Advances in the Assessment of Suicide Risk

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This article reviews and integrates empirically grounded advances in the assessment of suicidality. The practices discussed are consistent with existing standards of care, practice guidelines, and applicable research. The authors differentiate between risk assessment and prediction and then emphasize the important role of time in risk assessment. We present and illustrate a continuum of suicidality for risk assessment and offer practical recommendations for clinical decision making and treatment. © 2005 Wiley Periodicals, Inc. J Clin Psychol: In Session 62: 185–200, 2006.

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Clinicians in outpatient settings are increasingly faced with decisions about what to do when a patient reports suicidal ideation. For most clinicians, suicide assessment is an anxiety-provoking clinical activity, so it is not surprising that they typically adopt one of two extreme approaches, neither of which is recommended (Wingate, Joiner, Walker, Rudd, & Jobes, 2004). Some clinicians choose to be excessively cautious—the "better safe than sorry" approach—and overestimate suicidality under the assumption that any patient who mentions suicidal thinking may be at high risk for suicide. Such an approach can have several undesirable consequences, including inappropriate deprivation of patients' rights and squandering of scarce clinical resources. The alternative approach—underestimating suicidality as a result of a dismissive attitude or inept assessment—jeopardizes patient safety and risks clinician liability.

The purpose of this article is to approach suicide risk assessment from a clinically balanced and scientifically informed standpoint, translating empirical research into clinical practice. Our risk assessment model provides guidelines for assessing suicidal symptoms, directs clinical decision making, and embraces a best practices perspective.

Suicide Prediction Versus Risk Assessment

An expectation exists in the legal community and the court system that a clinician can predict a patient's suicidal or homicidal behavior, the legal concept of *foreseeability*. The

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notion of suicide prediction is problematic, however, because predicting low base-rate phenomena such as suicide with reliability is not possible. In other words, because completed suicide occurs so infrequently, a clinician would actually be correct much more often if he or she predicted that a patient would *not* commit suicide regardless of clinical presentation. However, the legal expectation that clinicians can reliably predict their patients' actions has influenced the existing standard of care. Practice guidelines have shaped day-to-day clinician work and will be increasingly used by the court system to establish the standard of care when clinical outcomes are bad. One of the more recently published guidelines is the *Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors* (American Psychiatric Association, 2003), which thoroughly reviews the empirical data associated with suicidality but is somewhat impractical in its length (117 pages), highlighting the need for a succinct guideline that is compatible with best practice recommendations.

The inability to predict suicidal behavior reliably does not mean important risk factors that place a patient at increased risk for suicide have not been identified through research. The clinician's task is not to predict suicide, but rather to recognize when a patient has entered into a heightened state of risk (risk assessment) and to respond appropriately. At its best, risk assessment both estimates the risk of suicidal behavior and explains it when used in a consistent fashion for all patients, providing a template for clinical management of any crisis, as well as short- and longer-term treatment targets.

The Importance of Accurate Terminology

A critical first step in accurate risk assessment is the use of standardized nomenclature. The advantages of using standard terminology include (1) improved clarity, precision, and consistency of a single clinician's practice both over time and across patients; (2) improved consistency of communication between clinicians; (3) improved clarity in documentation; (4) elimination of inaccurate and potentially damaging language from our vocabulary; and (5) elimination of the goal to predict suicide through recognition of the complexity of suicide intent in determining ultimate clinical outcome. We therefore recommend that clinicians implement the standard suicide terminology proposed by O'Carroll and associates (1996): "Suicide: Death from injury, poisoning, or suffocation where there is evidence that the injury was self-inflicted and that the decedent intended to kill himself/herself. The term completed suicide can be used interchangeably with the term suicide."

- Suicide attempt with injuries: An action resulting in nonfatal injury, poisoning, or suffocation where there is evidence that the injury was self-inflicted and that he/she intended at some level to kill himself/herself.
- Suicide attempt without injuries: A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended at some level to kill himself/herself.
- Instrumental suicide-related behavior: Potentially self-injurious behavior for which there is evidence that the person did not intend to kill himself/herself (zero intent to die) and the person wished to use the appearance of intending to kill himself/herself in order to attain some other end (to seek help, to punish others, or to receive attention). Instrumental suicide-related behavior can occur with injuries, without injuries, or with fatal outcome (accidental death).
- Suicide threat: Any interpersonal action, verbal or nonverbal, stopping short of a directly self-harmful act, that a reasonable person would interpret as communicating

or suggesting that a suicidal act or other suicide-related behavior might occur in the near future.

- Suicidal ideation: Any self-reported thoughts of engaging in suicide-related behavior.

In addition to the benefits described, use of the proposed nomenclature additionally reflects three essential elements of suicidal behavior (e.g., Maris et al., 1992): (1) outcome, (2) evidence of self-infliction, and (3) evidence of intent to die by suicide. The clinician who recognizes the importance of these elements and integrates them into his/her regular terminology will be able to document more clearly the critical role of intent, its variable nature, and the resultant difficulty in reliably predicting a patient's behavior.

