Rebuilding the Tower of Babel: A Revised Nomenclature for the Study of Suicide and Suicidal Behaviors
Part 1: Background, Rationale, and Methodology

Morton M. Silverman, MD, Alan L. Berman, PhD, Nels D. Sanddal, MS, Patrick W. O’Carroll, MD, MPH, and Thomas E. Joiner, Jr., PhD

Since the publication of the O’Carroll et al. (1996) nomenclature for suicidology, there have been a number of published letters and articles, as well as an active e-mail dialogue, in response to, and elaborating upon, this effort to establish a standard nomenclature for suicidology. This new nomenclature has been presented on a number of occasions at both national and international meetings. In this paper we provide the background, rationale, and methodology involved in the process of revising the O’Carroll et al. nomenclature, based on the feedback and discussions that have ensued over the past 10 years.

Those who have written and studied the phenomenon of suicide have not defined the term so simply... how the word is defined has implications and large effects for statistics that are compiled on the official number of suicides, and for researchers, so that there is clear communication regarding what and who is being studied.

Among writers in the field of suicidology there is no single common accepted definition... the term suicide refers not to a single action but more broadly to a great many varied behaviors. For example, one can speak of suicidal thoughts, intentions, ideation, gestures, attempts, completions, equivalents.

Thus far, no single term, definition, or taxonomy has served to sufficiently represent the complex set of behaviors that have been suggested as suicidal. A

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A standard set of terms and definitions are greatly needed to advance the science of suicidology and aid communication and understanding of the field.

McIntosh (1985, pp. 18–19)

Suicide researchers recognize that the generalizability of their findings is affected by the populations they study, participation rates they obtain, and the type of data they collect. Most agree that the use of inadequate and contradictory definitions of suicide and suicidal behavior is often a limitation of suicide research and communication. Limitations also include hindsight bias and informant bias regarding documentation of suicidal thoughts, intent, and behaviors (Duberstein & Conwell, 1997). There is a range of suicidal behaviors, which includes thoughts about suicide (Beck, Steer, & Brown, 1993), attempts ranging from low lethality to medically serious (Beautrais, Joyce, & Mulder, 1999), and deaths by suicide (Fischer, Constock, Monk, & Spencer, 1993). Yet the suicide literature remains replete with confusing terms, definitions, and classifications that make it very difficult, if not impossible, to compare and contrast one research study or epidemiological survey with another (Beck et al., 1973; Berman & Cohen-Sandler, 1982; Jenkins & Singh, 2000; Leenaars et al., 1997; Rudd & Joiner, 1998; Shneidman, 1985; Silverman, 2006), or to make comparisons, generalizations, or extrapolations (Linehan, 1997; Santa Mina & Gallop, 1998; Westefeld et al., 2000).

Suicide attempts are not only much more frequent than completed suicides, but the distribution of the most common methods and the populations exhibiting these behaviors is meaningfully different. No national or international surveillance system exists for the primary purpose of monitoring suicidal behaviors and estimating annual national rates of occurrence. Those national surveys that collect information on suicidal behaviors in the service of other primary missions use different terminologies and different definitions for suicidal behaviors. In order to conduct meaningful surveillance, the terms used need to be clearly defined and mutually exclusive (e.g., suicide ideation, suicide threat, suicide, self-harm, suicide attempt, etc.).

There are a large number of scales and measures that purport to quantitatively and qualitatively measure the presence of suicidal ideation, intent, and motivation, as well as the intensity, duration, frequency, and consequences of suicide attempts (Brown, 2001; Goldston, 2003). Most measures assume that the respondent already possesses a definition of suicidal ideation, intent, motivation, and attempt. Often researchers assume, even when they are using the same measures across studies and across populations, that all respondents are basing their responses on the same conceptualizations and definitions of suicide-related terms. Rarely do these measurement tools provide the respondent with clear definitions for the suicide-related terms (Kessler, Berglund, Borges, Nock, & Wang, 2005).

