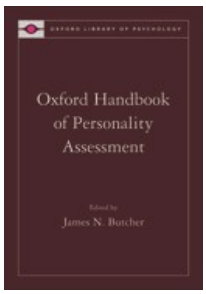

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CHAPTER

26 Assessment of Suicide Risk

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Abstract

The assessment of suicide risk remains one of the most important, complex, and difficult tasks performed by clinicians. Many suicidal individuals do not voluntarily report their thoughts or plans for self-harm to the professionals who are trained to act accordingly. If we work from the premise that not all patients are willing to admit their suicidal ideation to their health-care provider, then we must utilize other resources to guide our intervention strategies. Because suicide is one of the few fatal consequences of a psychiatric illness, accurate assessment of suicide risk is essential. The optimal risk assessment integrates a sound clinical interview with actuarial instruments providing supplementary or clarifying information. This article explores the historical and contemporary literature on the use of psychological tests, suicide scales, and risk estimators, as well as the epidemiological and clinical data on risk factors. It highlights the importance of formulation of clinical judgment via important clinical observations and key elements in the clinical interview, as integral components of a model of comprehensive clinical assessment and risk management.

Keywords: suicide, suicide risk, risk assessment, self-harm, clinical assessment, suicidal ideation, actuarial instruments, clinical interview, risk factors, risk management

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There are many reasons why the assessment of suicide risk is one of the most important aspects of clinical work. The fact that the majority (up to two-thirds) of those who commit suicide have had contact with a health-care professional in the month before their death (Kutcher & Chehil, 2007) illustrates this point profoundly. Because suicide is one of the few fatal consequences of psychiatric illness, accurate assessment of suicidal risk is essential (Packman, Marlitt, Bongar, & Pennuto, 2004). It is estimated that there are about a quarter million nonfatal suicide attempts each year in the United States. About 15% of those who attempt

suicide will eventually take their own lives, and one-third of those who complete suicide have had nonfatal attempts in their past (Yufit & Lester, 2005). Suicide was the 11th leading cause of death in the United States in 2000, when an estimated 29,350 deaths were attributed to it (National Institute of Mental Health, 2003).

The purpose of this chapter is to present the assessment of suicide risk from a clinically balanced and research informed standpoint. There is no question that clinicians are increasingly faced with decisions about what to do when a patient reports suicidal ideation or when assessment data lead to the same conclusion (Wingate, Joiner, Walker, Rudd, & Jobes, 2004). Unfortunately, many suicidal individuals do not voluntarily report their thoughts or plans for self-harm to the professionals who are trained to act accordingly. If we work from the premise that not all patients are willing to admit their suicidal ideation to their health-care provider (Glassmire, Stolberg, Greene, & Bongar, 2001; Johnson, Lall, Bongar, & Nordlund, 1999), then we must utilize other resources, namely the psychological assessment and a sound clinical review of risk factors, to guide our intervention starategies.

A wide array of instruments have been developed for the measurement of various aspects of suicidality. These actuarial instruments can be a helpful supplement in risk elevation (Bryan & Rudd, 2006) but they have a notoriously high false-positive rate. Thus, optimal risk assessment integrates a sound clinical interview with actuarial instruments providing supplementary or clarifying information.

A recent trend is to focus on new empirically based strategies in the assessment of suicide potential (Bongar, 2000; Bryan & Rudd, 2006). Some researchers have turned their attention away from making predictions of patient behavior to clinician'own views of critical factors when assessing for suicide (Bongar,
p. 502 1991; Bruno, 1995; Bryan & Rudd, 2006; ↳ Greaney, 1995; Kutcher & Chehil, 2007; Mahrer, 1993), attempting to identify the standards of care for this practice situation. This approach seeks to bridge the study of patient characteristics with that of clinician education, training, and experience in hope of describing reasonable and prudent practitioner behaviors. A profile of these behaviors not only is useful in identifying the standard of care, but can also help identify professional myths and deficiencies in practice, both essential to training and education efforts.

The assessment of suicide risk remains among the most important, complex, and difficult tasks performed by clinicians (Bongar, Maris, Berman, Litman, & Silverman, 1993; Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989; Motto, 1991; Reinecke & Franklin-Scott, 2005). Because suicidology literature is voluminous, diverse, and sometimes contradictory, clinicians may have difficulty determining the relative importance of various factors when assessing the individual. Some researchers have emphasized particular charts of variables. Gutheil and Appelbaum 1982, for example, stated that the best approach to gathering data "focuses on previous psychiatric history; recent behavior or behavioral change; significant alteration of circumstances (e.g., loss of job); bizarreness of ideation or action; threats to self or others, or related behavior such as the purchase of poison, rope, or a gun; history of substance abuse and the like" (p. 52). These authors pointed out that the central clinical and legal concerns involve negligence in evaluation and in involuntary interventions (i.e., hospitalization). Brent, Kupfer, Bromet, and Dew (1988) noted that an accurate diagnostic assessment is necessary with regard to primary and comorbid psychiatric disorder, alcohol and drug abuse, personality disorders, and attendant medical disorders. In addition, they pointed out that a proper assessment mobilizes the families and significant others in order to improve compliance with treatment and decrease the chance of a relapse.

Much of the difficulty in the assessment of suicide risk comes from the psychometric weaknesses of existing suicide scales and measures (Rogers & Oney, 2005). We suggest that all measures of suicide risk (e.g., scales, tests, and critical items) need to be reviewed in context of the assessment itself. What is the referral question, why is this person here with me at this time, and how previous experiences or cognitions may impact the current presentation are all vital to consider. Recent advances in risk assessment research show areas that have been empirically demonstrated to be essential to the risk assessment (Rudd, Joiner, & Rajab,

2001). Bryan and Rudd (2006) present a clear outline for a thorough risk assessment which includes an examination of:

1. predispositions to suicidal behavior (diagnosis, history of attempts, gender, etc.);
2. identifiable precipitant or stressors (loss, health problems, relationship problems, etc.);
3. symptomatic presentation (specific diagnosis with elevated risk factors);
4. presence of hopelessness (severity and duration);
5. the nature of suicidal thinking (intensity, duration, intent, means, lethality, etc.);
6. previous suicidal behavior (opportunity, frequency, and context of attempts, etc.);
7. impulsivity and self-control (subjective and objective control); and
8. protective factors (support, religion, children life satisfaction, etc.).

Kutcher and Chehil (2005) authored a quick structured approach to assessing suicide risk levels called the Tool for Assessment of Suicide Risk (TASR). Readers interested in a copy of the instrument and direction for its use are directed to Kutcher and Chehil 2007. One of the other useful components of the TASR is a list of important questions to ask. A few of those questions are listed here:

1. Do you have thoughts of death or suicide?
2. Do you have a specific plan?
3. What methods have you considered?
4. Do you have access to a plan?
5. Do you have a date and place in mind?
6. If you were alone now would you try to kill yourself?

Along these lines Fremouw, de Perczel, and Ellis (1990), as well as Bassuk (1982), noted that the assessment of a patient's potential suicide risk necessitates the gathering and weighing of a variety of information and data—and the importance of this particular assessment has led these psychologists to construct an impressive decision model that integrates and formalizes the steps for a thorough and reasonable decision about the risk for suicide for a particular patient. Somewhat like Bassuk's (1982) checklist system, their decision model involves seven steps for the psychologist:

1. *The collection of demographic information* (e.g., age, sex, race, marital status, and living situation) to determine whether the patient is in a high-risk or low-risk group.

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2. *The examination of clinical and historical indicators* as the more specific information that ↳ increases or decreases the patient's risk for suicide (e.g., unique historical, environmental, and psychological features that a patient presents in the intake interview, or during ongoing therapy).
    a. Questions about general historical-situational factors (which begin to lead the clinician to be concerned about a higher risk).
    b. Very specific clinical indicators and warning signs that often are the precursors of an imminent attempt (e.g., having a definite plan, strong self-destructive impulses).
    c. Psychological indicators such as recent losses, depression-anxiety, isolation-withdrawal,

hopelessness, disorientation-disorganization, alcohol and drug use, change in clinical features, suicide plan, and final arrangements for his or her own death.

3. *An initial screening for risk*, that is, after examining historical-situational, demographic, and clinical indicators, the clinician must make a decision about whether the potential risk for suicide warrants any further assessment. If there appears to be no risk, assessment and treatment proceed in a routine fashion. However, if there are risk factors in the demographic or clinical-situational-historical matrix, the clinician should assess the current risk for suicide through two formats, initially through interview, and if indicated, by self-report.

4. *Direct assessment of risk* using:

    a. *The clinical interview* (which includes the patient's reasons for feeling suicidal, as well as his or her reasons for living), and, where risk appears mild, moderate, or unknown.

    b. *Assessment by self-report* (e.g., the use of standardized assessment instruments such as the Beck Depression and Hopelessness scales to facilitate a thorough understanding).

5. *Determination of the level of risk and the implementation of a response* (e.g., none to low risk, mild, moderate, high).

6. *Determination of the imminence of risk* (e.g., assessment and documentation of rationale, consultation).

7. *Implementation of treatment strategies* (e.g., intensified outpatient care, voluntary hospitalization, involuntary hospitalization, etc.).

Although the above model is an important contribution as a systematic decision-making tool for the practicing clinician (and may very well represent the future general shape of standard models of assessment/intervention for suicide potential), Motto (1989), in a review of general problems in suicide risk assessment, pointed out one of the concerns is that to date we have no established and generally accepted procedure for clinicians to follow.

Motto (personal communication, July 1998) also noted that the accurate assessment of imminent risk does improve with clinical experience, and that supervision in working with suicidal patients should be a crucial element in all clinical training programs—"there is just no substitute for experience." Rosenberg (1997) pointed out that the suicide prevention literature primarily focuses on action-based interventions (e.g., assessment of risk factors and the use of direct interventions, such as hospitalization) for preventing suicide and that it lacks specific strategies to deal with the patient's emotional pain associated with suicidal ideation. In response to this need, Rosenberg (1997) designed a suicide assessment and intervention training model.

The clinical training approach suggested here differs from present training in several important ways. First, a systematic training model was developed and sequenced with respect to expertise and cognitive psychology principles (see Rosenberg, 1997). Few current training models utilize principles gleaned from this body of literature. Second, this model provides training in basic assessment skills, whereas most other programs focus on teaching basic interviewing or specific counseling skills (e.g., asking open-ended questions and learning reflection-of-feeling responses). Third, affective or feeling-based intervention strategies (intended to address underlying thoughts or feelings of suicide) are highlighted in this approach and supplement action-based strategies that are more commonly used.

Simon (1988) remarked that providing a reasonable standard of care in assessing and diagnosing suicidal patients preempts "the very problematic issue of prediction of suicide for which standards do not exist. Psychiatrists have not been held legally liable for inaccurate predictions of suicide per se" (pp. 86–87).

When discussing what clinicians can do to reduce their legal liability when treating a suicidal patient, Simon (1992) identified "failure to diagnose" (assess the risk of suicide) (p. 274) as one of the three broad categories of negligence of which clinicians should be aware. Only when they "have failed to collect necessary data and logically assess it in making a prediction of suicide have lawsuits against psychiatrists prevailed" (Simon, 1988, pp. 86–87).

