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claims can be brought (“statutes of limitations”), and capping the fees that attorneys can receive from such cases. The most effective laws set limits on non-economic damages that injured patients can recover, e.g., compensation for pain and suffering⁶. The variable impact of these changes in the law have stimulated medical associations and health systems to experiment with approaches outside the legal system that might reduce liability risk.

Medical associations, such as the American Psychiatric Association, have produced practice guidelines, in part as a means of reducing clinicians’ liability exposure. Practice guidelines attempt to define the parameters within which appropriate clinical care may take place, based on evidence in the relevant medical literature. They are often written so as to provide flexibility to clinicians, typically noting a variety of acceptable approaches to any clinical situation. Conformance to a generally accepted practice guideline will generally constitute a defense to malpractice claims by offering proof that the defendant-physician has complied with a professional standard of care. On the other hand, failure to comply with a practice guideline does not necessarily prove negligence; the physician can challenge the guidelines themselves or otherwise attempt to demonstrate that his/her behavior fell within the parameters of reasonable physician choice. As with many attempts to reduce malpractice claims, it has been difficult to demonstrate that practice guidelines have been effective for this purpose, even when systematic efforts have been made to encourage their use⁷.

A second innovative effort to reduce malpractice claims is exemplified by the approach adopted by the University of Michigan Health System⁸. When medical errors result in harm to a patient, the system encourages prompt apology by the physicians involved and an offer of payment that is usually well below what might be awarded by a court. Evaluation of the program demonstrated that it led to a reduction in the number of lawsuits, lower liability costs, and shorter time to resolution of cases. Its success may be based, at least in part, on many injured patients’ desire for an explanation of what went wrong and an apology for mistakes

that were made. However, apology laws may have paradoxical effects. One recent study found that they increased the risk of malpractice suits being filed against physicians who do not perform surgery, while having no effect on surgeons’ liability risk⁹. The effect may derive from patients’ greater knowledge that an error was made, which increases motivation to seek compensation.

Given the uncertain effectiveness of legal and systemic efforts to reduce the likelihood that a physician will be subject to a claim of malpractice, the best preventive measures may rest in the hands of individual clinicians. That psychiatrists are among the least frequently sued physicians is probably due, at least in part, to the deeper and more empathic relationships they tend to have with patients. Patients who believe that their psychiatrists truly care about their well-being are less likely to sue, even if something goes wrong. In addition to maintaining a caring doctor-patient relationship, other pillars of prevention include seeking consultation when facing a challenging clinical situation and documenting the rationale for treatment decisions in the patient’s record, including explanations of potential management options that were not selected¹. As a general matter, doing what is best for the patient remains the surest path to reduce risk of malpractice claims.

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The critical distinction between suicidal ideation and suicide attempts

Suicide remains a leading cause of death worldwide¹. A key reason for limited progress is inadequate understanding about the transition from suicidal ideation to suicide attempts. This knowledge is important because the majority of instances of suicidal ideation do not lead to suicide attempts. A World Health Organization study found that approximately two-thirds of individuals with suicidal ideation never make a suicide attempt², and a population-based study found that only 7% of individuals with suicidal ideation attempted suicide during the subsequent two years³.

Unfortunately, little is known about when or for whom ideation leads to attempts. For example, psychiatric disorders that predict suicidal ideation only weakly or negligibly predict progression from ideation to attempts². Similarly, in meta-analytic data, vari-

ables such as depression and hopelessness are strong correlates of suicidal ideation, but are weakly or negligibly associated with attempts among ideators⁴. Currently, not even a single strong predictor of suicide attempts among ideators has been identified.

To advance suicide knowledge and prevention we must better understand the transition from suicidal ideation to suicide attempts. A response to this need may be provided by the ideation-to-action framework, which suggests that the development of suicidal ideation and the transition from suicide ideation to attempts are distinct processes with distinct predictors and explanations⁵. This framework has implications for suicide research, risk assessment, intervention, and theory.

Regarding research, the framework underscores the need for

studies to identify variables that help predict and explain transition from ideation to attempts. Many studies on suicide attempts examine differences between attempters and non-attempters; however, because all (or virtually all) attempters have suicidal ideation, this common research design confounds attempts and ideation, making it impossible to tell what the differences are attributable to. Studies seeking to identify predictors of suicide attempts must in some way control for suicidal ideation; one option is to conduct analyses that test what predicts suicide attempts among those with ideation.