A Model for Risk Assessment: A Brief Overview

Clinical assessment of suicidality should answer some basic questions about the patient, such that the end result guides subsequent management and treatment decisions. The model described here focuses on the clinical interview—how to structure it, what categories have been empirically supported in the literature, and what questions should be asked. Additionally, a continuum of suicidality with associated categories of risk is presented, with distinction between *acute* and *chronic* risk. The assumption is that a complete intake history and diagnostic interview have been completed. Additionally, psychological testing should be used when possible and interviews with significant others conducted when available.

A brief clinical vignette will serve as a reference point for illustrating concepts in this article.

Case Vignette

JoAnn is a 46-year-old twice-divorced female who has a bachelor's degree and a master's degree in health education and fitness. She is in her third marriage (3 years long), and has reported, "It's a very good one." She currently works as a part-time personal trainer, spending the rest of her time caring for her two children (ages 12 and 8, one from each of her first two marriages). The children have little contact with their fathers. JoAnn reported that she is seeking treatment secondary to escalating symptoms of bulimia. Although initially she was hesitant, she reported "maybe two to three" binge-purge episodes each day. Further exploration reveals a long history of bulimic symptoms dating back to her early teens, although she could not be more specific. At the beginning of the disorder, she reported feeling "fat and ugly" but noted, "I don't really know why I do it now; maybe it's just a habit." JoAnn also reported lowered mood, anhedonia, middle and terminal insomnia, some attention and concentration problems, poor energy, and periods characterized by "feeling like I'm stuck and things will never get any better." She added that she feels "incredibly guilty" for her behavior and often thinks she is "worthless." JoAnn reported that a "few times" in her life she has "felt like dying," but only acted upon these impulses a couple of times, apparently overdosing on pills at ages 14, 17, and 18; she quickly added that she "never told anyone about any of it." When questioned about the duration of these symptoms, JoAnn stated that she has "always felt this way." She reported thinking about killing herself "maybe 15 times a day" but added that the thoughts last only a few seconds, and she does not currently plan "on doing anything about it." Joann reported thinking about overdosing but "doesn't have any pills right now." The primary stressors in her life were reported to be "work, kids, and trying to please my husband." She added that she "really doesn't like conflict" and "will do almost anything to avoid it," especially with people she is "close to."

JoAnn also reported being a chronic worrier. When asked about thought content, she said she worried about "just about everything in my life," noting that the only thing that "helps" is to drink occasionally and "sometimes to smoke a little pot." She was evasive about frequency of substance use when questioned further. JoAnn reported a history of mental health treatment but could not recall exactly how many professionals she had seen because she would reportedly go "for a few months and quit because it didn't really help." She also reported pharmacological treatment through her primary care physician over the last 10 years but again noted that she would "start and then quit because of side effects." When asked in more detail about her treatment experiences, JoAnn added that "it didn't work because I'm beyond help; I'm a hopeless case."

She described her current marriage as "better than the other two put together" and admitted that her previous marriages ended because of her infidelity (her current marriage was a result of an affair). Joann reported a "troubled" childhood marked by "some sexual abuse" by her father from the ages of 9 to 12. When questioned about the abuse, she commented that she has "gotten over it," adding "it really wasn't that big of a deal." JoAnn reported seeing her parents about "twice a year" around holiday events, with little contact in between. She noted that she has always felt like she "disappointed" her parents because they "expected much, much more from me." JoAnn added that she has distant relationships with her siblings and has "no true friends." She spoke in some detail about "trying to please her husband," noting that "it doesn't seem to work." She "feels that way with most people," that she is "a real pushover with everyone," particularly men. When asked what she wanted to get from therapy, JoAnn quipped, "Stop throwing up and just feel better," adding, "Maybe somebody can actually figure me out."

The case of JoAnn is used as an example for each area of risk that follows, with details both highlighted and discussed.

Components of a Risk Assessment Interview

There are a number of areas that have been empirically demonstrated to be essential to risk assessment and therefore should be covered when assessing suicidality (Rudd, Joiner, & Rajab, 2001). The areas are predisposition to suicidal behavior; identifiable precipitant or stressors; the patient's symptomatic presentation; presence of hopelessness; nature of suicidal thinking; previous suicidal behavior; impulsivity and self-control; and protective factors. These are presented in Table 1. The list of areas is not exhaustive; other areas could arguably be included. However, in our review of the literature, these areas have sound empirical support and emerge as clinically meaningful and critical to the assessment process.

We recommend a hierarchical approach to questioning, in which the clinician moves from identification of the precipitant (e.g., "How have things been going for you recently? Can you tell me about anything in particular that has been stressful for you?"), to the patient's symptomatic presentation (e.g., "From what you've shared so far, it sounds like you have been feeling depressed. Have you been feeling anxious, nervous, or panicky lately?"), to hopelessness (e.g., "It's not uncommon when depressed to feel that things won't improve and won't get any better; do you every feel this way?"), to the ultimate nature of the patient's suicidal thinking (e.g., "People feeling depressed and hopeless sometimes think about death and dying; do you ever have thoughts about death and dying? Have you ever thought about killing yourself?"). By gradually progressing in the intensity of the interview, the clinician can potentially reduce anxiety or agitation in the patient while improving rapport. As indicated by the series of questions listed, the patient's hopelessness and suicidal thinking are *normalized* within the construct of a depressive