However, Lewinsohn, Garrison, Langhinrichsen, and Marsteller (1989) pointed out that the low base rate of
p. 504 suicide makes it very difficult for screening ↳ instruments to predict accurately the degree of suicidal risk for any specific individual. Specifically, the low base rate results in a very large number of false-positive assessments relative to the number of true positives, even when the most effective screening instruments are used.

More recently, however, Bongar (2002) has constructed a comprehensive and integrated decision checklist that draws upon and recognizes the important contributions of Beck, Kovacs, and Weissman's (1979) empirical model (e.g., hopelessness, helplessness, negative cognitions), Fawcett and colleagues' (Fawcett, Scheftner, Clark, Hedeker, Gibbons, & Coryell, 1987) empirical model (e.g., chronic vs. acute, the social matrix, communication of intent), Hirschfeld and Davidson's (1988) epidemiological model, Simon's checklist model, Shneidman's psychological model, and Yufit's suicide assessment team/Suicide Assessment Battery/Suicide Screening Checklist (SAT/SAB/SSC) protocols (1988). This clinical and legal formulation of a standard of care for the assessment of elevated risk (Bongar, 2002) follows the decision checklist tradition and puts forward a large number of specific steps and detection-decision points. However, practitioners should be cautious: Such approaches often offer a possible set of known risk factors and often are not meant to be definitive or exhaustive. Mental health professionals will almost certainly tailor the assessment of elevated risk to what Motto (1989) has shown to be the uniqueness of every decision on suicide probability. Fawcett et al. 1987, using data from a large-scale prospective study of patients with major affective disorders, found that 25 patients (of a total of 954) committed suicide; hopelessness, loss of pleasure or interest, and mood cycling during the index episode differentiated the suicide group. These researchers noted that, although suicide is a relatively frequent event in depressed patients, it still has a statistically low base rate and, therefore, may be statistically unpredictable on an individual basis using cross-sectional measures. Fawcett (1988) did offer a model that, while acknowledging the limitations of the current knowledge base, enumerates a variety of both short-term (acute predictors) and long-term suicide risk features (chronic predictors).

In recognition of the methodological and clinical difficulties in predicting suicide, the core of this chapter on assessment of suicide risk will focus on the collection of critical data and decision points in the clinical formulation, detection, and documentation of "imminent and elevated risk" in the usual and customary populations seen in professional psychological practice. In view of publications that focus specifically on the issues of youth suicide and suicide among the elderly (Berman, Jobes, & Silverman, 2006; Groholt, Ekeberg, & Haldorsen, 2006; Gutierrez, 2006; Heisel & Flett, 2006; McIntosh, Santos, Hubbard, & Overholser, 1994; Wise & Spengler, 1997), this chapter will emphasize more general personality, clinical, and legal issues with regard to the formulation of a standard of care for adult clinical populations.

A clinical approach to the assessment of suicidal patients

1. recognizes the probabilistic nature of risk detection versus risk prediction;
2. acknowledges the strengths and limitations of the traditional diagnostic categories (e.g., DSM (Diagnostic and statistical manual)), as well as the various theories of psychotherapy and psychopathology;
3. understands epidemiologic and clinical risk factors within specific groups, taking into consideration the data on both acute and chronic predictors of risk;

4. remembers when consultation, supervision, and referral are necessary; and

5. integrates a careful clinical history, mental status examination, ongoing clinical evaluations, consultations, information from significant others, and data from psychological assessment and suicide risk estimators/scales into a broad-spectrum information-gathering procedure for systematic assessment and management of detected risk.

Recently, seven factors relevant to suicide risk were identified by Joiner, Walker, Rudd, and Jobes (1999): previous suicidal behavior, type of current suicidal symptoms, precipitant stressors, symptomatic presentation, self-control and impulsivity, predispositions, and protective factors. When present, these seven factors have different implications for overall risk of suicide and are influenced by the patient's status as either a suicide ideator, single attempter, or multiple attempter.

The Modified Scale for Suicidal Ideation (Joiner, Rudd, & Rajab, 1997) identified two factors, "resolved plans and preparation" and "suicidal desire and ideation," as highly indicative of increased suicide risk. "Resolved plans and preparation" include the following symptoms: "a sense of courage to make an attempt, availability of means to and opportunity for attempt, duration of suicidal ideation, and intensity of suicidal ideation" (Joiner et al., 1999, p. 448). The authors suggest that a patient who presents with these symptoms
p. 505 should be considered as at least a moderate ↳ risk for suicide. The second factor, "suicidal desire and ideation," includes the following symptoms: "reasons for living, wish to die, frequency of ideation, wish not to live, passive attempts, desire for attempt, expectancy of attempt, lack of deterrents to attempt, and talk of death and/or suicide" (Joiner et al., 1999, p. 448). In the absence of symptoms associated with the "resolved plans and preparation" factor and the other five factors listed above, and if the patient is not a multiple attempter, then the patient would not be considered at risk for suicide. The patient's past history of suicide attempts is used in conjunction with specific current suicidal symptoms, such as "resolved suicide plans and preparation," and is interpreted in relationship with the other five factors to produce a model for assessment of suicidal risk.

For example, a patient who expresses a wish to die, who talks of suicide, and who reports frequent suicidal ideation can be worrisome to the clinician. In the absence of symptoms from the resolved plans and preparation factor, however (and in the absence of multiple attempt status or complicating factors from other domains), these symptoms do not warrant a high-risk designation. As an additional example, a patient who expresses little desire for death and relatively infrequent suicidal ideation, but who senses high competence and courage to attempt to suicide, who has means and opportunity, and who reports details of a suicide plan, is at high risk, regardless of other factors (Joiner et al., 1999, p. 448).

However, before proceeding, it is essential to emphasize once again that hard and fast actuarial data on the long-term prediction of attempted or completed suicide—predictions that can be directly translated to the emergent clinical moment—do not presently exist. Currently, "there are no pathognomic predictors of suicide" (Simon, 1987, p. 259). Further, we will be following a tradition set by Monahan (1981) in his superb treatise on the clinical prediction of violent behavior, another clinical dilemma suffused with uncertainty and a lack of hard and fast actuarial data, namely, that this chapter represents "nothing more (or less) than the professional judgment of persons experienced at the task of prediction" (Monahan, 1981, p. 101) and that clinicians would do well to follow Meehl's advice that, "when actuarial data do not exist, we must use our heads" (Monahan, 1981, p. 108).

Recent Empirical Evidence on Risk Assessment Practices

In 1990, the Risk Assessment Committee of the American Association of Suicidology (AAS) reported the results of their survey on suicide risk assessment procedures among a random sample of practicing psychologists, psychiatrists, and clinical social workers (including members and nonmembers of the AAS). Although the results of this survey should be interpreted with caution due to the small sample size (n = 5414) and relatively low response rate (38%), they do provide at least an initial glimpse into the assessment practices of practitioners (Jobes, Eyman, & Yufit, 1990). Also of interest was the amount of assessment activity carried out by the respondents, many of whom appeared to be psychologists—they reported evaluating, on the average, 1.9 suicidal adolescents and 2.8 suicidal adults per month.

Specifically, Jobes, et al. (1990) found that:

1. Suicide assessment instruments appear to be used infrequently and are rated as having limited usefulness. For adolescents, the most frequently used were the Beck Hopelessness Scale (BHS) (28%) and the Beck Suicide Intent Scale (SIS) (23%). For adults the most frequently used were BHS (34%) and SIS (28%). These two scales were rated as "somewhat useful" for both adults and adolescents.

2. Although traditional psychological tests are used more frequently, they are not rated as very useful. The most commonly used tests were the Minnesota Multiphasic Personality Inventory (MMPI, 47%), Beck Depression Inventory (BDI, 46%), the Rorschach (44%), and the Thematic Apperception Test (TAT, 42%). Of these, only the BDI received a rating of "somewhat useful."

3. With a few exceptions, there are few major differences in the approaches used to assess acute versus chronic risk, and limited differences in the assessment of adults compared with the assessment of adolescents. Instead, most clinicians clearly rely primarily on the clinical interview to assess suicide (specifically, on certain valued questions and observations).

Linehan (Linehan, Rizvi, Welch, & Page, 2000) updated her 1981 model for analyzing risk factors associated with suicidal behaviors in an effort to determine whether risk factors among patients diagnosed with a personality disorder differ from those among individuals in the general population. Linehan noted that although many of the risk factors are the same, a few factors are actually not significant for individuals with borderline personality disorder. Linehan et al. (2000) also explored why age, marital status, and gender did not appear to indicate a heightened risk for suicidal behavior. They reported that the absence of an effect for
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marital status may be due to low variance in that individuals meeting criteria for ↳ this diagnosis are less likely to be married. The absence of an effect for age may have to do with the follow-up period in the studies reported. None of the studies followed elderly people meeting criteria for borderline personality disorder. The absence of gender difference in suicide parallels findings reported by Kreitman (1977) showing similar rates of suicide for males and females with histories of repeated parasuicidal acts—a criterion for borderlines.

Recent empirical studies of psychologists' reported practice behaviors confirm the primary reliance on the clinical interview as the major risk assessment tool in clinical practice (Card-Strong, 1998; Greaney, 1995; Peruzzi & Bongar, 1999). New empirically based strategies may well be needed to approach the assessment of suicidal potential. Some researchers have turned their attention away from making predictions of patient behavior to clinicians' own views of critical factors when assessing for suicide (Bongar, 1991; Bruno, 1995; Greaney, 1995; Mahrer, 1993), attempting to identify the standards of care for this practice situation. This approach seeks to bridge the study of patient characteristics with that of clinician education, training, and experience in hopes of describing "reasonable and prudent" practitioner behaviors. A profile of these behaviors not only is useful in identifying the standard of care, but can also help identify professional myths and deficiencies in practice, both essential to training and education efforts.

To shed some light on the preferences of active practitioners and their primary reliance on interview and observational data, this chapter will examine the historical and contemporary literature on the use of psychological tests, suicide scales, and risk estimators, as well as the epidemiological and clinical data on risk factors. This leads to the importance of formulation of clinical judgment via important clinical observations and key elements in the clinical interview, as integral components of a model of comprehensive clinical assessment and risk management.

Psychological Testing

The psychological assessment of suicidal risk is a process fraught with personal uneasiness and anxiety on the part of the mental health professional. The burden is awesome, and the responsibility is frightening (Neuringer, 1974a). Neuringer remarked that if all of the methodological problems associated with valid assessment of suicidal risk can be overcome, then the occurrence of false negatives will be severely diminished, which is the aim of suicide assessment.

Motto (1991) stated that because each individual is a unique entity, the nature of assessment and measurement is difficult. He noted that a measure and observation that may determine suicide risk in one person may have different significance or no relevance at all for another person. He concluded that if clinicians are given the opportunity to establish a level of trust that ensures candor and openness, then the clinician is in the optimal position to assess risk in individual cases.