Measures of suicide and nonfatal suicidal behavior continue to be hindered by the lack of: (1) a standard nomenclature (De Leo, Burgis, Bertolote, Kirkhof, & Bille-Brahe, 2004, 2006; Rudd & Joiner, 1998); (2) clear operational definitions (Garrison et al., 1993; Silverman & Maris, 1995; McKeown et al., 1998; Moscicki, 1989, 1995); and (3) standardized lethality measures (Berman, Shepherd, & Silverman, 2003; Farberow, 1980; Smith, Conroy, & Ehler, 1984). Reliable statistics on the numbers, types, and methods of nonfatal, intentional self-inflicted injuries, in conjunction with national and regional suicide mortality data, are required for the development, targeting, and evaluation of national and regional suicide prevention strategies (O’Carroll, 1989).

THE O’CARROLL ET AL. NOMENCLATURE

In 1995–96, under the auspices of the National Institute of Mental Health and the
American Association of Suicidology, a nomenclature working group was formed to clarify the nomenclature used in the field to describe suicidal ideations and suicidal behaviors. Faced with the recognition that certain terms are entrenched in the public’s vocabulary and in clinical communications, the nomenclature group nevertheless proposed terminology that best defined the range of suicidal behaviors and communications. The work of this group was summarized in a scientific publication in 1996 (O’Carroll et al., 1996), and is outlined in Table 1. O’Carroll et al. distinguished suicidal behaviors by three characteristic features: intent to die, evidence of self-inflicted injury, and outcome (injury, no injury, or death) (Figure 1). This nomenclature has been referred to as the “nomenclature for suicide-related behaviors in terms of outcome and intent to die from suicide” (Daigle & Cote, 2006).

The goal of developing a uniform nomenclature was to increase the ability of clinicians, epidemiologists, policy makers, and researchers to better communicate with each other and study similar populations at risk. If the nomenclature was accepted, the next step was to develop and test standard, operational means for applying these definitions in clinical practice, research, and public health. Disseminating and encouraging the use of an operationalized nomenclature would constitute a third stage in this process.

### TABLE 1
O’Carroll et al. (1996) Nomenclature

<table>
<thead>
<tr>
<th>An Outline Indicating Superset/Subset Relationships of the Proposed Nomenclature for Suicide and Self-Injurious Thoughts and Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Injurious Thoughts and Behaviors</strong></td>
</tr>
<tr>
<td><strong>A. Risk-Taking Thoughts and Behaviors</strong></td>
</tr>
<tr>
<td>1. With Immediate Risk (e.g., motocross, skydiving)</td>
</tr>
<tr>
<td>2. With Remote Risk (e.g., smoking, sexual promiscuity)</td>
</tr>
<tr>
<td><strong>B. Suicide-Related Thoughts and Behaviors</strong></td>
</tr>
<tr>
<td>1. Suicide Ideation</td>
</tr>
<tr>
<td>a. Casual Ideation</td>
</tr>
<tr>
<td>b. Serious Ideation</td>
</tr>
<tr>
<td>(1) persistent</td>
</tr>
<tr>
<td>(2) transient</td>
</tr>
<tr>
<td>2. Suicide-Related Behaviors</td>
</tr>
<tr>
<td>a. Instrumental Suicide-Related Behavior (ISRB)</td>
</tr>
<tr>
<td>(1) Suicide threat</td>
</tr>
<tr>
<td>(a) Passive (e.g., ledge sitting)</td>
</tr>
<tr>
<td>(b) Active (e.g., verbal threat, note writing)</td>
</tr>
<tr>
<td>(2) Other ISRB</td>
</tr>
<tr>
<td>(3) Accidental death associated with ISRB</td>
</tr>
<tr>
<td>b. Suicidal Acts</td>
</tr>
<tr>
<td>(1) Suicide attempt</td>
</tr>
<tr>
<td>(a) With no injuries (e.g., gun fires, missed)</td>
</tr>
<tr>
<td>(b) With injuries</td>
</tr>
<tr>
<td>(2) Suicide (completed suicide)</td>
</tr>
</tbody>
</table>