Table 1
Areas of Risk Assessment

I:	Predisposition to suicidal behavior
	Previous history of psychiatric diagnoses (increased risk with recurrent disorders, comorbidity, and chronicity)
	Previous history of suicidal behavior (increased risk with previous attempts, high lethality, and chronic disturbance)
	Recent discharge from inpatient psychiatric treatment (increased risk within first year of release)
	Same-sex sexual orientation (increased risk among homosexual men)
	Male gender
	History of abuse
II:	Identifiable precipitant or stressors
	Significant loss (e.g., financial, interpersonal relationship[s], identity)
	Acute or chronic health problems
	Relationship instability
III:	Symptomatic presentation
	Depressive symptoms (e.g., anhedonia, low self-esteem, sadness, dyssomnia, fatigue [increased risk when combined with anxiety and substance abuse])
	Bipolar disorder (increased risk early in disorder's course)
	Anxiety (increased risk with trait anxiety)
	Schizophrenia (increased risk after active phases)
	Borderline and antisocial personality features
IV:	Presence of hopelessness
	Severity of hopelessness
	Duration of hopelessness
V:	The nature of suicidal thinking
	Current ideation frequency, intensity, and duration
	Presence of suicidal plan (increased risk with specificity)
	Availability of means
	Lethality of means
	Active suicidal behaviors
	Explicit suicidal intent
VI:	Previous suicidal behavior
	Frequency and context of previously suicidal behaviors
	Perceived lethality and outcome
	Opportunity for rescue and help seeking
	Preparatory behaviors
VII:	Impulsivity and self-control
	Subjective self-control
	Objective control (e.g., substance abuse, impulsive behaviors, aggression)
VIII:	Protective factors
	Presence of social support
	Problem-solving skills and history of coping skills
	Active participation in treatment
	Presence of hopefulness
	Children present in the home
	Pregnancy
	Religious commitment
	Life satisfaction
	Intact reality testing
	Fear of social disapproval
	Fear of suicide or death

episode (or other mental disorder). Reduction of anxiety ultimately enhances the honesty of the patient's report, providing for more detailed responses and a more accurate risk assessment. In a case such as JoAnn's, hierarchical questioning might not be necessary because the patient enters the office talking openly about suicidal thoughts and behaviors.

It is important to highlight and clarify the difference between implicit and explicit intent (Beck & Lester, 1976). Explicit or subjective intent is the patient's stated intent, in other words, what the patient actually says during the interview (e.g., "Even though I've

thought about killing myself, I'm not going to do anything about it"). Implicit or objective intent is estimated by the patient's current and past behaviors, as well as his or her expressed understanding of the lethality of the chosen method.

Ideally there would be high concordance between implicit and explicit intent, but in clinical practice conflicting reports, especially among chronically suicidal patients, are not uncommon. In such cases, the clinician must carefully consider and weigh the objective markers of intent, and ask the patient for his or her thoughts about this discrepancy. Using JoAnn as an example, evidence for implicit intent (multiple past suicide attempts of moderate lethality, current frequent thinking about suicide during the day) does not completely align with explicit intent (minimization of suicidality, stating she does not plan to "do anything about it"). JoAnn's clinician might point out this discrepancy to her: "You've told me that you are not planning to do anything about your suicidal thoughts, but some of your past behavior seems to suggest otherwise. I'm hoping we can spend a few minutes to talk in detail about your daily thoughts about killing yourself, and if you might act on those thoughts now." It is critical for clinicians to resolve any apparent discrepancy between implicit and explicit intent. In those instances when there is not agreement, clarification provides for a more accurate risk assessment and, ultimately, better clinical decision making.

As with the construct of intent, distinguishing between the important variables of subjective and objective markers of self-control provides a means to evaluate the accuracy of a patient's self-report. We strongly recommend that the clinician ask about the suicide method at least twice because a suicidal patient frequently omits mentioning the most lethal or accessible method. It is as simple as asking, "Have you considered any other methods?" This tendency is particularly prevalent among chronically suicidal patients and may represent the ambivalence that marks the suicidal crisis. Use of "gate" questions—target questions that direct the clinician to ask the patient more detailed questions—to streamline risk assessments is similarly problematic because many suicidal patients respond negatively to gate questions, thus reducing the likelihood of accurate assessment.

A 1-to-10 rating scale can be useful in several ways when questioning suicidal patients. First, it provides a mechanism by which the patient can both quantify and clarify an emotional experience (e.g., "Could you rate the severity of your hopelessness on a scale of 1 to 10, with 1 being hopeful and 10 being absolutely no hope?"). Second, ratings permit comparisons over time and adjustments in risk assessment ratings (e.g., "Could you rate your intent to kill yourself right now on a scale of 1 to 10?"). Third, it provides a simple means by which the patient can both recognize and monitor fluctuations (including improvements) in symptom level (e.g., "Today you are rating your intent to kill yourself at 3. The last time we met you rated your intent at 7. Let's talk about this change for a while."). Finally, it can potentially improve communication when multiple clinicians are involved in the patient's care. An implicit and potentially powerful consequence of patient ratings is that they tend to enhance the patient's sense of self-control, quantifying elusive constructs during what is most likely an overwhelming crisis.