Kaplan, Asnis, Sanderson, and Keswani (1994) reported that there is a high level of agreement between patients disclosing the same information about suicidal behaviors on a self-report measure compared with face-to-face communications with a clinician in a clinical interview. Kaplan found the one exception is that many patients tend to disclose more information regarding recent suicidal ideation on self-report forms. He did not find any discrepancies between self-report and verbal communication on suicidal information that was historical in nature.

However, it should be emphasized that the assessment of a patient's risk for suicide should never be based on a single score or scale. A complete evaluation of risk factors, such as the patient's psychiatric diagnosis, substance abuse, previous suicide attempts, a family history of suicide, and current level of functioning, should be considered in conjunction with psychological assessment results (Bongar, 1992; Maris, Berman, Maltsberger, & Yufit, 1992).

The Rorschach Inkblot Technique

While there has been little agreement on a single assessment tool that can adequately predict suicide, there is agreement that a thorough evaluation includes both a clinical interview and available psychological tests. The Rorschach Comprehensive System (Exner, 2003) is one of the psychological tests frequently used in clinical settings for this purpose (Ganellen, 2005). The following is a review of current approaches and a review of the historical literature on thistopic.

There are several ways to analyze a Rorschach Inkblot method protocol. The traditional method is that of the single sign approach. This approach hinges on the identification of Rorschach variables thought to be associated with suicide. Fowler, Hilsenroth, and Piers (2001) remind us to be cautious of this approach because individual variables are almost always less reliable and have less statistical power than approaches including multiple variables.

The best known single Rorschach variable claimed to be associated with suicidality is the color-shading
p. 507 blend (Ganellen, 2005). An early study by Applebaum ↳ and Holtzman (1962) found an association between one or more color-shading blends and a vulnerability to suicidal behavior. The results have been replicated

throughout the years with and without success (Applebaum & Colson, 1968; Fowler et al., 2001; Hansell, Lerner, Milden, & Ludolph, 1988; Silberg & Armstrong, 1992). Most recently Fowler et al. (2001) found that a near-lethal suicide group of subjects produced significantly more color-shading blend responses than two other control groups.

Another single sign approach is that of examining the record for transparencies or cross-sectional responses. The first significant findings came from a study by Blatt and Ritzler 1974. They compared their small sample (n = 12) of patients who had committed suicide with a matched control group and found that the best differentiating variable was the number of transparencies/cross-sectional responses. These results have been studied and expanded upon by several authors (Fowler et al., 2001; Hansell et al., 1988; Silberg & Armstrong, 1992). A consistent problem with this approach is the relatively high occurrence of transparencies and cross-sectional responses in the protocols of nonsuicidal patients.

A progressive approach to identifying suicide risk with the Comprehensive System was developed by Exner and Wylie 1977. Their pursuit resulted in a cluster of Rorschach variables associated with suicidal behavior. With this cluster of variables, they were initially able to correctly identify 75% of the suicide completes from a sample of both patients and non-patients. This cluster of variables became known as the Rorschach Suicide Constellation (S-CON). It was found to have a high rate of true positives while maintaining a low rate of false positives (Ganellen, 2005). S-CON was eventually revised in 1993 but Wood, Nezworski, and Stejskal (1996) still questioned the validity and reliability of the measure and pointed out that many of the original statistical findings remained unpublished. Fowler et al. (2001) responded to the criticisms by conducting a large-scale study. They found the revised S-CON to do well in distinguishing suicidal and near-lethal suicidal behavior from parasuicidal behavior. Fowler, Hilsenroth, and Piers (2001) did recommend that lowering the S-CON cutoff score would increase its sensitivity. The current recommendation is to use a cut off score of 7 or above.

An articulate and well-structured summary of Rorschach data useful in the identification of individuals at elevated risk for suicide is presented by Ganellen (2005). He identifies five high-risk affective states and the corresponding Rorschach data for each.

> Hopelessness/Despair: Lambda 〈.45; D-score 〈 0; M = 0 or FC + CF + C = 0; m 〉 2 and/or Y 〉 2.
>
> Guilt/Self-Hatred: V 〉 0; FD 〉 2; Fr 〉 0; egocentricity index 〈.33 or 〉.44 with Fr + 0.
>
> Loss/Abandonment: T 〉 or = 2; Food 〉 0; p 〉 a + 1; Mp 〉 Ma
>
> Loneliness/Isolation: Isolation index 〉.33; CDI 〉 or = 4; H 〈 (H) + Hd + (Hd)
>
> Impulsivity: D 〈 0; FM 〈 or = 2; C 〉 0; Zd 〈 or = -.35; M- or Formless M 〉 0

Other interesting studies have been completed recently looking at using the Rorschach in nontraditional ways. Lundback et al. (2006) investigated the link between Cerebrospinal fluid 5-hydroxyindoleacetic acid CSF 5-HIAA and scores on the Rorschach of patient with recent suicide attempts. They found a strong relationship between low CSF 5-HIAA levels and high S-CON and vista scores on the Rorschach for these patients. Grava, Ceroni, Rucci, and Scudellari (2006) found that by using some of Klopfer and Davidson's (1962) indexes they were able to identify the quality of mood, the degree of bad impulse management, and the degree of aggression. These personality structures were linked to a "pathway of suicide" by the authors.

Historically, the Rorschach technique was the most commonly used method for estimating the risk of suicide, although it has been supplanted by more sophisticated psychometric instruments such as the MMPI and various suicide lethality scales (Neuringer, 1974b). Neuringer noted that there has not been any

particular determinant, sign, or set of signs, or content which appears to be associated with suicide under all or even most conditions.

However, the Rorschach may still be a potent tool for assessing the risk of suicide, if it is used correctly. Meyer (1989) argued that Exner's (1978) research provided an elegant and effective tool for the prediction for suicide potential. He cited a large number of specific factors from Exner's seminal contribution *The Rorschach: A Comprehensive System* (Exner, 1978) (e.g., FV + VF + V + FD is greater than 2; occurrence of a color-shading response; Zd is greater than or equal to 3.5; 3r + (2)/R is less than 0.30, experience potential is greater than experience actual; CF1C is greater than FC; S is greater than 3; X1% is less than 0.70; pure H is less than 2; P is greater than 8, or less than 3; R is less than 17). Meyer (1989) noted that a number of authors concur with Exner that the number of responses is low in suicidals, especially when they are depressed, that
p. 508 less integrated color responses are more ↳ common, and that the number of popular responses are either very high or low (Swiercinsky, 1985).

Meyer (1989) also pointed out the importance of content that suggests decay or geographic depression as indicators of suicidal ideation. He noted that "responses that suggest hanging or drowning or other direct means of suicide should obviously alert the examiner to further consideration" (p. 319). Here he is in agreement with Neuringer (1974b), who suggested that the clinician rely most on content from the Rorschach. Neuringer wrote that if suicidal content appears on the Rorschach, it should be taken very seriously since its manifestation could be an indication that self-destructive behavior is close to the surface and that the patient is trying communicate to the examiner.

Meyer (1993) examined the effect of the response frequency (R) on the suicide constellation to determine the effects of the constellation's ability to discriminate among groups when reports deviate from the average length. He determined that within the suicide constellation, longer protocols are significantly more likely to have more than two vista or form dimension scores, a color-shading blend, more than three morbid scores, and more than three space responses. He concluded that more frequent responses are associated with higher scores on the S-CON. Frank (1994) warned that if a person manifests suicidal ideation or behavior and has a Rorschach with indicators of poor form quality (CF5C.FC and X1%, 70), this individual should be considered at risk for suicide.

Eyman and Eyman (1991) maintained that although single signs on the Rorschach have been used to predict suicide potential (e.g., transparency responses and color shading), the results of studies on single signs have been mixed. There is some clinical support for the use of these variables to assess suicide risk but, thus far, the research is insufficient to allow a clinician to feel confident in their use (Eyman & Eyman, 1991).

Silberg and Armstrong (1992) sought to determine the usefulness of the Rorschach in uncovering suicidal potential in hospitalized adolescents. They compared severely depressed nonsuicidal patients with severely depressed suicidal patients to isolate the factors unique to suicidal behavior and unrelated to diagnostic variables. They had 138 subjects with ages ranging from 12 to 18 and carrying a wide variety of diagnoses. They concluded that the adult suicidal constellation did not significantly discriminate among the groups. However, they found that four of the six features of the index selected 64% of suicidal subjects. This indicated that suicidal adolescents are painfully introspective (with FV + VF + V 〉 0), exhibit painful arousal (color-shading blends .1), are morbidly preoccupied (MOR 〉 0), are impulsive (CF1C.FC), and have misperceptions of people (M- and distorted reasoning skills, weighted special scores 〉 9) (Silberg & Armstrong, 1992).

Perhaps the Rorschach can be most useful in the assessment of suicide risk if it is combined with appropriate and sound clinical judgment (Eyman & Eyman, 1991). Eyman and Eyman (1991) cautioned that suicide is too complex a behavior to be adequately captured by a single sign. They suggested that the configurational or constellation approach also shows promise for the use of the Rorschach for the

assessment of risk. They noted that "characterological features can be found among people who are seriously suicidal that differentiate them from mild-attempters and these characteristics can be assessed using the Rorschach and the TAT" (p. 48).

Neuringer (1974b) further cautioned that the clinician should not make an inference about suicidal intention from the Rorschach by itself; that case history material, and data from other psychometric instruments, can help to maximize the accuracy of the decision-making process. He concluded that "the clinician should strive to have all the data possible available to him. The presence of previous suicidal attempts and threats should compound the danger associated with the presence of suicidal Rorschach content" (p. 91). For additional information on use of the Rorschach with the suicidal patient, the reader is directed to Exner (1978, 1986), Eyman and Eyman 1991, Meyer 1989, and Neuringer (1974b).

Minnesota Multiphasic Personality Inventory (MMPI, MMPI-2, and MMPI-A)

The MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) and its corresponding adolescent version, the MMPI-A (Butcher et al., 1992), are the most widely used instruments for assessing psychopathology in clinical practice (Greene, 2000) and are the most widely used objective personality assesment measures in the world (Archer & Newsom, 2000; Friedman, Lewak, Nichols, & Webb, 2001).

Inconsistent findings among retrospective comparisons of suicide attempters and nonattempting comparison groups have led some researchers (e.g., Eyman & Eyman, 1991) to conclude that, despite considerable research effort, no MMPI item, scale, or profile configuration has been found to consistently differentiate suicidal and nonsuicidal patients. They did concede that the restandardized MMPI-2 may provide more valid indicators of suicidality.

p. 509 An articulate decription of the current trend in MMPI suicide research is presented by Friedman, Archer, and Handel (2005) who wrote:

> The move to a risk assessment model from dangerousness prediction per se can also be applied to MMPI interpretation. Numerous factors influence an individual to think and behave in a suicidal (homocidal) manner. ... The exacerbation of severe psychiatric symptoms may also increase suicidal risk such as common hallucinations, intolerable depressive symptoms, or alcohol and/or drug intoxication. The value of the MMPI lies in being part of a risk assessment mosaic that includes interview data, collateral sources of information, and other psychometric data to help serve the mission of estimating suicide potential rather than the prediction of actual suicide. In this fashion, the test data can help inform and guide a risk management strategy. (p. 65)

With the release of the MMPI-2, there became available to practitioners the Koss-Butcher Critical Item Set-Revised, listing 22 items that are related specifically to depressed suicidal ideation. However, Butcher (1989) noted that these critical items are not "designed to operate as scales. They are used to highlight item content that might be particularly significant in the individual's case. As sources of clinical hypotheses, the critical items might be used to key the clinician into problem areas or concerns the patient may have" (Butcher, 1989, p. 17). (For additional information on the specifics of these critical items, the reader is directed to the work of Butcher, 1989; Butcher et al., 1989).