**Adoption of the O’Carroll et al. Nomenclature**

A number of investigators have adopted the O’Carroll et al. nomenclature and applied it in their studies (Bryan & Rudd, 2006; Daigle & Cote, 2006; Goldston, 2003; Kidd, 2003; Rudd & Joiner, 1998; Wagner, Wong, & Jobes, 2002). Others have acknowledged its role in highlighting the need for clarification of terms (Dear, 1977, 2001; De Leo et al., 2004, 2006; Hjelmeland & Knizek, 1999; Linehan, 1997, 2000; Marusic, 2004; Rudd, 1997, 2000; Rudd, Joiner, Jobes, & King, 1999). In addition, the American Psychiatric Association (2003) has acknowledged and adopted the O’Carroll et al. definitions as the basis for their recently issued practice guidelines for the assessment and treatment of patients with suicidal behaviors. In contrast, the nomenclature has not been widely used in the research and clinical communities.

Following the publication of the O’Carroll et al. terminology the authors received over 100 communications (letters, e-mail, phone calls) from around the world commenting on the proposed nomenclature—offering further recommendations, revisions, and refinements. Despite its utility and general acceptance in the mental health community, the nomenclature has not been universally accepted, due, in part, to its intro-
duction of new terminology and definitions. Of particular note is that some of the terms proposed (instrumental suicide-related behavior; non-zero intent; and suicide act) were deemed by others to be too broad, too vague, or too unwieldy. In fact, others have subsequently offered alternative nomenclatures, including ones that attempt to avoid the concepts of motivation, intent, and planning (Marusic, 2004; Brown, Jeglic, Henriques, & Beck, 2006).

Some members of the initial work group (ALB, MMS) continued to refine the nomenclature and to seek ongoing input by making presentations on the proposed nomenclature nationally and internationally (O’Carroll et al., 1997). This resulted in a decision to undergo a total revision of the initial effort. Before discussing our revised nomenclature, we share the background to our deliberations.

### THE CURRENT STATE OF OUR NOMENCLATURE

There remains confusion about exactly what constitutes suicidal behavior, deliberate self-harm, suicide-related behavior, parasuicide, or suicidality, and how to define suicide and suicide attempt (De Leo et al., 2006; Silverman, 2006). The plethora of terms has re-

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**Figure 1. O’Carroll et al. (1996) nomenclature.**

<table>
<thead>
<tr>
<th>Terms for suicide-related behaviors</th>
<th>Intent to die from suicide</th>
<th>Instrumental thinking</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumental suicide-related behavior</td>
<td>No</td>
<td>Yes</td>
<td>✓</td>
</tr>
<tr>
<td>- with injuries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- without injuries</td>
<td>No</td>
<td>Yes</td>
<td>✓</td>
</tr>
<tr>
<td>- with fatal outcome</td>
<td>No</td>
<td>Yes</td>
<td>✓</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>Yes</td>
<td>+/-</td>
<td>✓</td>
</tr>
<tr>
<td>- with injuries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- without injuries</td>
<td>Yes</td>
<td>+/-</td>
<td>✓</td>
</tr>
<tr>
<td>Completed suicide</td>
<td>Yes</td>
<td>+/-</td>
<td>✓</td>
</tr>
</tbody>
</table>

*Conscious intent to ends one’s life through the suicidal behavior.

*Note that a fatal outcome of instrumental behavior is properly considered accidental death, since by definition there is no intent to die from suicide.*
sulted in a lack of clarity and precision in the scientific literature, and among suicidologists, clinicians, researchers, theoreticians, and epidemiologists (Mayo, 1992; Rosenberg et al., 1988; Sommer-Rotenberg, 1998; World Health Organization [WHO], 1968, 1986). While a clear set of definitions is valuable, it is possible that the roles and needs of the various disciplines that comprise suicidology (e.g., coroners and medical examiners, clinicians, researchers, public health practitioners) are sufficiently heterogeneous to require a number of indicators rather than a single measure. Although it is necessary to recognize that different disciplines have different needs for their understanding and prevention of suicide, it still holds that a uniform set of criteria and definitions offers the potential to advance all these fields simultaneously (Silverman, 2006). Using a similar rationale, in April 2004, the National Center for Injury Prevention and Control (Centers for Disease Control and Prevention) convened a group of experts to begin development of uniform definitions for self-directed violence surveillance. This effort is still underway.