The framework also has implications for risk assessment and prevention. One implication is that suicide risk factors should not comprise a single list, but be organized according to whether they raise risk for suicidal ideation, suicide attempts among ideators, or both. For example, research to date suggests that depression primarily is a risk factor for suicidal ideation, access to lethal means is a risk factor for suicide attempts among those with ideation, and nonsuicidal self-injury increases risk for both. The framework has similar implications for intervention. Specifically, any intervention for suicide risk should be clear about which aspects are meant to reduce suicidal ideation and which are meant to stop transition from ideation to attempts.

The ideation-to-action framework also applies to suicide theory. Historically, different theories of suicide emphasized different factors, such as social isolation, psychological pain, and hopelessness; these theories have been extremely beneficial for guiding research and providing a foundation that informs contemporary theories. At the same time, traditional theories share a common limitation: they tend to treat suicidality as a single phenomenon in need of a single explanation^{1,6}. As a result, these theories did not provide separate explanations for suicidal ideation and suicide attempts.

In this context, the Interpersonal Theory of Suicide (IPT)⁷ represents an important theoretical advance. The IPT provides separate explanations for the development of suicidal ideation and the progression from suicidal ideation to suicide attempts. Specifically, the IPT suggests that suicidal desire is caused by thwarted belongingness and perceived burdensomeness, whereas progression from suicidal desire to suicide attempts occurs when one has acquired the capability to make a suicide attempt. Thus, the IPT may be viewed as the first of a new generation of suicide theories that positioned themselves within an ideation-to-action framework⁶.

The most recent ideation-to-action theory is the Three-Step Theory of Suicide (3ST)⁸. In brief, the 3ST suggests that: a) suicidal ideation is caused by the combination of unbearable pain (usually psychological) and hopelessness, b) suicidal ideation is strong when one's pain exceeds or overwhelms one's connectedness (to valued people, communities, or sources of purpose and meaning), and c) transition from strong suicidal ideation to potentially lethal suicide attempts is facilitated by dispositional, acquired and practical contributors to capability for suicide. Thus, the 3ST is a concise theory that explains suicide in terms of just four variables: pain, hopelessness, connectedness, and suicide capability.

A growing body of research – including studies on correlates of suicidal ideation and suicide attempts, predictors of suicidal ideation and suicide attempts, motivations for suicide, warning signs for suicide and suicide attempts, and means safety interventions – support the validity of the 3ST⁸. As a result, the 3ST has been incorporated into suicide education and prevention programs, including continuing education courses, campus-based suicide prevention programs, and self-help suicide prevention materials⁸.

An advantage of the 3ST is that it provides a context for understanding the impacts of diverse biopsychosocial risk factors and interventions. Specifically, anything that impacts pain, hopelessness, connection, and/or suicide capability would be expected to impact suicide risk. For example, if an antidepressant were to reduce suicide risk, we might hypothesize that this occurs by reducing depression, and thus psychological pain. We might further hypothesize that an improvement in depression may increase one's sense of hope for the future, and/or enhance one's ability to engage with valued connections. Similarly, the 3ST can be applied to understand elevated risk in various populations. For example, increased suicide risk in transgender individuals is likely due to increased pain, hopelessness, and disconnection caused by widespread prejudice and discrimination, whereas elevated suicide risk in certain medical professionals may be best explained by elevated suicide capability (i.e., knowledge and access to lethal means). Thus, the 3ST can improve understanding of suicide risk across a variety of clinical, social and scientific contexts.

Despite recent theoretical advances, it remains critical for the field to continue to clarify the conditions under which ideation results in attempts. Perhaps the most promising variable to date explaining this progression is suicide capability. As noted above, this construct was first introduced in the IPT⁷ and subsequently elaborated by the 3ST⁸. In short, because suicide involves the potential for pain, injury and death, and because people are biologically (and arguably evolutionarily) disposed to fear and avoid pain, injury and death, making a suicide attempt requires the capability to overcome these barriers.

Different definitions and measures of suicide capability have been proposed, and much of the evidence is mixed. Perhaps the most robust finding is that risk of attempts among ideators is higher when practical capability is higher (practical capability refers to knowledge of, access to, and expertise with lethal means). This conclusion is supported not only by recent studies demonstrating a relationship of practical capability to suicide attempts⁸, but also by a long history of research showing impacts of access to lethal means and means safety interventions on suicide rates⁹.

Moving forward, it is imperative that research better illuminate when and for whom suicidal ideation leads to suicide attempts. This effort requires use of multiple measurements within longitudinal designs so that the ebb and flow of variables that contribute to suicidal ideation and attempts can be captured precisely and accurately. Understanding the phenomena of suicidal ideation and suicide attempts through the ideation-to-action lens will accelerate the development and refinement of essential suicide research, theory and clinical care.