Although the majority of studies investigating the utility of the MMPI instruments during suicide assessment focused on the original version of the test, two recent studies evaluated the utility of the revised version of the test (the MMPI-2: Butcher et al., 1989) for the assessment of suicide potential. Sepaher, Bongar, and Greene (1999) found that approximately 20% of psychiatric patients endorsed items 506 and 520 among nine different well-defined MMPI-2 code types. These items were referred to as the "I mean business" items by Sepaher et al. because both directly inquire about a recent history of suicidal ideation or

intent. Glassmire et al. (2001) found that these and four additional similar items (150, 303, 524, and 530) were often endorsed by psychotherapy patients who had recently denied a history of suicidality during an intake interview. The authors found that a large percentage of patients who endorsed at least one of the MMPI-2 suicide items also denied suicidal ideation or behavior during a telephone intake interview. The authors found that these six items could be grouped together to provide a highly face-valid and internally consistent scale of self-reported suicide potential they called the Suicide Potential Scale (SPS). The reader is referred to this article by Glassmire et al. for a table containing linear T-score conversions for this scale based on a large clinical sample.

Additionally, a study (Stolberg, Glassmire, Ricci, Greene, & Bongar, 1999) designed to establish practice guidelines and a standard of care for the use of the MMPI-2 with suicidal patients examined how a select group of specialists used the MMPI/MMPI-2 to assess risk. Delphi methodology was used, which resulted in expert consensus on the following questions: (a) How (if at all) do you use the Validity Scales to assess for suicide potential? (b) How (if at all) do you use the Clinical Scales to assess for suicide potential? (c) Which specific items, or questions, if any, do you use when assessing for suicide potential? (d) "How (if at all) do you use other Scales (e.g., Content, Supplementary, Research Scales) to assess for suicide potential?

Clopton (1974), in an extensive review of the MMPI and the assessment of suicide risk, pointed to the findings of Dahlstrom, Welsh, and Dalhstrom (1972) that the degree of the person's depression, that is, an elevated score on Scale 2 (D) of the MMPI, was a mood state frequently associated with a preoccupation with death and suicide. He continued:

> The implication of high scores on scale 2 depend on other features of the MMPI and upon the behavior of the person taking the test. For instance, it is their conclusion (Dahlstrom et al., 1972) that suicidal risk is greater when a person's MMPI results show a significant elevation on scale 2 but his behavior does not give any indication of depression, and he denies depressive thoughts and feelings, than when the depression indicated by a scale 2 elevation is clearly reflected in the person's behavior. (p. 118)

Clopton also noted that the one standard MMPI scale found the most frequently to differentiate suicidal and nonsuicidal groups was Scale 2. Meyer (1989) agreed, and stated that the prototypical pattern for suicidal individuals is the 2–7/7–2 combination on the MMPI. He felt that this code specifically indicates the presence of suicidal ideation, and that whenever Scale 2 is elevated above 80T, the clinician should raise the possibility suicidal ideation.

Meyer also pointed out that the critical items on the MMPI concerning suicide should always be carefully
p. 510 checked and that the likelihood of suicidal ↳ ideation "being actualized increases as scores on scale 4, 8, and 9 rise, reflecting greater loss of control over impulses, a rise in energy available for behavior, and an increasing sense of isolation and resentment toward other people" (p. 317), respectively. Specifically, a rise in Scale 8 indicates that suicidal patients may actually kill themselves whether or not they want to succeed; their impaired judgment may bring about an inadvertent suicide. He also noted that people can become suicidal following a severe loss in their psychosocial world and that a high spike on Scale 2 is characteristic of these circumstances. Meyer believes that the "2–4/4–2 code is more likely to reflect a manipulative suicide. Where both scales 4 and 6 are elevated, in addition to at least a moderate elevation on scales 2 and 7, repressed anger and interpersonal hostility are as basic to a suicide attempt as manipulation" (p. 318).

Craig and Olsen (1990) compared drug addicts without a history of suicide attempts to drug addicts with a history of suicide attempts. They found that suicide attempters were characterized by higher levels of maladjustment (mostly in the areas of depression) and feelings of alienation, were more prone to utilize projection and externalization, and were more emotionally withdrawn. Significant differences were found

on scales F, K, Depression, Hysteria, Psychopathic Deviance, Masculinity/ Femininity, Paranoia, Psychasthenia, Schizophrenia, and Social Introversion.

Except for K, the suicidal attempters obtained higher mean scores. The modal profile of the suicide attempter group (excluding scales Mf and Si) had an average T-score elevation of 73.12 compared with 66.12 of the nonsuicidal group. In addition, suicidal ideators scored highest on the Pd scale compared with nonattempters and attempters. Suicide attempters scored higher on content scales DEP, ORG, and MOR compared with the no-history of attempt group. Attempters and ideators scored higher on the FAM content scale compared with the no-history group. Code types found to be unique to the suicide attempt group were 1–8/8–1, 2–9/9–2, 4–3, and 5–9. Code types that were specific to the no-history group were 2, 5, 9, 1–9, 6–2, and 8–9. In the suicide attempt group, 42% of the codes comprised the 2–4/4–2, 4–9/ 9–4, 4–8/8–4, and 6–8/8–6 code types.

Finally, Osborne 1985, after reviewing the use of the MMPI in psychiatric practice, argued that the MMPI is best used within the context of other information-gathering techniques and should be viewed as providing the clinician with hypotheses that can be verified with other methods. Such other methods could include the use of other psychological tests, suicide scales, and risk estimators, and a comprehensive clinical interview and history (Hendren, 1990).

In addition to the extensive research on the MMPI/MMPI-2 there are several MMPI-A studies that can guide the interested clinician. Forbey and Ben-Porath (1998) developed a critical item set for the MMPI-A using a combination of empirical and rational procedures. Their six-item set includes two items (177 and 283) that explicitly inquire about suicidal ideation. Archer and Slesinger (1999) included one additional item (399) which asks about hopelessness and explored the endorsement frequency of these three items in relation to MMPI-A mean clinical scale elevations and codetype classifications (Friedman et al., 2005). They found that adolescents who endorsed these three items more frequently produced spike 2 or spike 8 profiles, and 4–8/8–4, 8–9/9–8, 6–8/8–6 profiles.

16-PF

Meyer and Deitsch (1996) noted that on the Sixteen Personality Factors (16-PF), suicide attempters appear consistently to show themselves as shy, tense, suspicious, expedient, emotionally unstable, apprehensive, self-sufficient, somewhat introverted, and extremely anxious: "Translated into 16 PF scales, this means high scores on Q4, O, 1, Q2 and lower scores on G, H, and C. Furthermore, repeat attempters typically score lower on scales Q3 and C than do first-time attempters, indicating less stability and more impulsivity" (p. 318).

Millon Clinical Multiaxial Inventory: MCMI-III and MACI

McCann and Suess (1988) examined the Millon Clinical Multiaxial Inventory (MCMI) profiles of 131 psychiatric inpatients to identify 1–2–3–8 code types on the basic personality scales. This profile reflects a schizoid, avoidant, dependent, and passive-aggressive blend of personality traits. Approximately 25% of the subjects obtained the 1–2–3–8 code type. The authors' analyses of the diagnoses and clinical records of these patients suggested that this profile reflects an affect/mood disturbance with prominent depressive features and suicidal ideation or suicide attempt prior to admission in the hospital. Summarizing, Meyer and Deitsch (1996) wrote of the MCMI that:

> As might be expected, elevations on the MCMI of 85 or higher on D and CC, and a high score on the Desirability Scale would be indicative of suicide potential ↳ (Choca, 1992). If N begins to increase and a very high D begins to decrease on repeated testing, the patient may be acquiring the

> necessary resolve and energy to complete the act; thus suicide potential may be high. Those personality patterns most likely to exhibit suicide potential are indicated by elevated scores on 2, 8A, 5, and/or C. These patterns are the most inconsistent and they are particularly susceptible to poorly developed support systems. High scores on scale 8A are particularly associated with manipulative suicide potential. (pp. 382–383)

McCann and Gergelis (1990) compared MCMI-II profiles of 40 psychiatric inpatients admitted for suicidal ideation with those of 40 patients admitted for a suicide attempt. They concluded that suicide attempters scored significantly higher on Scale Y (desirability) compared with ideators. Elevations on Scale Y indicate suicide attempters have a higher tendency to deny problem areas, generate socially desirable response sets, and conceal psychological and interpersonal difficulties. Ellis, Rudd, Rajab, and Wehrly (1996) cluster-analyzed MCMI scores from 299 suicidal psychiatric outpatients. Four personality profiles emerged from their cluster analysis: negativistic/avoidant/schizoid, avoidant/dependent/ negativistic, antisocial, and histrionic/narcissistic.

The Millon Adolescent Personality Inventory (MACI) 1993 includes scales not found on its parent inventory, the MCMI-III. Most importantly, the MACI contains two points of reference for identification of suicidal ideation. Scale GG (Suicidal Tendency) assesses suicidal ideation and planning. Adolescents who score high on this scale may contemplate suicide as an option to end their pain and suffering. Their depressive states are described as severe even to the point of losing sight of reasons to live (Strack, 2002). Additionally, the MACI contains a scale named Borderline Tendency (Scale 9). Adolescents who score high on this scale experience periods of marked behavioral and emotional dysregulation. Scale 9 has four content scales, one of which is called Suicidal Impulsivity. This content scale highlights the self-destructive ideations and suicide attempts that are associated with the borderline personality structure (Strack, 2002).

The Personality Assessment Instrument

The Personality Assessment Instrument (PAI; Morey, 1991) is another commonly used personality assessment instrument that has been used for the identification of suicidal ideation and hopelessness. The PAI contains a treatment scale called Suicidal Ideation (SUI). The SUI includes items that range from thinking about death, to contemplating suicide to a current serious consideration of suicide (Morey, 2003). High scores on this scale indicate that a person is thinking about suicide, it is not a prediction of suicide completion tool. As scores on this scale go up, so does the level of risk. Scores above 100T indicate a morbid preoccupation of death and suicide. Potential for suicide must be assessed immediately and interventions should be implemented without delay (Morey, 2003). The SUI scale has been found to correlate with suicide precaution status in clinical patients who have conveyed suicidal ideation (Morey, 1991). Similarly, Rogers, Ustad, and Salekin (1998) found correlations between the PAI SUI scale and suicidal symptoms as assessed via structured clinical interview.

