it is clear Maggie was highly distressed, it may be best to avoid the high-risk classification. This is particularly important as these classifications often guide our decision to engage in autonomy-restricting interventions like hospitalization. And, in the case of Maggie, clinicians may feel it necessary to threaten hospitalization as not only a perceived ethical-legal requirement, but also to keep her engaged in psychotherapy. Knowing we cannot predict suicide and that risk classifications are contraindicated, clinicians are thereby free to treat suicidal clients with more autonomy-supportive interventions. For example, instead of threatening to call the police during the first interaction with Maggie, we might recommend starting with the hope that treatment could help her escape her pain. This humanistic treatment is likely to decrease attrition from psychotherapy and increase trustworthiness in both the clinician and other mental health professionals.

CONCLUSION

In this case study, Henriques presents the utility of UTOK as a psychotherapy approach. Although we laud the focus on developing unified psychotherapy approaches that could address the complexity of today's clients and community members, we wished for more congruence between UTOK and practice. As well, we believe CALM-MO is a helpful, yet perhaps unnecessary, novel technique that may serve clinicians and clients as a heuristic. Finally, regarding suicidal treatment, we are impressed to see some best practices (e.g., a focus on drivers of suicide and a humanistic approach) that were only recently developed in the literature and which were present in a case that was conducted in 2016. However, we note that some practices (e.g., risk categorization, hospitalization) should be reconsidered in future, or similar, cases.

REFERENCES

- Aboussouan, A., Moscardini, E. H., Cerel, J., & Tucker, R. P. (2022). Experiences of hospitalization for suicide ideation and suicide attempt in gender diverse adults. *Suicide and Life-Threatening Behavior*, 52(3), 427–438. <https://doi.org/10.1111/sltb.12832>
- Aftab, A., & Druss, B. G. (2023). Addressing the Mental Health Crisis in Youth—Sick Individuals or Sick Societies? *JAMA Psychiatry*. <https://doi.org/10.1001/jamapsychiatry.2023.1298>
- Arakelyan, M., Freyleue, S., Avula, D., McLaren, J. L., O'Malley, A. J., & Leyenaar, J. K. (2023). Pediatric Mental Health Hospitalizations at Acute Care Hospitals in the US, 2009-2019. *JAMA*, 329(12), 1000–1011. <https://doi.org/10.1001/jama.2023.1992>
- Blanchard, M., & Farber, B. A. (2020). “It is never okay to talk about suicide”: Patients’ reasons for concealing suicidal ideation in psychotherapy. *Psychotherapy Research*, 30(1), 124–136. <https://doi.org/10.1080/10503307.2018.1543977>