In JoAnn's case, her reports of suicidal ideation are conflicting and murky and therefore interfere with the clinician's ability to gauge her risk level accurately. The clinician might ask her to clarify the severity of her ideation by giving it a rating: "You have told me that you think about killing yourself 15 times each day. Could you rate the severity or intensity of these thoughts on a scale of 1 to 10, with 1 being not intense at all, and 10 being extremely intense?" The same approach can be taken with respect to intent: "Can you rate on a scale of 1 to 10 the likelihood that you'll act on your suicidal thoughts, with 1 being absolutely no chance and 10 meaning that you'll definitely act?" The clinician would also gain a better picture of JoAnn's hopelessness by asking a similar question

"You said that you feel stuck, and things will never get any better. On a scale of 1 to 10, how severe would you rate these feelings of hopelessness?"

Areas to Assess in Suicide Risk Assessment

In the following sections, we discuss the clinical interview exploring suicidality, focusing on how to structure the interview, which areas have empirical support in the literature, and which questions to ask. This article expands on empirical evidence gathered since the original publication of this risk assessment model by Rudd and Joiner (1998).

I: Predisposition to Suicide

The clinician first attempts to identify preexisting vulnerabilities to suicidal behavior, including previous history of psychiatric diagnoses, previous history of suicidal behavior, and history of abuse.

Increasing evidence supports heightened risk for suicide attempt after a patient's release from inpatient psychiatric treatment, with the first year a particularly high-risk period (Goldston et al., 1999). Suicidal behavior among patients diagnosed with a major depressive episode occurs on average within 13 weeks of index admission (Gladstone et al., 2001). These findings support the notion of acute versus chronic risk—although a patient's acute symptoms may be stabilized during hospitalization, chronic suicide risk persists. Thus, it is particularly important to monitor patients who have been recently discharged from inpatient treatment closely; such patients may require increased frequency of sessions.

Recent investigations into demographic variables associated with suicide risk have revealed complex interactions. For example, major depression is a significant risk factor for both men and women, but specific risk factors differentiate risk in men and women: Advancing age and high suicidal intent are significant risk factors for women, and previous suicide attempts and violent methods are risk factors for men (Skogman, Alsen, & Ojehagen, 2004). Gender also appears to interact with marital status—married men and unmarried women are at highest risk (Gladstone et al., 2001). A relatively new and growing body of research on gay, lesbian, bisexual, and transgendered (GLBT) sexual orientation has consistently found elevated suicide risk among GLBT individuals; homosexual men are at particularly high risk (Russell & Joyner, 2001).

In JoAnn's case, relevant predisposing factors for suicide include a history of bulimia nervosa and psychiatric treatment, history of abuse by the father, and past suicide attempts of moderate lethality. As will be discussed later, JoAnn is identified as a multiple attempter and, accordingly, has chronic risk regardless of acute symptomatology.

II: Precipitants or Stressors

When considering what triggered the suicidal crisis, the clinician should consider any significant loss (e.g., financial, interpersonal, identity), acute or chronic health problems, and family instability.

Medical illness has been associated with increased suicide risk, particularly when in the presence of psychiatric symptoms (American Psychiatric Association, 2003). Medical conditions can increase suicide risk by contributing to psychiatric symptoms such as mood disturbance or anxiety or by increasing stress level. Objective severity of illness, however, is unrelated to history of suicide attempts, and is unlikely to predict future attempts (Mann, Waternaux, Haas, & Malone, 1999). Primary health professionals are in

a unique position to detect suicidal behavior and direct the patient to obtain appropriate treatment.

Returning to JoAnn, no clear precipitant is identified, although she describes a chronic escalation of stressors and problems (having a history of relationship instability, feeling unable to please her husband and others, and being a chronic worrier). She also expresses distress related to "work, kids, and trying to please my husband." Of particular importance, it appears that JoAnn's support system may be unstable, inaccessible, and/or unavailable.

III: Symptomatic Presentation

When determining the patient's symptom picture, consider Axis I and II diagnoses (with particular focus on depression and anxiety) along with the severity of symptoms. Determining the level of anger, agitation, and sense of urgency is similarly important, as well as identifying comorbidity.

Extensive empirical evidence has confirmed that a significant risk factor for suicide is the presence of a major mood disorder, especially during depressive phases. But because less than 1% of individuals who have affective disorders commit suicide, the challenge for practitioners is determining which individuals who have affective disorders are at elevated risk for suicide. Of all depressive symptoms, hopelessness has been identified as a particularly strong predictor of suicidal behavior; it is discussed later in this article. Low self-esteem is another symptom that is frequently comorbid with substance dependence and has been shown to be a significant predictor of suicide probability (Demirbas, Celik, Ilhan, & Dogan, 2003). Risk is especially high early in the course of bipolar disorders. Patients who report anhedonia and insomnia combined with severe anxiety symptoms, alcohol abuse, or emotional turmoil associated with continuously cycling moods are at greatest short-term risk for suicide (Kleespies & Dettmer, 2000). The nature and duration of anxiety symptoms are important variables for consideration, as trait anxiety has a stronger relationship with suicide probability than state anxiety (Demirbas, Celik, Ilhan, & Dogan, 2003; Goldston et al., 1999).