Similar to the MACI, the PAI has a scale which measures borderline features (Borderline Features, BOR). It has a subscale appropriately called Self-Harm (BOR-S). This scale reflects a tendency to act impulsively, without concern of the consequences. High scores on BOR-S reflect levels of recklessness that may include self-mutilation and suicidal behavior (Morey, 2003). Appropriate steps should be taken to evaluate the level of dangerousness for individuals who score high on this scale.

Thematic Apperception Test

After a review of the literature on the TAT as a diagnostic instrument for the assessment of suicide risk, McEvoy (1974) concluded that the literature on the use of the TAT as an estimator of suicide risk is clearly disappointing. He stated that the research is scarce and not easily compared. Perhaps the only general conclusion is that the test has not proved to be useful for this purpose.

Since that time there have been numerous studies on the utility of the TAT for identifying suicidal ideation (Adkins & Parker, 1996; Junuwine, 2001; Litinsky & Haslam, 1998; Ngai, 2001; Yufit, 2005). Despite a body of literature on the topic there has always been strong "clinical lore" that specific TAT cards could be used for the assessment of suicide risk. The "suicide cards" (3BM and 14) were thought to offer ambiguous scenarios that elicited responses from patients that were contemplating suicide. Card 3BM shows a figure sitting on the floor with what can be perceived as either a set of keys or a gun on the floor next to the individual. Card 14 shows a male figure in silhouette in a window frame. Clinical tradition indicates that people contemplating suicide more often tell a story in which the figure jumps out the open window (Litinsky &
p. 512 Haslam, 1998). Other ↳ cards that have shown promise in the assessment of risk include cards 1 and 12BG (Yufit, 2005) A thorough review of any suicidal content is always recommended, regardless of the card.

Beck Depression Inventory and Beck Hopelessness Scale

Although the BDI is a widely accepted measure of face valid depression, it has not escaped criticism (Reinecke & Franklin-Scott, 2005). These concerns lead to the development of a revised BDI, the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996). Overall, 23 changes were made to the existing scale. The changes included dropping items (4), adding items (4), and rewording 17 questions. The BDI-II still consists of 23 items rated on a 0–3 scale. Total scores range from 0 to 63. While the two instruments have a high correlation (.93), the mean BDI-II score appears to be 1.54 times higher than the mean BDI score (Reinecke & Franklin-Scott, 2005). Thus, it is suggested that a higher cutoff score is needed. Little research with suicidal patients has been done with this instrument and a large number of clinicians still rely heavily on the tried and true BDI.

As Piotrowski, Sherry, & Keller 1985, Beck and Steer (1987) themselves observed, during the last 26 years the "BDI has become one of the most widely accepted instruments in clinical psychology and psychiatry for assessing the intensity of depression in psychiatric patients (Piotrowski, Sherry, & Keller, 1985) and for detecting possible depression in normal populations (Beck, Steer, Kovacs, & Garrison, 1985)" (p. 1). A BDI total score can provide an estimate of the severity of the overall depression. Yet Beck and Steer stressed that it is also important to attend to specific item content.

In particular, special attention should be given to those symptoms relevant to suicide ideation (p. 7). Beck et al. (1985) have pointed out that that the BDI's pessimism item (Item 2) "was nearly as predictive of eventual suicide in 211 suicide ideators as the 20 item Hopelessness Scale (HS)" (Beck, Weissman, Lester, & Trexler, 1974). Patients admitting to suicide ideation (Item 9) and hopelessness (Item 2) with ratings of 3 or 4 should be closely scrutinized for suicide potential.

It is also important to observe the overall pattern of the depression symptoms that the patient is describing. The BDI reflects not only cognitive and affective symptoms, but also somatic and vegetative symptoms. For example, some suicidal patients will not express suicide ideation, but have actually stopped eating and sleeping (Beck & Steer, 1987, pp. 7–8).

Because scores on the BHS produce only an estimate of the overall severity of hopelessness (i.e., the severity of an individual's negative attitudes about the future), Beck and Steer (1988) pointed out that it is clinically important to pay attention to other aspects of psychological functioning, in particular the patient's levels of

suicidal ideation and depression. They noted the study by Beck and coworkers (1985) which reported that BHS scores of nine or more were predictive of eventual suicide in 10 out of 11 depressed suicide ideators who were followed for 5–10 years after discharge from the hospital, pointing to earlier findings that hopelessness has repeatedly been found to be a better predictor of suicidal intention than depression per se (Beck, 1986). Beck and Steer (1988) concluded that patients describing moderate to severe levels of hopelessness should be closely scrutinized for suicide potential.

Furthermore, Beck et al. (1985) found that, in a 10-year prospective follow-up of 165 psychiatric patients who had been hospitalized for suicidal ideation, hopelessness was highly predictive of eventual suicide. Of the 11 patients in their study who went on to complete suicide, 10 (90.9%) had BHS scores greater than or equal to 9. Beck and colleagues recently extended this investigation to an outpatient population and found that in a prospective study of 1,958 outpatients seen at the Center for Cognitive Therapy, hopelessness (as measured on the BHS) was significantly related to completed suicide (Beck, Brown, Berchick, Stewart, & Steer, 1990). Beck and colleagues specifically found that a BHS cutoff score of 9 or above identified 16 (94.2%) of the 17 eventual suicides, thus replicating a previous study with hospitalized patients. The high-risk group identified by this cutoff score was 11 times more likely to commit suicide than the rest of the outpatients. The BHS thus may be used as a sensitive indicator of suicidal potential (p. 190).

Bongar (2002) reviewed research by Beck and colleagues and concluded that a score of 9 or more on the BHS is a useful cutoff for elevated risk. However, it is important to note that Beck and Steer (1988) also gave several case examples to demonstrate the complexities involved in using the BHS and BDI as predictors of suicide during therapy. They cited the case of a patient who, at the time of his evaluation, showed on his self-report and interview report the signs of severe depression, but no suicidal ideation.

His BDI score, for example, was 45. He endorsed Item 9 as "I don't have thoughts of killing myself."

p. 513 Similarly, the Scale for Suicide Ideation (SSI) did not indicate current suicidal thoughts or plans. However, his BHS score was 20. He came in for three consecutive sessions, cancelled the fourth, and did not show up for the next scheduled appointment. Scores on the BDI during the three sessions he had kept dropped from 45 at admission to 35, 37, and 37, respectively. During the sessions the patient denied verbally and on self-report forms any suicidal thoughts or plans. However, his BHS remained high (again a score of 20; Beck & Steer, 1988, p. 22).

The case of this patient, who killed himself 3 days prior to the next scheduled appointment, demonstrates that "in the presence of a high BHS and dropping BDI, a psychotherapist should be alert to the possibility of a suicide attempt" (Beck & Steer, 1988, p. 22). Here, Beck and Steer noted that the BHS accurately reflected suicidal risk "whereas the patient&s self report of suicidal ideation or suicidal item on the BDI did not" (p. 22). Beck and Steer also emphasized the need to inquire about reasons for any specific hopeless responses to BHS items, as the clinical exploration of these responses may lead to the patient's acknowledging suicidal wishes. They noted that the BHS is also a valuable tool for indicating that the patient is still pessimistic (and possibly suicidal) even though significant improvement in symptoms has occurred. By discussing the specifically endorsed items on the BHS with the patient, the therapist can pinpoint some of the particular situational and psychological factors contributing to a therapeutic impasse. Focusing on specific relevant items on the BHS can help to break up a pervasive hopelessness and foster collaboration (Beck & Steer, 1988, pp. 24–25).

For the purposes of risk detection, a score of 9 or higher on the BHS is of particular importance, because the BHS attempts to identify the "potential for fatal suicide attempts and not the behavior itself. ... In interpreting the results of the present studies, hopelessness may best be construed as a risk factor, perhaps analogous to a history of smoking or elevated blood pressure as a predispositional factor in heart disease" (Beck et al., 1990, p. 194). Young et al. (1996) reported that stable levels of hopelessness over time may be

more predictive of suicide attempts than a high level of current hopelessness at any one point in time, in patients with remitted depression.

Beck, Brown, Steer, Dahlsgaard, and Grisham (1999) designed a study to calculate odds ratios and to determine the usefulness of using the BHS for suicide ideation at its worst point in the patient's life (SSI-W), for measuring current suicide ideation (SSI-C), and for identifying patients at higher risk for suicide. They found that patients who scored in the "higher risk" category for "suicide ideation at its worst point in their lives" had 14 times higher odds of committing suicide than patients who scored in the "lower risk" category. In contrast, patients who scored in the "higher risk" category for current suicide ideation or for hopelessness had approximately 6 times higher odds of committing suicide (p. 7).

The SSI-W was found to be a significant predictor of eventual suicide and there was a "significant trend for the unique contribution" of hopelessness, as captured by the BHS. Current suicide ideation (SSI-C) was not found to be a significant predictor of suicide. This study indicated that clinicians should assess for the severity of past suicide ideation and for stable levels of hopelessness over a continued period of time as opposed to focusing solely on the patient's current suicidal ideation (Beck et al., 1999). It was noted that outpatients with high scores on the SSI-W and consistently high scores on the BHS who do not respond to therapy should be considered as a high-risk group for eventual suicide (Beck et al., 1999).

Assessment of Suicidal Ideation, Intent, and Behavior

A number of years ago, the Suicide and Suicidal Behavior Program of the Mood, Affective, and Personality Disorders Research Branch of the Division of Clinical Research at the National Institute of Mental Health convened a workshop to discuss and address "common problems and issues in research methodology with emphasis on developing a common core of assessment tools and standardized terminology (e.g., suicide versus attempted suicide)" (Alcohol, Drug Abuse, and Mental Health Administration, 1989, pp. 1–81) for use in the study of suicide. Also, the Child and Adolescent Disorders Research Branch of the Division of Clinical Research commissioned an exhaustive study that reviewed scales suitable for epidemiological and clinical research for the assessment of suicidal behavior in adolescents (Lewinsohn et al., 1989). Although these activities are certainly an important step toward promoting comparative nationwide clinical research efforts for the study of suicide via the use of a standardized set of assessment instruments, it is important to note that these recommendations and workshops have as their purpose the optimization of efforts toward collaborative and comparative clinical research, rather than the setting of "standards for frontline clinical practice."

p. 514 This ambitious attempt to standardize the assessment of suicide risk for the purposes of clinical research follows a long tradition of efforts at estimating and assessing the risk of attempted and completed suicide. These efforts have included assessment protocols that contain both standardized psychological tests and suicide risk estimator and lethality scales.

Motto (1989) noted that methodological and practical problems have plagued the development of scales of suicide risk. Some of the important obstacles have been small samples, limited data, a low base rate, nongeneralizabilty of critical stressors, and the individual uniqueness of suicidal persons.

Lewinsohn and colleagues 1989, after comprehensively evaluating all available assessment instruments used to study suicidal behaviors in adolescents and young adults for the NIMH, concluded that the success of the various instruments to determine which individuals are at high risk for suicidal behavior or other forms of self-destructive action has not been determined (pp. 97–98).