- Bruno, G. (1995). *Suicide assessment practices among psychologists*. [Dissertation, Pacific Graduate School of Psychology].
- CAMH. (2023). *The Crisis Is Real*. <https://www.camh.ca/en/driving-change/the-crisis-is-real>
- Chan, M. K. Y., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R. C., Kapur, N., & Kendall, T. (2016). Predicting suicide following self-harm: Systematic review of risk factors and risk scales. *British Journal of Psychiatry*, *209*(4), 277–283. <https://doi.org/10.1192/bjp.bp.115.170050>
- Connor, M. J., & Walton, J. A. (2011). Demoralization and remoralization: A review of these constructs in the healthcare literature. *Nursing Inquiry*, *18*(1), 2–11. <https://doi.org/10.1111/j.1440-1800.2010.00501.x>
- Coppersmith, D. D., Ryan, O., Fortgang, R. G., Millner, A. J., Kleiman, E. M., & Nock, M. K. (2023). Mapping the timescale of suicidal thinking. *Proceedings of the National Academy of Sciences*, *120*(17), e2215434120.
- Corrigan, F., Fisher, J., & Nutt, D. (2011). Autonomic dysregulation and the window of tolerance model of the effects of complex emotional trauma. *Journal of Psychopharmacology*, *25*(1), 17–25. <https://doi.org/10.1177/0269881109354930>
- Cureton, J. L., & Clemens, E. V. (2015). Affective constellations for countertransference awareness following a client's suicide attempt. *Journal of Counseling and Development*, *93*(3), 352–360. <https://doi.org/10.1002/jcad.12033>
- Curtin, S., & Garnett, M. (2023). *Suicide and homicide death rates among youth and young adults aged 10–24: United States, 2001–2021*. National Center for Health Statistics (U.S.). <https://doi.org/10.15620/cdc:128423>
- Deisenhammer, E. A., Ing, C.-M., Strauss, R., Kemmler, G., Hinterhuber, H., & Weiss, E. M. (2009). The duration of the suicidal process: How much time is left for intervention between consideration and accomplishment of a suicide attempt? *Journal of Clinical Psychiatry*, *70*(1), 19.
- Dubue, J. D. (2023). *Psychologists' practices, training, and experiences conducting suicide risk assessment in Canada: An explanatory sequential mixed methods study*. [Dissertation, University of Alberta]. Education and Research Archive.
- Dubue, J. D., & Hanson, W. E. (2020). Psychologists' experiences conducting suicide risk assessments: A phenomenological study. *Canadian Journal of Counselling and Psychotherapy*, *54*(4), 819–845. <https://doi.org/10.47634/cjcp.v54i4.69433>
- Ellis, T. E., & Patel, A. B. (2012). Client suicide: What now? *Cognitive and Behavioral Practice*, *19*(2), 277–287. <https://doi.org/10.1016/j.cbpra.2010.12.004>
- Espeland, K., Hjelmeland, H., & Loa Knizek, B. (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(1), 1868737.
<https://doi.org/10.1080/17482631.2020.1868737>
- Fawcett, E., & O'Reilly, G. (2022). Hospital presenting suicidal ideation: A systematic review. *Clinical Psychology & Psychotherapy*, 1–12. <https://doi.org/10.1002/cpp.2761>
- Foster, A., Alderman, M., Safin, D., Aponte, X., McCoy, K., Caughey, M., & Galynger, I. (2021). Teaching suicide risk assessment: Spotlight on the therapeutic relationship. *Academic Psychiatry*, 45(3), 257–261. <https://doi.org/10.1007/s40596-021-01421-2>
- Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., Musacchio, K. M., Jaroszewski, A. C., Chang, B. P., & Nock, M. K. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological Bulletin*, 143(2), 187–232. <https://doi.org/10.1037/bul0000084>
- Fumero, A., Peñate, W., Oyanadel, C., & Porter, B. (2020). The effectiveness of mindfulness-based interventions on anxiety disorders. A systematic meta-review. *European Journal of Investigation in Health, Psychology and Education*, 10(3), 704–719. <https://doi.org/10.3390/ejihpe10030052>
- Harris, K. M., & Goh, M. T.-T. (2017). Is suicide assessment harmful to participants? Findings from a randomized controlled trial. *International Journal of Mental Health Nursing*, 26(2), 181–190. <https://doi.org/10.1111/inm.12223>
- Harris, R. (2021, June 21). ACT Tips: The “Four As” of Acceptance. *ACT Blogs*. <https://psychwire.com/harris/blog/1radzhw/act-tips-the-four-as-of-acceptance>
- Hawton, K., Lascelles, K., Pitman, A., Gilbert, S., & Silverman, M. (2022). Assessment of suicide risk in mental health practice: Shifting from prediction to therapeutic assessment, formulation, and risk management. *The Lancet Psychiatry*, S2215036622002322. [https://doi.org/10.1016/S2215-0366\(22\)00232-2](https://doi.org/10.1016/S2215-0366(22)00232-2)
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and Commitment Therapy: The Process and Practice of Mindful Change*. Guilford Press.
- Henriques, H. (2023). The many reasons why not to commit suicide: The case of “Maggie.” *Pragmatic Case Studies in Psychotherapy*, 19(3), Article 1, 184-241. Available: <https://pcsp.nationalregister.org/>
- Hom, M. A., Albury, E. A., Gomez, M. M., Christensen, K., Stanley, I. H., Stage, D. L., & Joiner, T. E. (2019). Suicide attempt survivors’ experiences with mental health care services: A mixed methods study. *Professional Psychology: Research and Practice*, 51(2), 172–183. <https://doi.org/10.1037/pro0000265>
- Jobes, D. A. (2012). The collaborative assessment and management of suicidality (CAMS): An evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior*, 42(6), 640–653. <https://doi.org/10.1111/j.1943-278X.2012.00119.x>
- Jobes, D. A., & Chalker, S. A. (2019). One size does not fit all: A comprehensive clinical approach to reducing suicidal ideation, attempts, and deaths. *International Journal of*