The Benefits of a Revised Nomenclature

The refinement of investigative tools and techniques can only improve the efficiency, effectiveness, sensitivity, and specificity of clearly describing the populations and behaviors being studied. For research, clinical, and prevention purposes, the use of mutually exclusive terminology would more clearly define subgroups for study. If the nomenclature can be revised in a manner that satisfies the needs of the clinical, research, and/or public health communities, then this can lead to a greater use of this nomenclature, which would, in turn, greatly improve communication between and among researchers, clinicians, administrators, policy makers, and the public. It would allow for better comparability between and among research studies and clinical trials. It would clarify relationships between concepts and categories. The further benefit of clarifying terms would be to assist genetic studies in differentiating valid phenotypes from one another, so that underlying genotypes can be more accurately identified. A valid and reliable nomenclature will allow the development of a classification for suicidology.

Classification systems have been attempted in the past and each one has its merits and applicability (Arensman & Kerkhof, 1996; Barber, Marzuk, Leon, & Portera, 1998; Beck et al., 1973; Ellis, 1988; Farberow, 1980; Hammad, Laughren, & Raccoosin, 2006; Kreitman, 1977; Lester, 1990; Maris, 1992; Orbach, 1997; Shneidman, 1968). As a whole, however, they lack universal appeal because of the reliance on different terminologies and definitions of key constructs (De Leo et al., 2006). Hence there remains a need to simplify the nomenclature, even while recognizing that suicide is a behavior (not a disorder or diagnosis), and all behavior is multidetermined and multidimensional.

Further clarification of the nomenclature would also lead to a better understanding of the relative predictive value of each term retained. For example, what percent of individuals who make a suicide attempt have had a prior ideation or threat that was related to the present suicide attempt? To what extent have prior “indirect self-destructive behaviors” predicted future suicide-related behaviors (Farberow, 1980; Maris, Berman, & Silverman, 2000; Santa Mina & Gallop, 1998)? More specifically, to what extent are self-harm behaviors related to future suicidal behaviors?

In addition, a standardized nomenclature will lead to a standardized set of questions for determining the presence or absence of suicidal cognitions, motivations, emotions, and behaviors. For example, suggested questions in the clinical literature to ascertain the presence of suicidal ideation currently range from, “Have you ever thought of hurting yourself?” to “What do you see for yourself in the future?” Just because a person says, “I feel like life is not worth living” or “I can’t take anymore of this,” does not necessarily imply that that
person has the thought, motivation, or intent to end their life. Suicide and other self-destructive behaviors often are the consequences of intention, motivation, and preparation (which have cognitive, emotional, and behavioral components). A full discussion of the role of intention vs. motivation in the development and expression of suicide-related behavior has been presented elsewhere (Hjelmeland & Knizek, 1999). Motivation to die and preparation to die do not, necessarily, place an individual at either acute or high risk for suicide.

**Challenges to the Development of a Revised Nomenclature**

A critical stumbling block is how to affirm and assess suicidal intent. Is it simply based on a patient's self-report of a wish or desire to die, to cease suffering, and/or is it based on an independent assessment of, or inference from, the lethality of the means or methods by which the behavior was undertaken (the instrumentality of the behavior) (De Leo et al., 2004, 2006; Range & Knott, 1997; Wagner et al., 2002)? Without the individual self-report, can we infer intent, and, if so, using what criteria? Because suicide, by definition, is self-initiated, we would take the position that it is predicated on the intent to die. Hence we are dependent upon the cooperation and collaboration of the individual to best ascertain the labeling of the behavior under investigation. The relative weight placed on prior suicidal ideations is important, as is assessment of past and present suicidal threats and attempts in determining the presence of intent. The difficulty is in searching for prior verbal expressions of intent, prior behaviors that imply intent (suicide notes, warning signs, suicide attempts, or verbalizations), or approximations of intent based on information provided by others (i.e., implicit or explicit evidence) (Berman, 1993; Jobes, Berman, & Josselson, 1987; Jobes, Casey, Berman, & Wright, 1991).