As can be seen from the ongoing efforts of the NIMH, there continues to be enormous interest in the development of suicide risk scales and estimators. Motto (1989) stated that historically the only well-known measure was a little-used suicide risk scale of the MMPI and that contemporary efforts at scale construction began in 1963 when the Los Angeles Suicide Prevention Center developed a special scale for assessing callers to their center (Farberow, Helig, & Litman, 1968). Motto noted that this scale has been widely used by suicide prevention and crisis centers.

The Los Angeles Suicide Prevention Center Scale focuses on demographic and clinical characteristics of patients. Bassuk (1982) noted that, in this regard, it is similar to Tuckman and Youngman's (1968) Scale for Assessing Suicide Risk (SASR). The SASR is a scale used to identify among suicide attempters those persons with a high potential to commit suicide. However, citing problems of replication, Eyman and Eyman (1991) conclude that the "scale [SASR] is not useful for a psychiatric population and [we] also believe its use is premature in a general population as the original finding has not been replicated" (p. 23).

Also, the Index of Potential Suicide (Zung, 1974), which measures potential suicide risk and includes both clinical and social-demographic variables, has been shown to distinguish adequately between patients with no suicidal behavior and those with a history of suicidal behavior. However, this scale does not seem to have good predictive validity (Eyman & Eyman, 1991).

With regard to the evaluation of an actual suicide attempt scale, there have been several important developments. The Firestone Assessment of Self-Destructive Thoughts (FAST) was developed by Firestone and Seiden (1990) and is based on the concept that suicide and self-destructive behavior are influenced by an inner "voice" (e.g., a negative thought process). The voice process represents a well-integrated pattern of thoughts, attitudes, and beliefs, antithetical to self and hostile toward others, that is at the core of the patient's self-limitations and self-defeating actions. The voice varies along a continuum of intensity ranging from mild self-criticism to angry self-attacks and suicidal thoughts.

The FAST is a self-report questionnaire designed to be used as a screening instrument (Firestone & Firestone, 1996). The patient endorses frequency of negative thoughts on a 5-point Likert-type scale. These self-destructive thoughts can be conceptualized along the Continuum of Negative Thought Patterns and help clinicians direct their interventions toward the areas where their patients are experiencing psychological pain (Firestone & Firestone, 1996; Firestone & Seiden, 1990). Knowledge of where a patient score falls on the continuum can also assist clinicians in identifying patients who are at increased risk for suicide. Table 26.1 presents some of the items on the FAST.

The Suicidal Ideation Questionnaire (SIQ) (Reynolds, 1987, 1988), the Adult Suicidal Ideation Questionnaire (ASIQ) (Reynolds, 1991), and the Suicidal Behavior History Form (SBHF) (Reynolds & Mazza, 1992) were developed in response to the growing demand by clinicians for an effective and efficient way to assess for suicide ideation and systematically obtain information on a patient's history of suicidal behavior (Reynolds, 1987, 1988, 1991; Reynolds & Mazza, 1992). The ASIQ is a derivation of the 30-item SIQ that was initially developed for the assessment of suicidal ideation in adolescents. The ASIQ consists of 25 items that measure a specific suicidal thought or behavior. The patient rates each ASIQ item on a 7-point scale, ranging from general wishes of death to specific thoughts or plans, which assess the frequency of occurrence within the past month. High scores indicate frequent suicidal thoughts. The SBHF provides a format for the evaluation and documentation of previous suicidal behaviors. It can be used with adults and adolescents.

One historically important scale is the Risk-Rescue Scale developed by Weissman and Worden (1974), which
p. 515 defines a suicide attempt as an "event ↳ where the risk of death is extremely high and probability of rescue is extremely low" (Shneidman, 1985, p. 20). Smith, Conroy, and Ehler developed an 11-point scale, the Lethality of Suicide Attempt Rating Scale (LSARS), to measure the degree of lethality of a suicide attempt. Eyman and Eyman 1991, in their review of the assessment of suicide using psychological tests, found that

the LSARS was a valuable tool in assessing the lethality of intent and method from a previous suicide attempt.

Table 26.1. **Selected items from the Firestone Assessment of Self-Destructive Thoughts.**

Level 1: ***Self-depreciating thoughts of everyday life***
You just don't fit in.
You're different from other people.
Level 2: *Thoughts rationalizing self-denial*
You're too shy to make any new friends.
Look at all you have to do.
You're never going to get finished.
You can't take any time off.
Level 3: *Cynical attitudes toward others*
Can't you see he (she) is just taking advantage of you?
He (She) is such an exploitative person.
You can't trust men (women). Just depend on yourself.
Level 4: *Thoughts influencing isolation*
Just stay in the background.
Don't make waves.
Just look normal, don't let anybody know how you really feel.
Level 5: *Self-contempt: vicious self-abusive thoughts*
You can't do anything right!
You're disgusting!
You're a failure, a total failure.
Level 6: *Thoughts that support the cycle of addiction*
Have another drink (cookie).
You need to relax.
Go ahead and drink, you deserve it.
Level 7: *Thoughts contributing to a sense of hopelessness*
Your future is hopeless; things will never get better.
You're a burden to your family.
They'd be better off without you.
Level 8: *Giving up on oneself*
Nothing makes any difference anymore.
Why go on living?

The world is not a place that you can live in.
Level 9: *Injunctions to inflict self-harm*
Step off the curb, walk in front of that car.
Smash yourself, get yourself off this earth.
Level 10: *Thoughts planning details of suicide*
Pick a time, find a time when nobody will notice you're missing.
You're so miserable; you can't stand it anymore.
Just get out of it.
Get the pills to do it.
Level 11: *Injunctions to carry out suicide plans*
Why don't you end it all?
Go ahead! It'll be over in a minute.
Just do it. Kill yourself!

However, despite the development of a number of alternative instruments (Beck, Schuyler, & Herman, 1974; Cohen, Motto, & Seiden, 1966; Poeldinger, Gehring, & Blaser, 1973; Weissman & Worden, 1972; Yufit & Benzies, 1973; Zung, 1974), such instruments remain primarily useful "as research tools rather than aids for frontline clinicians" (Motto, 1989, p. 249).

As Motto (1989) noted, an alternative approach to the search for generalized indicators of risk has been to examine precisely defined populations and settings and to develop scales that would be "situation-specific" (p. 249), as, for example, the attempt by Litman (1975) to provide:

"An estimate of risk for nineteen different patient populations, such as suicide attempters seen in the hospital (moderate risk), depressed alcoholic middle-aged male callers to Suicide Prevention Center (high risk), and young female suicide attempters (low risk). Subsequent work continues to focus on "clinical models," defined in terms of personality characteristics or clinical picture; for example, "stable with forced change," "alienated," "nice person," "alcohol abuse," "drug abuse" (Motto, 1977, 1979), or "suicide attempter" (Pallis, Barraclough, Levey, Jenkins, & Sainsbury, 1982; Pallis, Gibbons, & Pierce, 1984) ... as with earlier studies, these reports generated interest among researchers but did not have a demonstrable impact on clinical practice (p. 249)."

To the appraisal contained in the above list, Eyman and Eyman (1991) would add the work of Buglass and McCulloch (1970) and their Scale for Predicting Subsequent Suicidal Behavior, as well as Miskimins, DeCook, Wilson, and Maley's (1967) Suicide Potential Scale.

One probable explanation for the lack of impact of such scales, collectively or individually, is that in their development, "little attention was paid to providing clinicians with a simple brief procedure that could be quickly translated into a clear indication of suicide risk" (Motto, 1989, p. 250). However, there have been recent attempts to construct clinically useful screening instruments for utilization by the clinician. The following examples are meant to be representative of this approach to the assessment of suicide, rather

than an exhaustive list of all available instruments. (For a model of such lists, the reader is directed to Eyman and Eyman [1991], and to Lewinsohn et al. [1989].)

p. 516 Fremouw and colleagues (1990) noted the utility of the Reasons for Living Inventory (Linehan, 1985), a self-report measure with 48 items, including items that reveal the belief systems of a patient that "may serve as mediators of suicidal behaviors" (n.b., psychometric properties are still under investigation, and cutoff scores for the scale are currently unavailable). They pointed out that this self-report measure has been found to discriminate between suicidal and nonsuicidal individuals; specifically, Linehan's (1985) findings indicated "the absence of strong positive reasons to live are most indicative of suicidal behavior" (Fremouw et al., 1990, p. 56).

Eyman and Eyman (1991) noted that the Hillson Adolescent Profile (Inwald, Brobst, & Morrissey, 1987), which contains 310 true/false items, appears to be a promising tool for distinguishing suicidal and nonsuicidal adolescents in school and offender populations. They also noted that the Suicidal Ideation Questionnaire (SIQ; Reynolds, 1988), which was developed to assess adolescents' thoughts about death and suicide, may be more appropriate and useful for school populations than for psychiatric ones.

The Suicide Probability Scale (SPS) is a short self-report measure designed to assist in the assessment of suicide risk in both adults and adolescents. This 36-item self-report measure asks patients to rate their present and past behaviors on a 4-point Likert scale. Cull and Gill (1982) pointed out that the assessment of suicide risk can be shown in three summary scores: a total weighted score, a normalized T-score, and a suicide probability score that can be adjusted to accommodate different a priori base rates for particular clinical populations.

This instrument, although serving as a useful model for interesting future directions in the development of assessment instruments, has a number of limitations. The intent of the scale is not particularly disguised, and it assesses an individual's reported feelings and behaviors only at one point in time. However, as the authors themselves recognized, further research on this instrument is needed to establish predictive validity, replicate findings with a wider range of representative samples, and assess the incremental validity of the SPS "in predicting suicidal behaviors beyond what could be predicted on the basis of commonly available patient demographic and clinical characteristics alone" (Cull & Gill, 1982, p. 61).

Beck and colleagues developed two important scales for the measurement of suicidal ideation and intent. These are the SSI and the Suicide Intent Scale (SIS) (Beck, Kovacs, & Weissman, 1979; Beck et al., 1974). The SSI has been used in several studies to measure intensity, duration, and specificity of psychiatric patients' wishes to commit suicide (Beck, Steer, & Ranieri, 1988). The SSI is a 19-item instrument that a trained clinician may use to rate the severity of a patient's suicidal thoughts and plans on a 3-point scale that ranges from 0 to 2. Rather than employing cutoff scores, a clinician who detects any positive ideation on Item 4 (Active Wish-to-Die) or Item 5 (Passive Wish-to-Die) rates the patients on the remaining 14 items of the scale. The Center for Cognitive Therapy recommends that SSI total scores be used only as measures of suicide ideation in "true" ideators and not in general clinical populations. From a clinical standpoint, the Center for Cognitive Therapy considers an SSI score of 10 or higher as indicating suicidal risk and suggests that patients be followed closely.