- Environmental Research and Public Health*, 16(19).
<https://doi.org/10.3390/ijerph16193606>
- Johnson, I. D., & Lewis, R. (2023). Victim-survivors' prioritization of reasons for non-reporting adult sexual assaults to law enforcement. *Journal of Interpersonal Violence*, 38(3–4), 4293–4316. <https://doi.org/10.1177/08862605221114146>
- Jones, N., Gius, B. K., Shields, M., Collings, S., Rosen, C., & Munson, M. (2021). Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care. *Social Psychiatry and Psychiatric Epidemiology*, 56(11), 2017–2027. <https://doi.org/10.1007/s00127-021-02048-2>
- Kinchin, I., & Doran, C. M. (2017). The Economic Cost of Suicide and Non-Fatal Suicide Behavior in the Australian Workforce and the Potential Impact of a Workplace Suicide Prevention Strategy. *International Journal of Environmental Research and Public Health*, 14(4), 347. <https://doi.org/10.3390/ijerph14040347>
- Kleespies, P. M., Penk, W. E., & Forsyth, J. P. (1993). The stress of patient suicidal behavior during clinical training: Incidence, impact, and recovery. *Professional Psychology: Research and Practice*, 24(3), 293–303. <https://doi.org/10.1037/0735-7028.24.3.293>
- Large, M. M., Kaneson, M., Myles, N., Myles, H., Gunaratne, P., & Ryan, C. (2016). Meta-analysis of longitudinal cohort studies of suicide risk assessment among psychiatric patients: Heterogeneity in results and lack of improvement over time. *PLoS ONE*, 11(6), 1–17. <https://doi.org/10.1371/journal.pone.0156322>
- Large, M. M., & Ryan, C. J. (2014). Suicide risk categorisation of psychiatric inpatients: What it might mean and why it is of no use. *Australasian Psychiatry*, 22(4), 390–392. <https://doi.org/10.1177/1039856214537128>
- Large, M. M., Ryan, C., Walsh, G., Stein-parbury, J., & Patfield, M. (2014). Nosocomial suicide. *Australasian Psychiatry*, 22(2), 118–121. <https://doi.org/10.1177/1039856213511277>
- Large, M. M., Sharma, S., Cannon, E., Ryan, C., & Nielssen, O. (2011). Risk factors for suicide within a year of discharge from psychiatric hospital: A systematic meta-analysis. *Australian and New Zealand Journal of Psychiatry*, 45(8), 619–628. <https://doi.org/10.3109/00048674.2011.590465>
- Large, M. M., Smith, G., Sharma, S., Nielssen, O., & Singh, S. P. (2011). Systematic review and meta-analysis of the clinical factors associated with the suicide of psychiatric in-patients. *Acta Psychiatrica Scandinavica*, 124(1), 18–29. <https://doi.org/10.1111/j.1600-0447.2010.01672.x>
- Madigan, S., Korczak, D. J., Vaillancourt, T., Racine, N., Hopkins, W. G., Pador, P., Hewitt, J. M. A., AlMousawi, B., McDonald, S., & Neville, R. D. (2023). Comparison of paediatric emergency department visits for attempted suicide, self-harm, and suicidal ideation before and during the COVID-19 pandemic: A systematic review and meta-analysis. *The Lancet Psychiatry*, 10(5), 342–351. [https://doi.org/10.1016/S2215-0366\(23\)00036-6](https://doi.org/10.1016/S2215-0366(23)00036-6)