Recent estimates among individuals who have schizophrenia place lifetime risk for suicide at about 4% (American Psychiatric Association, 2003). Incidence of suicide among individuals with schizophrenia peaks during young adulthood, or relatively early in the course of the disorder (Kleespies & Dettmer, 2000). Suicide in schizophrenic patients is less likely to occur during active psychotic phases than during the periods of improvement that follow these active periods, suggesting that as a person's thinking becomes more clear and rational, and insight into the implications of the disorder and awareness of lost abilities increase, so does suicide risk. Not surprisingly, depressed mood and hopelessness among patients who have schizophrenia mark an increased risk.

When considering personality disorder diagnoses, borderline personality disorder and antisocial personality disorder have been most consistently connected with increased risk of suicide attempts (American Psychiatric Association, 2003). Individuals who have borderline personality disorder present an especially complicated challenge in suicide risk assessment because of the high frequency of nonfatal and self-soothing—yet self-destructive—behaviors that must be differentiated from behaviors with suicidal intent. Patients who are diagnosed with cluster B personality disorders and engage in instrumental suicidal-related behavior are at higher risk (as compared to cluster B personality disorders who do not engage in instrumental suicide-related behavior) because they report more distress from suicidal thoughts and have distorted perceptions of suicide attempts

that place them at higher risk. They are more likely to underestimate the lethality of their suicidal behavior, believe they will be rescued after an attempt, and view death with less finality (Stanley, Gameroff, Michalson, & Mann, 2001).

Three distinct clusters of prominent personality traits among suicidal psychiatric patients with comparable psychiatric diagnoses and negative life stress have been identified (Rudd, Ellis, Rajab, & Wehrly, 2000). Negativistic and avoidant traits characterize all three clusters, two show strong borderline traits, and each one displays a distinct trait: schizoid, dependent, or antisocial. Externalizing symptoms (e.g., antisocial behavior and substance dependence) have stronger associations with suicidal behavior in both men and women than internalizing symptoms (e.g., major depression and anxiety disorders), although women demonstrate less externalizing psychopathology (Verona, Sachs-Ericsson, & Joiner, 2004).

Relevant features of JoAnn's symptomatic presentation include a diagnosis of bulimia nervosa, significant depressive symptoms, agitation suggestive of trait anxiety, active substance abuse, and probable personality disorder. JoAnn's symptomatic presentation confirms the presence of an *acute exacerbation* of chronic risk.

IV: Presence of Hopelessness

The clinician should assess not only the presence of hopelessness, but also its severity and duration. The majority of suicidal patients report the presence of severe hopelessness, the relief of which might be a primary motivator for suicide. Degree of hopelessness is determined by both state and trait variables, and, along with subjective depression and suicidal ideation, is greater in suicide attempters than in nonattempters despite similar rates of objective severity of depression or psychosis (Mann, Waternaux, Haas, & Malone, 1999). Hopelessness may not be as strongly associated with suicide among some cultural groups, as cultural and moral experiences and beliefs may act as a buffer against hopelessness (Sayar, Kose, Acar, Ak, & Reeves, 2004).

Hopelessness is a prominent feature in JoAnn's case, as evidenced in many of her behaviors and comments. She feels "like I'm stuck and things will never get better" and feels unable to please her husband and friends. She reports terminating treatment early several times because "I'm beyond help; I'm a hopeless case." JoAnn's hopelessness is persistent and enduring and contributes to a pessimistic worldview that places her at chronic risk for suicide.

V: The Nature of Suicidal Thinking

The dimensions of suicidal thinking that need to be assessed by clinicians include frequency (e.g., "How often do you think about suicide?"), intensity (e.g., "Could you rate the intensity of your suicidal thoughts on a scale of 1 to 10, with 1 being not at all intense and 10 being extremely intense?"), and duration (e.g., "When did you first have these thoughts?") of current ideation. Other dimensions pertain to specificity and plans ("Have you thought about how, when, and where to kill yourself?"), availability of means ("Do you have access to a [gun]?"), active behaviors ("Have you taken any steps to prepare for suicide, such as write a note, get your financial affairs in order, or do anything else?"), explicit intent ("When you're thinking about suicide, what helps you feel better, feel more hopeful about life?"), and deterrents to suicide ("What stops you from killing yourself?").

When inquiring about suicidal ideation, the clinician can reduce resistance in the patient by asking about distant suicidal episodes before asking about more recent episodes.

For example, the clinician working with a patient who is either resistant or uncomfortable discussing current risk might ask, "You mentioned that you thought about suicide many years ago. Can you tell me more about the incident?" The clinician could then ask about reported ideation from 1 year ago, then 1 month ago, then last week, then currently.