Lewinsohn et al. (1989) recognized the SSI as a carefully developed, reliable instrument for measuring suicidal ideation. Beck et al. (1988) also reported that the SSI, in a self-report version, can be a reliable method for measuring the severity of suicide ideation in both outpatients and inpatients. However, they noted that "although the present study indicates that the SSI represents a valid and reliable method for rapidly estimating suicide ideation in psychiatric patients, it is not recommended that the self-report version of the SSI replace clinical interviewing as a method for evaluating a patient's suicide plans and

thoughts. The self-report version represents another tool for multimethod assessment of suicide ideation" (p. 504).

Lewinsohn and coworkers (1989) concluded: "given that intentionality is an important construct in the study of suicide, the SIS represents the only rationally derived scale to evaluate suicidal intent" (p. 15). They cited Steer and Beck's (1988) belief that "the information elicited by this test can help clinicians judge how serious the attempt was and might be again, while noting that its use is restricted to people who have made a previous attempt which is a high risk group" (Lewinsohn et al., 1989, p. 15). The SSI and the SIS represent important directions for future clinical research efforts and further the cause of combining clinical interview with clinical assessment protocols such that suicidal ideation and intent may be assessed more systematically. From a general clinical assessment perspective, Bassuk (1982) concluded that "by using the
p. 517 scale for suicidal ideation, the hopelessness scale, and the suicide ↳ intent scale, the interviewer can assess either directly or indirectly the seriousness of the patient's intent or subjective wish to die" (p. 29).

Hirschfeld and Russell (1997) designed an Algorithm for Assessing the Risk of Suicide to be used in conjunction with identified risk factors for suicide and attempted suicide. If the patient is found to be at risk for suicide, they recommend that the Algorithm for the Management of Suicidal Thoughts or Behavior be used by the clinician. The authors note that once treatment is started for patients identified as high risk there should be close follow-up and continued assessment, as "some patients are at even greater risk for suicide for the first few days after treatment has been started" (Hirschfeld & Russell, 1997, pp. 912–913). For individuals with chronic suicidal ideation, the goal of the clinician is to change risk factors that can be modified in an effort to increase patient safety. The authors note that a person who is determined to kill himself or herself will probably prevail despite the best efforts of family members and health-care professionals. However, the overwhelming majority of people who desire to kill themselves at one time will feel very different after improvement in their depression or after receiving help with other problems (Hirschfeld & Russell, 1997, p. 914).

Motto, Heilbron, and Juster (1985) developed an empirical suicide risk scale for adults hospitalized due to a depressive or suicidal state. Their study of 2,753 suicidal patients prospectively examined 101 psychosocial variables. After a 2-year follow-up, 136 (4.94%) of the subjects had committed suicide. The authors employed rigorous statistical analysis, including a validation procedure, to identify 15 variables as significant predictors of suicidal outcome. Their findings were translated into a paper-and-pencil scale that gives an estimated risk of suicide within 2 years. Motto (1989) noted that instruments such as these can provide a valuable supplement to clinical judgment, as well as the kind of quantitative expression of suicide risk that represents to many clinicians "fine tuning" of their clinical judgment.

However, Clark, Young, Scheftner, Fawcett, and Fogg (1987) undertook a field test of Motto and colleagues' Risk Estimator for Suicide (Motto et al., 1985) that "raised questions" about the instrument though without invalidating the scale (Clark et al., 1987, p. 926). Clark and colleagues selected a subset of psychiatric patients with major or chronic affective disorders that corresponded to those in Motto's sample. The subjects in their sample exhibited distinctly lower suicide rates over a 2-year follow-up (2.4%) than the sample reported by Motto (4.9%). What the 1987 study does highlight is the critical need to understand the limitations of all such scales particularly the likelihood that suicide scales derived by multivariate analysis of a large number of clinical, psychosocial, and demographic variables may tend to be arbitrary and sample-specific. They propose that serial assessments which pay attention to clinical symptoms, changing stress levels, and long-standing character structure in concert (Smith, 1985) would provide a better method of estimating suicide risk.

Assessing Suicide Through Structured Interviews and a Psychological Battery

Yufit (1988, 2005) proposed that the assessment of suicidal behavior is best conducted through the use of a SAT and a battery of specific assessment measures termed the Suicide Assessment Battery (SAB). Such a team would be composed of a multidisciplinary staff of psychologists, social workers, nurses, and psychology graduate students, specially trained in the use of a focused screening interview format and other assessment techniques for the identification and evaluation of suicide potential. SAT assessment would involve three levels: a focused interview (Level I), this interview plus specialized rating scales (Level II), and an extended psychological assessment (Level III) including the above interviews and ratings as well as special psychological assessment techniques, the SAB (Yufit, 2005).

The SAB would be used to make an extended evaluation of suicide potential beyond interview ratings (Level I) and the scores on the specialized suicide rating scales (Level II). Before proceeding to Level III, the clinician already would have conducted the structured interview and used rating scales such as the BDI, as well as the Risk-Rescue Scale and the Los Angeles SPC Assessment of Suicide Potential to evaluate the patient. As Yufit noted, Level III techniques "would most likely be used with inpatients who make suicidal threats or attempts, or where suicide can be inferred" (1988, p. 26).

One of the most important elements in the SAB is the Time Questionnaire (TQ). The TQ, a semi-projective personality assessment technique, has been found to correlate with suicide potential (Yufit & Benzies, 1979). The TQ has been administered to "over 1,500 persons, including clinical and nonclinical samples, as well as matched sample populations; it has consistently differentiated high lethal suicidal persons from lower levels of suicide lethality and nonsuicidal persons as well as a variety of psychiatric diagnostic groups,
p. 518 on the basis of ↳ uniquely different time perspectives· the TQ is a key technique in the SAB" (Yufit, 1988, p. 27). Yufit (personal communication, April 1990) added the Coping Abilities Questionnaire, a 15-item instrument that measures the range of coping ability (from excellent to minimal).

In addition to the TQ and Coping Abilities Questionnaire, other possible key elements in a SAB include the following:

1. Q-sort set, a 22-item set representative of "descriptive items relating to variables often associated with suicidal behavior" (Yufit, 1988, p. 28);
2. Suicide Assessment Checklist, a 36-item checklist to provide a supplement to clinical judgment;
3. Experience Inventory, in which the patient is asked to list 10 most important experiences (Cottle, 1976);
4. Motto Suicide Risk Assessment, an empirically derived instrument using significant items from a large-scale prospective study of a clinic instrument used to assess suicide (Motto et al., 1985);
5. A specially devised sentence completion, a 32-item form with sentence stems especially selected to elicit affect related to morbid thoughts, self-destruction, hope, trust, the future, and so on;
6. Draw-A-Person, DAP in the Rain, a variation of the "Draw-A-Person in the Rain projective technique in which rain is an ambiguous stimulus … Scoring is subjective in nature, but the work of Machover and other exponents of DAP can be utilized" (Yufit, 1988, p. 30);
7. autobiography, in which the patient is asked to write his or her life history in any way that he or she wishes;

8. Rorschach, primarily used for associational content;
9. TAT, quantitative analysis of story themes related to isolation, hopelessness, mistrust, morbid content, and future orientation;
10. Object Relations Technique, a variant of the TAT that usually gives more elaborate data than the more structured TAT;
11. Erikson Questionnaire, a multiple-choice instrument giving scores on Erikson's developmental model of stages related to intimacy-isolation, trust-mistrust, autonomy-shame, and doubt;
12. Humor Test, a 104-item, objectively scored questionnaire that gives polar opposite scores on 13 factor analytically determined scales;
13. Hope Scale, a Fawcett-Sussman scale of items relating to the evaluation of hope as personality variable.

These 13 assessment techniques represent a broad array of available and useful measures from which a SAB can be derived, usually including five or six of the techniques (e.g., the core SAB battery might include the suicide checklist, Coping Questionnaire, TQ, and Q-sort) (Yufit, personal communication, August, 1990).

Yufit (1988) pointed out that the use of the SAB, which includes a number of scales still in experimental form, "may be questioned, but they are considered very useful to trying to fill the lacunae and tap the nuances in the complex task of identification and assessment of suicide potential" (p. 32). He concluded that at this stage of development, these techniques are not necessarily conclusive, nor are they often objective, but they very often do serve as important "guidelines" to assist in the identification and the assessment of the components of suicide potential. They should supplement clinical judgment, not substitute for it (p. 33).

Recently the Question, Persuade, Refer, and/or Treat (QPRT) was developed by Quinnett and Bratcher (1996) to help clinicians evaluate, counsel, and treat suicidal patients. This structured risk assessment interview can be used in conjunction with other scales, such as the BDI or the BHS. The QPRT is a "tactical interview guide" created to help the clinician obtain dynamic and critical information regarding the urgency, nature, and context of a suicidal crisis, as well as to assess the current level of immediate risk. A decision tree format is used to guide the clinician and patient in creating a crisis management plan.

In an effort to formalize and distill the elements of risk detection (as well as to try to increase the accuracy of diagnosing suicide risk), Yufit (1989) developed and field-tested a new integrated instrument, the SSC. The SSC is used by a clinician or interviewer to assess an individual for the "purpose of identification of suicidal potential. Suicidal potential (or suicide risk) refers to the likelihood that such a person will engage in behavior that will directly or indirectly lead to self-destruction" (p. 4–129). The SSC is a screening instrument constructed from empirical data and utilizing known and presumed correlates of suicidal behavior, is designed to complement and improve "the validity of clinical judgment" (p. 4–139). In short, instruments such as the SSC (as well as batteries such as the SAB) may allow clinicians to supplement their own clinical intuition with a systematized approach to collecting assessment information (Yufit, personal communication, August 1990). An accurate (and widely accepted) ↳ model for the assessment of elevated risk in the suicidal patient may require a future research effort that would involve a large-scale collaborative multicenter study designed to evaluate *all* of the existing assessment procedures for both efficacy and significance (Yufit, personal communication, August 1990).

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Limitations of Theoretical Orientation and DSM-IV Diagnosis

When clinicians select assessment criteria and then implement an appropriate intervention strategy with suicidal patients, they may find that traditional theories of psychotherapy, and traditional psychiatric diagnostic categories, are of limited practical value in precisely assessing suicidal risk. As Beutler (1989) pointed out, "the descriptive dimensions embodied in the current diagnostic system bear little relationship to the selection of the mode or frequency of psychosocial interventions ... while it would be unthinkable in any practice of medicine for the mode of treatment to be independent of patient diagnosis, this is precisely the case in the assignment of psychotherapy modes and formats" (p. 272).

An integrated perspective on assessment and treatment of the suicidal patient must be maintained (Simon, 1988). For example, psychoanalytic approaches may tend to deemphasize discussion of the suicidal patient's condition with family members, or deemphasize an evaluation for the efficacy of organic therapies —in which case vital information can be lost. Conversely, biologically based approaches may not place enough emphasis on the need for an ongoing treatment relationship, that is, may diminish the role of the therapeutic alliance as an essential element of sound psychopharmacologic intervention. Finally, Simon (1988) noted the danger of medications being prescribed in lieu of the patient being seen more frequently.