A related problem is how to define and classify suicidal risk, be it a classification using high vs. medium vs. low, short-term vs. long-term, or imminent vs. acute vs. chronic (Rudd, Joiner, & Rajab, 1999; Silverman, 2006; Simon, 2006). Often there seems to be some “fuzzy logic” in exactly what criteria are being used to label a suicidal risk (Wagner et al., 2002). Does it pertain to the risk for dying by suicide, or does it refer to the risk for a range of suicide-related behaviors (that may include self-harm, threats, attempts, and suicide)? A clarification of the behavioral outcomes (e.g., self-harm, suicide attempt, suicide) may also help clarify “risk factors for suicide,” “risk factors for suicide attempt,” and “risk factors for self-harm behavior” (Kraemer et al., 1997). Not all risk factors convey acute risk (Simon, 2006). It would be helpful if the nomenclature could lead to a better classification of risk factors whereby the presence of a particular risk factor clearly contributes to a determination of acute vs. short-term vs. long-term risk (or low vs. medium vs. high risk) for a range of self-destructive behaviors (Fawcett et al., 1990).

**THE PROCESS OF REVISING THE O’CARROLL ET AL. NOMENCLATURE**

The major challenges O’Carroll et al. (1996) encountered when they developed their nomenclature included: (1) ascertaining the need to establish the presence or absence of intent in order to define a behavior as suicidal; (2) clarifying the role of intention versus motivation; (3) selecting among the terms deliberate self-harm, parasuicide, and suicide attempts to best convey self-destructive behavior that doesn’t end in death; (4) retaining such commonly used, but poorly defined terms as suicide attempt, suicidal threat, suicidal gesture, and suicidal ideation; and (5) distilling the existing suicide terminology to its most basic conceptual categories.

In our efforts to revise the nomenclature, we faced similar challenges. Our initial review of the extensive literature on nomenclature, terminology, and classification provided us with certain constraints that were immutable given the degree to which certain
terms and conceptual ideas had become permanently embedded in the language of suicidology. For example, in order to separate intentional injuries (suicide and homicide) from unintentional injuries (accidents), we had to acknowledge and incorporate the psychological concept of intent. Suicide and other suicidal behaviors involve purposeful action or movement toward a desired outcome. Thus, intent is an integral component of our nomenclature.

**Defining Intent**

We determined that we needed the term *intent* to distinguish between and among self-destructive behaviors, and also to remain consistent with the coroner’s Natural-Accident-Suicide-Homicide (NASH) and CDC’s Operational Criteria for the Determination of Suicide (OCDS) classification systems (Rosenberg et al., 1988; O’Carroll et al., 1996). We also wanted to remain consistent with the emerging terminology in the public health, injury control, and violence prevention literature. Over the last decade, the international community of injury control and prevention experts has developed a nomenclature and classification system that establishes a major distinction between intentional injuries (homicides and suicides) and unintentional injuries (motor vehicle crashes, worksite injuries). Thus, we have avoided the old term of *accident* and replaced it with *injury*.

Hjelmeland and Knizek (1999) attempted to clarify some of the terminology used in the literature regarding nonfatal suicide acts. They suggested that an “intent” implies an action to change the future, while “motivation” implies an effort to affect interpersonal relations and a change in social milieu. Our position is that intent refers to the aim, purpose, or goal of the behavior. Although it implies an action, the action itself is not a given (“I intend to kill myself by hanging” does not mean that the action has occurred). In addition to investigating the presence of intent, we may also need to assess certain reasons and rationales for certain actions in order to determine if the actions are truly suicidal in nature. There are a set of self-reported “reasons for suicide” that are commonly identified in studies (Hjelmeland & Hawton, 2004). They include a wish to escape, a desire to obtain relief from an unbearable situation, and a wish to end overwhelming psychological or emotional pain. Hence, a motivation to die can be understood as the driving force behind the ideation or intent, and may also change the future social milieu.