An important factor for clinicians to keep in mind is culture in suicidal ideation. For example, African Americans disclose suicidal ideation less readily than whites, although those African Americans who do report suicidal ideation report significantly more reasons not to kill themselves, higher moral objections to suicide, and better survival and coping beliefs (Morrison & Downey, 2000). The suicidal ideation of such "hidden ideators," who exist in all demographic groups, becomes apparent only when a full suicide risk assessment is completed. We recommend that direct probing for suicidal intent be practiced as a general rule, not as a special circumstance.

When assessing JoAnn, the clinician would benefit from asking about her suicidal thinking in the past, then move forward in time to current suicidal thinking. JoAnn reports recurrent suicidal thinking of high frequency ("15 times a day") of brief or mild intensity (a few seconds). She has considered a method (overdose) but denied current access to means. Evidence for explicit suicidal intent is questionable (she has no current plans "to do anything about it"), although considerable evidence for implicit intent exists. The clinician should probe JoAnn for other unreported methods for suicide and work to clarify the previously noted conflict between stated intent and implicit markers consistent with her chronic risk status.

VI: Previous Suicidal Behavior

When searching for a history of suicidal behavior, the clinician should determine frequency and context of the suicidal behavior (e.g., "How often have you attempted to kill yourself or hurt yourself in the past? What was going on at this time in your life?"), perceived lethality (e.g., "Why did you choose that particular method? Did you think it would be enough to complete suicide successfully?"), opportunity for rescue (e.g., "Did you know your spouse would come home to find you?"), and the amount of identifiable preparations for death (e.g., "Have you been putting your will in order in case of your death? Have you been giving away your possessions?"). As noted in relation to terminology, it is critical to differentiate between previous suicide attempts and other instrumental behaviors; that can only be accomplished by evaluating *each and every* episode.

Although the presence of multiple suicide attempts increases risk for future suicide, and two or more attempts indicate chronic risk (Wingate, Joiner, Walker, Rudd, & Jobes, 2004), the absence of attempts does not conversely indicate reduced risk. The method of previous suicide attempts has been found to be more strongly associated with suicidal behavior than the number of previous suicide attempts (Modai et al., 2004). This finding highlights the importance of confirming that previous attempts were, in fact, suicide attempts and not instrumental behavior. Completed suicides and serious suicide attempts form two overlapping populations, although some differences exist between them: Those at high risk for fatal suicide attempts include men who have nonaffective psychosis and those at high risk for nonfatal suicide attempts include women who have anxiety disorders and poor social contact (Gladstone et al., 2001). Clinicians must be careful not to underestimate suicide risk in patients who engage in instrumental suicide-related behavior, as these patients often underestimate the lethality of their suicide attempts. As evidenced in the terminology provided, differentiating the behaviors means clarifying the intent associated with the behavior.

Because JoAnn reports at least three previous suicide attempts, she is at chronic risk for suicide (assuming all three are confirmed to have been suicide attempts after careful evaluation). The clinician should attempt to elicit information about her perceptions of the lethality of previous attempts, objective indicators of lethality (e.g., type of pills and amount taken), and life events surrounding these attempts. If there was indeed evidence of intent to die for each, then JoAnn would appropriately be characterized as a multiple attempter.

VII: Impulsivity and Self-Control

The clinician should assess the patient's subjective sense of self-control (e.g., "Do you consider yourself to be impulsive? Why or why not? Have you recently felt out of control?") and compare it with objective identifiers of self-control (e.g., "How often do you drink or use substances? Have you had problems with impulsive behavior of any type? Have you ever been arrested?"), engagement in impulsive or self-destructive behaviors (e.g., violent, aggressive, or sexual acting out), and methods for coping with stress (e.g., substance abuse, social withdrawal).

Use of alcohol and drugs has consistently been found to be associated with elevated suicide risk. Alcohol use can increase suicidality in a variety of ways: It impairs judgment, reduces inhibition, increases depression, correlates with social isolation, and is more likely to be comorbid with antisocial personality disorder. Acute intoxication may be a causal factor for suicide by increasing the probability of a head injury because it leads to disinhibition and a greater probability of suicidal behavior (Mann, Waternaux, Haas, & Malone, 1999). Substance abuse is also related to aggression, impulsivity, and comorbid personality disorder, each of which is individually associated with increased suicide risk.

Impulsivity may actually be a more significant indicator of suicide attempt than the presence of a specific suicide plan, because many suicide attempts are reactions to an environmental event. Because impulsivity is a stable trait and multiple attempt status is a static variable, impulsive multiple attempters should be considered to have long-standing suicide risk. In general, a personality style marked by pronounced impulsivity and aggression characterizes individuals who are at risk for suicide attempts regardless of psychiatric diagnosis (Mann, Waternaux, Haas, & Malone, 1999).

JoAnn exhibits a high degree of impulsivity: regular alcohol and narcotic use, inconsistent treatment compliance, and relational struggles associated with extramarital affairs. Important information the clinician should obtain from JoAnn is the extent to which she feels a lack of control—a quality that seems apparent although not explicitly stated.

VIII: Protective Factors

Several factors associated with reduced risk for suicidal behavior—known as *protective factors*—have been identified and should be considered in conjunction with risk factors. Pertinent questions include "Do you have access to family or friends whom you can talk to and depend on? What reasons do you currently have for living?"