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Thinking too much: rumination and psychopathology

Patients suffering from mental health problems often complain about thinking too much. Their mind is frequently focused on negative thoughts about their symptoms, problems, or negative experiences.

Traditionally, researchers and clinicians have either regarded this type of rumination as an epiphenomenon or consequence of suffering from mental health problems, or – as in the case of cognitive therapy – have mostly been interested in the *content* of these thoughts. However, there is increasing evidence suggesting that rumination, defined as a *process* of repetitive negative thinking, is a causal mechanism involved in the development and maintenance of psychopathology¹.

The vast majority of research on rumination has been conducted in the context of depression. In her seminal response styles theory, S. Nolen-Hoeksema introduced rumination as a way of responding to depressed mood that is characterized by repetitively and passively focusing on the symptoms of depression, and their possible causes and consequences². The tendency to engage in a ruminative response style appears to be a reasonably stable trait, and can be assessed with the Response Styles Questionnaire (RSQ)².

There is now extensive longitudinal research showing that rumination assessed in this way: a) predicts the onset of new episodes of depression; b) predicts the maintenance of already existing depressive symptoms; c) is a mediator between other known risk factors (e.g., negative cognitive styles, childhood adversity, psychosocial stress) and depression, and d) is related to reduced response to treatment¹⁻⁴.

Converging evidence comes from experimental research showing that induced rumination leads to negative thinking, poor problem solving, inhibition of instrumental behavior, biased information processing, and impaired interpersonal functioning^{1,2,4}.

Importantly, however, rumination is not only related to depression, but is involved in the development and/or maintenance of a broad range of disorders, including post-traumatic stress disorder (PTSD), anxiety disorders, insomnia, eating disorders, somatic symptom disorder, and substance use disorders^{2,3}.

It has been argued that repetitive negative thinking (RNT) is a transdiagnostic process, and that rumination can be subsumed under this overarching concept^{3,5}. For example, our group has defined RNT as a style of thinking about one's problems (current, past or future) or negative experiences (past or anticipated) that is: a) repetitive, b) intrusive, c) difficult to disengage from, d) perceived as unproductive, and e) capturing mental capacity⁶.

Importantly, RNT is characterized by its process features, not its content. Specifically, the transdiagnostic perspective states that RNT shares the same process across different disorders, but is applied to disorder-specific and/or idiosyncratic topics. Thus, phenomena that have traditionally been studied from a disorder-specific perspective (e.g., depressive rumination, excessive worry in generalized anxiety disorder, trauma-related rumination in PTSD, or post-event processing in social anxiety) are now regarded as different expressions of the same underlying construct.

Supporting evidence for this conceptualization comes from research showing that the common aspects of RNT (i.e., the transdiagnostic process) are more predictive of depression and anxiety disorders than unique features of disorder-specific worry or rumination⁷. Different questionnaire measures to assess the transdiagnostic properties of RNT have been developed, including the Perseverative Thinking Questionnaire (PTQ)⁶.

Thus, current evidence is in line with the idea that RNT in general (as well as rumination as a specific subfacet) can be regarded as an important process, involved in the development and maintenance of psychopathology across different diagnostic categories.

Why do some individuals then frequently engage in RNT despite the proven negative consequences? A number of different theoretical perspectives have been put forward to explain this puzzling phenomenon^{1,5}. An important basic tenet of many models is the assumption that RNT is essentially a normal process that usually serves the adaptive function to alert us to a current goal discrepancy and motivate us to engage in action to reduce this discrepancy. However, excessive RNT observed in the context of psychopathology has apparently lost this function.

According to Wells⁸, excessive RNT is maintained by a combination of positive metacognitive beliefs (e.g., "RNT helps me to better cope with problems"), negative metacognitive beliefs (e.g., "RNT is dangerous") as well as dysfunctional control strategies (e.g., thought suppression) triggered by negative metacognitions. In addition, there is evidence that RNT in the context of psychopathology often serves the function to avoid both unpleasant experiences (e.g., negative emotions, arousal, aversive imagery or memories) as well as action, leading to negative reinforcement. Moreover, RNT can become a mental habit that can be triggered independent of goal pursuit simply by contextual cues.

From an information processing perspective, RNT can be regarded as the consequence of cognitive biases leading to the frequent involuntary activation of representations with negative content. In addition, deficits in cognitive control then lead to a lack