- Maris, R. W. (2019). *Suicidology: A comprehensive biopsychosocial perspective*. Guilford Press.
- Marquis, A., Henriques, G., Anchin, J., Critchfield, K., Harris, J., Ingram, B., Magnavita, J., & Osborn, K. (2021). Unification: The fifth pathway to psychotherapy integration. *Journal of Contemporary Psychotherapy*, *51*(4), 285–294. <https://doi.org/10.1007/s10879-021-09506-7>
- McCabe, R., Sterno, I., Priebe, S., Barnes, R., & Byng, R. (2017). How do healthcare professionals interview patients to assess suicide risk? *BMC Psychiatry*, *17*(1), 122. <https://doi.org/10.1186/s12888-017-1212-7>
- McIntyre, R. S., Lui, L. M., Rosenblat, J. D., Ho, R., Gill, H., Mansur, R. B., Teopiz, K., Liao, Y., Lu, C., & Subramaniapillai, M. (2021). Suicide reduction in Canada during the COVID-19 pandemic: Lessons informing national prevention strategies for suicide reduction. *Journal of the Royal Society of Medicine*, *114*(10), 473–479. <https://doi.org/10.1177/01410768211043186>
- Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer, M. K. (2005). Complicated grief and suicidal ideation in adult survivors of suicide. *Suicide & Life-Threatening Behavior*, *35*(5), 498–506. <https://doi.org/10.1521/suli.2005.35.5.498>
- Öst, L.-G. (2014). The efficacy of acceptance and commitment therapy: An updated systematic review and meta-analysis. *Behaviour Research and Therapy*, *61*, 105–121. <https://doi.org/10.1016/j.brat.2014.07.018>
- Pashak, T. J., Percy, C. S., Trierweiler, E. J., Bradley, S. M., Conley, M. A., & Weaver, J. S. (2022). Awareness isn't saving lives: An experimental exploration of suicide risk reduction methods for emerging adults. *Suicide and Life-Threatening Behavior*, *52*(4), 740–751. <https://doi.org/10.1111/sltb.12857>
- Reeves, A., & Mintz, R. (2001). Counsellors' experiences of working with suicidal clients: An exploratory study. *Counselling & Psychotherapy Research*, *1*(3), 172–176. <https://doi.org/10.1080/14733140112331385030>
- Regehr, C., Enosh, G., & Bosk, E. (2021). An ecological model for high-risk professional decision-making in mental health: International perspectives. *International Journal of Environmental Research and Public Health*, *18*(14), 7671. <https://doi.org/10.3390/ijerph18147671>
- Regehr, C., Paterson, J., Sewell, K., Birze, A., Bogo, M., Fallon, B., & Regehr, G. (2022). Improving professional decision making in situations of risk and uncertainty: A pilot intervention. *The British Journal of Social Work*, *52*(3), 1341–1361. <https://doi.org/10.1093/bjsw/bcab131>
- Roush, J. F., Brown, S. L., Jahn, D. R., Mitchell, S. M., Taylor, N. J., Quinnett, P., & Ries, R. (2018). Mental health professionals' suicide risk assessment and management practices: The impact of fear of suicide-related outcomes and comfort working with suicidal individuals. *Crisis*, *39*(1), 55–64. <https://doi.org/10.1027/0227-5910/a000478>

- Rudd, M. D. (2021). Recognizing flawed assumptions in suicide risk assessment research and clinical practice. *Psychological Medicine*, 1–2.
<https://doi.org/10.1017/S0033291721002750>
- Siegel, D. J. (2021). *Wheel of awareness* [Blog]. <https://drdansiegel.com/wheel-of-awareness/>
- Siegel, M. (1979). Privacy, ethics, and confidentiality. *Professional Psychology: Research and Practice*, 10(2), 249–258. <https://doi.org/10.1037/0735-7028.10.2.249>
- Sommers-Flanagan, J., & Shaw, S. L. (2017). Suicide risk assessment: What psychologists should know. *Professional Psychology: Research and Practice*, 48(2), 98–106.
<https://doi.org/10.1037/pro0000106>
- Sutherland, D. (2021). *The road to nowhere: New Zealanders struggle to get the help they need, 2 years on from a funding boost for mental health services*. The Conversation.
<https://theconversation.com/road-to-nowhere-new-zealanders-struggle-to-get-the-help-they-need-2-years-on-from-a-funding-boost-for-mental-health-services-158868>
- Swift, J. K., Trusty, W. T., & Penix, E. A. (2021). The effectiveness of the Collaborative Assessment and Management of Suicidality (CAMS) compared to alternative treatment conditions: A meta-analysis. *Suicide and Life-Threatening Behavior*, March, 1–15.
<https://doi.org/10.1111/sltb.12765>
- Tal Young, I., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurtti, M., & Zisook, S. (2012). Suicide bereavement and complicated grief. *Dialogues in Clinical Neuroscience*, 14(2), 177–186. <https://doi.org/10.31887/DCNS.2012.14.2/iyoung>
- Ward-Ciesielski, E. F., & Rizvi, S. L. (2020). The potential iatrogenic effects of psychiatric hospitalization for suicidal behavior: A critical review and recommendations for research. *Clinical Psychology: Science and Practice*, February, 1–15.
<https://doi.org/10.1111/cpsp.12332>