Jacobs (1989) asserted that the clinician must go beyond formal psychiatric diagnosis, because many suicides occur in individuals who have not been labeled as psychiatrically ill. He cited Mack and Hickler's research (1981), which found that the problem of suicide cuts across all diagnoses; many of those who take their own lives are mentally ill, but some are not; some are psychotic, but most are not; and some act impulsively, but most do not. Jacobs (1989) also noted that the next concern for the clinician with regard to assessment relates to an understanding of demographic and clinical risk factors.

Linehan and colleagues (2000) noted that the limited research associating Axis II disorders with suicide is largely attributable to the fact that Axis II disorders were not formally diagnosed before 1980. In hierarchical and principal diagnosis systems, Axis II diagnoses are typically assigned only when an Axis I disorder is absent. In this context, suicidal ideation or behavior is viewed as a symptomatic response to an Axis I disorder. The high comorbidity of Axis I and Axis II disorders guarantees a significant underestimate of the prevalence of personality disorders.

Furthermore, personality disorders are typically represented by dimensional rather than categorical measures. That is, a specific number of criterion behavior patterns need to be present, and typically the greater the number of behaviors the greater the disorder. Linehan, Rizvi, Welsh, and Page (2000) noted that while studies have attempted to examine the relationship of personality disorders the methods used have been inconsistent. In the absence of clear methodology, we are left with information obtained from categorical diagnostic systems. Widiger and Frances (1987) point out that criterion behaviors are at times used as indicators of some underlying pathology (diagnostically), and at other times, they are used as operational criteria of a disorder (definitionally). Research, in many cases, does not sufficiently distinguish which criteria are definitional and which (if any) diagnostic.

Clark (1990) believed that there are a number of different types of suicide, based on different demographics, motives, or diagnoses. He thought that developing specific risk profiles for each of these different types of patients would be prudent. Clark and Fawcett (1992) advocated the formulation of diagnosis-specific suicide risk profiles. Clark (1990) provided four reasons for why diagnosis-specific profiles may be useful. First, he noted the relationship between mental illness and suicide (e.g., psychological autopsy studies). These studies indicate that most people who die from suicide suffered from some form of mental illness.

Second, Clark described follow-up mortality studies of patients with major affective disorders, alcoholism, and schizophrenia that indicated an elevated risk of death by suicide for each of these diagnoses. Third, he

pointed out that different diagnoses (e.g., major depression, alcoholism, and schizophrenia) have different clinical presentations, courses, prognoses, and treatments, so the risks for suicide in patients with these diagnoses are also likely to differ. Fourth, Clark believed that the advent of structured interviews and well-
p. 520 delineated diagnostic ↳ categories would make reliable research of these categories possible.

Along these lines, Peruzzi and Bongar (1999) identified eight critical risk factors for suicide in patients with major depression: the medical seriousness of previous attempts, history of suicide attempts, acute suicidal ideation, severe hopelessness, attraction to death, family history of suicide, acute overuse of alcohol, and the experience of recent loss or separation. Additionally, Canapary (1999) found a two-tier series of suicide risk factors with an alcoholic population. The first tier of risk factors includes the seriousness of previous attempts, past suicide attempts, and the communication of suicidal ideation; the second tier includes feelings of hopelessness, a family history of suicide, and the current use of alcohol.

Suicide is not a psychopathological entity that is recognized by the DSM (Lewinsohn et al., 1989). Indeed, major depression and borderline personality disorder are the only diagnoses in the DSM-IV for which suicidality is a criterion. Zubin (1974) noted that suicide is the final stage of a very complex process that encompasses a heterogeneous set of phenomena and that occurs in people who are anything but homogeneous (Lewinsohn et al., 1989, p. 1).

In summary, at the level of a diagnostic and initial assessment of the suicidal patient, we believe that the psychologist should concentrate primarily on dispositional assessment and on the formulation and documentation of "risk detection" in the assessment and diagnostic stage, rather than on specific behavior prediction (Maris et al., 1992; Murphy, 1988b). However, the mental status examination, clinical interview, and DSM-IV diagnostics are essential and critical elements in a comprehensive clinical evaluation process (see also Lester, 2005) and, for the purposes of the present chapter, are important tools in the detection of suicide risk.

General Formulation of Clinical Judgment in the Clinical Interview

Maltsberger (1988) believed that there are five specific components in the general formulation of suicide risk:

1. assessing the patient's past responses to stress, especially losses;
2. assessing the patient's vulnerability to three life-threatening affects—aloneness, self-contempt, and murderous rage;
3. determining the nature and availability of exterior sustaining resources;
4. assessing the emergence and emotional importance of death fantasies;
5. assessing the patient's capacity for reality testing (p. 48).

He added that "what is sometimes called the 'formulation of suicide risk' offers the clinician a disciplined method for assessing suicide danger that integrates and balances the presenting clinical material from the patient's past history, his present illness, and the present mental status examination" (p. 48).

Another approach to the formulation of clinical judgment and the assessment of risk is a clinical checklist method of conducting the assessment (Bassuk, 1982). In this approach, one uses combinations of structured interviews, checklists, standard psychological instruments, and suicide risk scales and estimators to ensure a comprehensive evaluation. (For additional information on comprehensive assessment and interviewing strategies, see Hendren, 1990.)

Yufit (1988) noted that the assessment of suicide potential will often be accomplished through the initial focused interview (based on either a referral from the emergency room, inpatient service, or outpatient clinician). The Level I (focused interview) would explore:

1. the patient's conscious intent of actually ending his/her own life;
2. risk of rescue or possible interruption during suicide attempt;
3. degree of planning;
4. behavior level (e.g., threats, ideation, gestures, overt attempt);
5. lethality of attempt made;
6. extent of physical injury and/or toxicity;
7. precipitant factors;
8. intensity of current life stress;
9. history of previous attempts, gestures, threats, and ideation;
10. degree of depression;
11. the patient's ability to relate to the examiner during the interview, overt dress and grooming, posture, degree of agitation, ability to discuss the problem, and so on;
12. changes in the patient's behavior during the initial contact;
13. overall psychological status (e.g., the examination of any DSM-IV disorders).

The majority of patients at the Center for Cognitive Therapy at the University of Pennsylvania carry a
p. 521 diagnosis of depression, and therefore ↳ hopelessness and suicidal ideation will often be ongoing therapeutic issues. The center's policy manual indicates that when the patient's suicidal ideation is either continuous or intermittent, that is to say consists of low to moderate levels of purely ideational symptoms, it can be dealt with as with any other depressive symptom, that is, primarily by the treating therapist with regular supervision (R. J. Berchick, personal communication, September 20, 1989). However, the center's special procedure for suicidal patients is:

> The therapist should maintain especially close monitoring of *all* suicidal thoughts as well as concomitant levels of hopelessness and depression. Regular administration of the first five items of the SSI (and the rest of the scales if any of these are positive), the BHS, and BDI at each session is strongly recommended, because these scales will provide a reliable means of monitoring any changes in these variables over time.

Richman and Eyman 1991, citing the previous work of Smith 1985, Eyman 1987, and Smith and Eyman (1988), have developed a model for understanding why a person chooses to commit suicide based on the data from the Suicide Research Project at Menninger's. This model posits three conditions for suicide:

1. a narrowly defined, unrealistic, and fragile identity;
2. an event that jeopardizes the individual's identity;
3. deficits in the management of affect and difficulties in problem solving (Richman & Eyman, 1991, p. 2).

Motto (1989) held that the central clinical task is to "determine and monitor the patient's threshold for pain (either physical or psychological)." This would take into consideration the person's pathology, strengths, and available defensive patterns. If the pain level exceeds the pain threshold (even briefly), Motto saw suicide as imminent. Therefore, the psychologist must carefully assess and monitor the patient's threshold for pain and estimate how close the current level of pain comes to it. "The better we know the patient, the more sensitive we can be to the influences that can alter these two critical determinants of a suicidal act. Treatment aims ideally at both raising the threshold by maturational development, and decreasing the pain level by providing emotional support and by resolution of pain-generating conflicts" (Motto, 1989, p. 254).

Shneidman (1987) likewise believed that:

"The central feature of suicide is pain, and that the key to suicide prevention lies in the reduction of that individual's psychological pain. All else—demographic variables, family history, previous suicidal history—is peripheral except as those factors bear on the presently felt pain. Ultimately, suicide occurs when there is the co-existence of intolerable pain, intense negative press, and extreme perturbation with perceptual constriction and an irresistible penchant for life-ending action (pp. 176–177)."

Clinicians must also, according to Shneidman (1984, 1986a), exercise extreme caution with any patient who is perturbed and who has a lethal means available. This would include clinical work with patients with poor impulse control who are in crisis and are unable to decrease their level of perturbation in the therapeutic encounter. Shneidman (1987) Shneidman (1987) presented a theoretical cubic model of suicide that includes the combined effects of psychological pain, perturbation, lethality, and what he termed "press" to attempt to identify those individuals most at risk for suicide. Here "press" is similar to what Murray (1938) called pressure—that is, those aspects of the inner or outer world or environment that touch, move, impinge on, or affect an individual, and to which he or she reacts. "Press" can be either positive or negative.

Practically speaking, Pokorny (1983) noted that the identification and care of the suicidal patient in clinical practice is made up of a *sequence of small decisions*, a point we wish to underscore. Murphy (1988a) expanded on this dictum by noting that:

The first decision might be based on some alerting sign or clinical configuration, and the decision would be to investigate further. After further investigation, one might stop, if no additional alerting or confirming indicator were found. Or one might decide to explore the situation even further; perhaps even to hospitalize, for example. In each case, the decision is not what to do for all time, but rather what to do next, for the near future (Pokorny, 1983) ... there is continuing opportunity for feedback, and thus for modification of risk assessment and intervention (p. 53).

From the standpoint of any potential malpractice action, the most crucial element in the formulation of clinical judgment is that the psychologist's professional behavior not significantly deviate from what is usual and customary for the care of patients with these particular signs and symptoms. That is to say, the psychologist will have demonstrated the behavior of a reasonable and prudent practitioner and not made
p. 522 any significant omissions in assessment, as well ↳ as have taken appropriate precautions to minimize the risk of a patient suicide (Berman & Cohen-Sandler, 1982, 1983). The importance of thorough documentation cannot be overstated.

Patient suicide is not a tragedy that exclusively confronts the mental health professions, but "the incidence of its occurrence is such a frequent issue, both professionally and sometimes legally, that it demands special consideration" from mental health professionals (Smith, 1986, p. 62). Authorities who investigate suicidal phenomena have not reached consensus on the key risk factors, whether short term and long term, that distinguish suicide completers. Ironically, for the practicing clinician, this lack of consensus offers some protection from a legal perspective. Courts and juries have often held that when it comes to suicide, there is no single correct or perfect solution in the management of the suicidal patient. Rather, both courts and

juries tend to judge the clinician's actions in comparison with what seemed reasonable in compliance with the accepted standards of their profession (Simon, 1988).

Finally, the psychologist must understand that the final decision as to suicide risk is an intuitive judgment, that "we are obliged to accept that no matter how much information is gathered, sooner or later all the data must be weighed together and an intuitive estimate of risk recorded. That it is only an educated guess does not diminish its importance or its value as a consideration in management and treatment planning" (Motto, 1989, p. 2).

Notes

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