Interestingly, suicide-related writing may serve a protective function through the reduction of impulsive and maladaptive problem solving and allowance of more effective affect regulation. However, suicide-related writing that serves as a means to communicate suicidal plans and preparation does not serve a protective function (Joiner, Walker, Rudd, & Jobes, 1999). Although risk factors have a stronger relationship with suicidality than protective factors, suicide interventions that focus on increasing protective factors while reducing risk factors are more effective than those that focus on risk factors alone.

A lack of protective factors marks JoAnn's case. She reports feeling isolated from family and friends and lacks hopefulness and positive problem-solving skills. These feelings are not at all unusual for those at chronic risk, as their support systems erode over time.

Actuarial Instruments in Risk Assessment

A vast array of instruments has been designed for the measurement of various aspects of suicidality (e.g., intent, ideation, hopelessness, depressive symptomatology). Actuarial instruments can be a helpful supplement in risk evaluations because patients tend to disclose more significant levels of suicidal ideation on these self-report measures (Johnson, Lall, Bongar, & Nordlund, 1999), and doing so can contribute to a decrease in probable assessment errors.

Despite the benefits of actuarial measures, several limitations detract from their use in clinical settings. First, self-report measures are notorious for their high false positive rate, suggesting that these measures alone are not sufficient for distinguishing those individuals truly at risk for suicidal behavior. Second, actuarial instruments commonly use historical data and static variables that do not change with time, and they may underestimate level of acute exacerbation. Third, the predictive validity for most suicide measures has not been established. Fourth, generalizability may be limited by the specialized settings in which suicide assessment measures are developed and utilized. Most studies utilize brief screening measures for research purposes, as opposed to the standardized suicide assessment measures used in primary care settings. Finally, most instruments have been developed by using predominantly white adolescent and young adult populations, raising concerns about their utility for elderly and minority populations. Extensive reviews and critiques of suicide assessment instruments can be found in Goldston's (2003) *Measuring Suicidal Behavior and Risk in Children and Adolescents* and Brown's (2000) *A Review of Suicide Assessment Measures for Intervention Research with Adults and Older Adults*.

Optimal risk assessment integrates clinical and empirical methods with clinician expertise. Because of the limitations inherent in risk assessment measures, patient evaluation should never be based solely on actuarial methods. The core of the comprehensive suicide assessment is the face-to-face clinician interview, with actuarial instruments providing supplementary or clarifying information.

No-Harm Contracts

A common practice in clinical situations is to implement a no-harm contract as part of treatment. The assumption is that the patient who is unwilling or unable to enter a commitment of self-preservation is at a heightened risk for suicide. However, there is currently no empirical evidence that those patients who agree to no-harm contracts are any less likely to commit suicide than those patients who say they cannot or will not. The no-harm contract appears to be a better tool for measuring the strength of the therapeutic alliance than for assessing suicide risk (American Psychiatric Association, 2003), because those patients who reject a no-harm contract are communicating a lack of faith in the therapeutic relationship and an inability or unwillingness to commit to the relationship. When used in this capacity, the no-harm contract can be a means for determining the extent to which the patient believes the clinician can help him or her.

On the other hand, we do not recommend the use of no-harm contracts as a tool for risk assessment. The use of no-harm contracts with patients who are impulsive, agitated, intoxicated, or incapable of providing informed consent is discouraged, as is their use in settings that do not allow for adequate development of a relationship between clinician

and patient. An alternative to the no-harm contract—the "commitment to treatment statement"—is discussed by M. David Rudd in another article in this issue.

Clinical Decision Making, Management, and Treatment

Risk Categories

We advise clinicians to distinguish among the four risk categories designated in Table 2. Two dimensions are considered: baseline risk and acute risk. Baseline risk is the level of risk when the patient is not in a state of acute crisis and is asymptomatic, or is in general at his or her relative best. All suicidal individuals have a baseline risk to which they return during periods of relative calm and remissions of psychopathology, but baseline risk is not comparable for all groups. One of the primary goals of time-limited treatment is a return to baseline, not a substantial modification of baseline severity. However, for some patients (such as multiple attempters), the baseline risk level is high and indicates chronic risk, regardless of any acute crisis. Acute risk, by contrast, is the level of risk presented during an acute suicidal crisis, when the patient is symptomatic and at his or her worst. By definition, acute risk is time limited, although the duration of risk can vary from minutes to hours or even days. Severity of risk is always relative. Accordingly, the variable nature of suicide, even among those at chronic high risk, can be acknowledged by adding the descriptor *acute exacerbation* when necessary. This term communicates the time-limited elevation of risk, even for those falling in this high-risk category.

A Continuum of Suicidality

We use a modification of the continuum of suicidality originally proposed by Somers-Flanagan and Somers-Flanagan (1995), emphasizing the terminology proposed by O'Carroll and colleagues (1996) and integrating protective factors and the role of chronic suicidal behavior to assess those patients at high risk for suicide. Acute risk increases from nonexistent to mild, moderate, severe, to extreme as intent emerges and becomes clearer in terms of both objective and subjective indicators.

Suicide risk assessment is complicated by temporal factors in at least two ways. First, identifiable risk periods are inconsistently defined in the literature. Second, chronic suicidality complicates risk estimates. In every risk assessment, the clinician should ask the question "Is this person a multiple attempter?" If not, the clinician will be considering acute risk.

Table 2
Categories of Suicide Risk

Risk Category	Criteria
Baseline	Absence of an acute overlay, no significant stressors or prominent symptoms; only appropriate for ideators and single attempters
Acute	Presence of acute overlay, significant stressor(s), and/or prominent symptoms; only appropriate for ideators and single attempters
Chronic high risk	Baseline risk for multiple attempters, absence of acute overlay, no significant stressors or prominent symptoms
Chronic high risk with acute exacerbation	Acute risk category for multiple attempters, presence of acute overlay, significant stressor(s) and/or prominent symptoms

If the patient is a multiple attempter, however, the clinician will be considering the chronic nature of the patient's suicidality and should automatically be considered at least a moderate risk (Wingate, Joiner, Walker, Rudd, & Jobes, 2004). We recommend, therefore, that risk assessment be a continuous and routine task throughout the course of treatment.

A distinct risk assessment scheme will ideally translate into straightforward, clinically informed, and effective decisions. Table 3 provides a summary of risk levels with indicated clinical responses or options. There is no room for debate about the standard of care for patients at extreme or severe suicide risk, which demands immediate evaluation for inpatient hospitalization (voluntary or involuntary, depending on the circumstances). Outpatient management of those at moderate (and possibly severe) risk can be accomplished

Table 3
Suicide Risk Continuum and Indicated Responses

Risk Level	Description	Indicated Response
Nonexistent	No identifiable suicidal ideation	No particular changes in ongoing treatment
Mild	Suicidal ideation of limited frequency, intensity, and duration; no identifiable plans, no intent, mild dysphoria/symptoms, good self-control, few risk factors, and identifiable protective factors	Evaluation of any expressed suicidal ideation to monitor change in risk
Moderate	Frequent suicidal ideation with limited intensity and duration; some specific plans, no intent, good self-control, limited dysphoria/symptoms, some risk factors present, and identifiable protective factors	1. Recurrent evaluation of need for hospitalization 2. Increase in frequency or duration of outpatient visits 3. Active involvement of the family 4. Frequent reevaluation of treatment plan goals 5. 24-Hour availability of emergency or crisis services for patient 6. Frequent reevaluation of suicide risk, noting specific changes that reduce or elevate risk 7. Consideration of medication if symptoms worsen or persist 8. Use of telephone contacts for monitoring 9. Frequent input from family members with respect to indicators 10. Professional consultation as indicated
Severe	Frequent, intense, and enduring suicidal ideation; specific plans, no subjective intent but some objective markers of intent (e.g., choice of lethal method[s], available/accessible method, some limited preparatory behavior), evidence of impaired self-control, severe dysphoria/symptoms, multiple risk factors present and few if any protective factors	Immediate evaluation for inpatient hospitalization (voluntary or involuntary, depending on situation)
Extreme	Frequent, intense, and enduring suicidal ideation; specific plans, clear subjective and objective intent, impaired self-control, severe dysphoria/symptoms, many risk factors and no protective factors	

safely and effectively but implicates a number of ongoing treatment considerations outlined in Table 3. Those determined to be at mild or nonexistent risk require no particular change in ongoing treatment aside from ensuring evaluation of any expressed suicidal ideation to determine any change in risk. To illustrate the assessment process and associated treatment implications, consider JoAnn's assessment:

- Risk category: Chronic high risk with acute exacerbation.
- Risk indicators: *I*: Previous psychiatric history, prior suicide attempts, and family abuse history. *II*: Relational instability, family stress, and work stress. *III*: Diagnosis of bulimia nervosa, alcohol and marijuana abuse, depressive episode, trait anxiety, and likely personality disorder. *IV*: Marked hopelessness. *V*: Frequent and specific ideation, unknown access to means, clear markers of implicit intent, questionable markers of explicit intent, no identified deterrents. *VI*: Multiple past attempts, current ideation of potential lethality to require medical care, no help-seeking behaviors or preparations for death. *VII*: High objective impulsivity, evidence of subjective lack of control, active substance use. *VIII*: No identifiable protective factors.
- Severity rating: 10
- Treatment response: Consider hospitalization to reduce acute dysphoria, hopelessness, and associated suicidality if, after clarification, there is reported intent. If no active intent, then JoAnn can be closely monitored on an outpatient basis until some of the agitation subsides. In all likelihood, we would refer JoAnn for a medication consultation, particularly for medicine that would target her dysphoria and agitation. Additionally, detoxification for alcohol consumption (if required), control of impulsivity, mobilization of social support system (if possible), and initiation of individual psychotherapy would follow. There is evidence that patients like JoAnn can be treated safely and effectively on an outpatient basis as long as the acute exacerbation of symptoms and intent are closely monitored.

Clinical decision-making and management of suicidality are surprisingly straightforward when an accurate risk assessment is completed. Both are functions of the limited options available for outpatient management, as well as of the sole option of hospitalization under severe or extreme risk. Contrary to persistent myths about working with suicidal patients, outpatient treatment can be accomplished in a safe and effective manner.

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