The assessment of intent is the most difficult part of any investigation into the true nature of self-injurious behaviors. Different stakeholders (statisticians, public health practitioners, coroners, medical examiners, death scene investigators, and prevention-oriented suicidologists) require different standards of evidence, different levels of certainty for such evidence, and place different emphases on different aspects. A number of pieces of evidence are taken into account when arriving at a decision that a self-destructive behavior was intentional in nature. Such evidence includes: (1) intention to take the action; or (2) intention to harm himself or herself by the action; or (3) intention to die as a result of the action; and/or (4) at the time of acting, a capacity to understand the likely consequences of the act and form the desire to die (Moller, 1997).

Intent connotes a conscious desire or wish to leave (or escape from) life as we know it. This phrasing is intentional, as some persons who die by suicide intend to continue in an afterlife, or to be reborn, or to be transformed. Intent also connotes a resolve to act. It does not necessarily denote that an individual has undertaken an analysis or has knowledge of the medical lethality of different methods/means (although having such is indirect evidence of intent), knowledge of how to invoke the method/or means, or how to choose among them (Berman et al., 2003). A clear understanding of what we mean by *intent* is essential for selecting the techniques and methods used to investigate its presence.
The level at which we decide what constitutes “intent to die” will determine how many questions need to be asked and how much exploration will be required to determine its presence. As Shea (1999) recommends, information must be gathered from as many sources, and in as many formats, as possible in order to determine if intent is present; however, we need to bear in mind that an individual’s level of intent can change quite rapidly and without obvious warning, moving one’s current status from intentional to unintentional, or vice-versa (Daigle & Cote, 2006).

Rudd (2006b) suggested that there are two types of suicidal intent: (1) subjective or expressed intent; and (2) objective or observed intent. He opined that, because of the nature of the underlying illness and/or current emotional/physical state (e.g., overdose), acutely suicidal patients are unable to provide us with a clearly expressed intent. Rudd placed the onus on the clinical evaluator to rely on other tools and techniques to arrive at the true nature of the intent by seeking clarification and resolution of discrepancies between the observed behavior and the reported cognition.

O’Carroll et al. (1996) struggled with the distinction between “asking about” intent vs. “measuring” intent objectively (Beck, Schuyler, & Herman, 1974). We felt that the quantification of intent was beyond the nomenclature, but may be more suitable for classification. We explored the relationship between intent and lethality, as well as the causal relationship between intent, lethality, and outcome (no injury, injury, or death) (Bridge, Barbe, Birmaher, Kolko, & Brent, 2005), and concluded that the presence of intent assumes: (1) a desire or wish to end life as a conscious experience; (2) knowledge (accurate or inaccurate) of risk associated with a behavior; (3) some perception that means or methods are available to achieve the desired outcome; and (4) some knowledge about how to use the means or methods. We recognized that at times it may be difficult to establish intent, but without the inclusion of intent, it is virtually impossible to distinguish between types of suicide-related behaviors and other self-injurious behaviors. We also are aware that there is an imperfect correlation between intent and outcome.

O’Carroll et al. differentiated the terminology of suicide-related phenomena along three major axes: the presence or absence of intent to die (differentiating suicidal acts from instrumental suicide-related behaviors, respectively); the presence or absence of instrumental thinking; and whether the behavior resulted in injuries (with or without injuries) or death (accidental or completed suicide). Many colleagues objected to invoking the dichotomous concepts of “zero intent to die” and “non-zero intent to die.” Some critics argued that these are very difficult concepts to verify in practice, and that “non-zero intent to die” was too broad and all-encompassing. Due to this controversy, as well as appreciating that in emergency settings an individual may be unable to clarify whether suicidal intent was present or not, we decided to reorganize the nomenclature along three categories: no intent, uncertain intent, and intent (Kjoller, Norlev, & Davidsen, 2004).

The Concept of Lethality

Another stumbling block was whether or not a truly suicidal act must result in an observable injury. This distinction led O’Carroll et al. to the debate about whether the lethality of the means or methods should be a determining factor. We decided that, although establishing a lethality index is an important clinical determination to undertake (Berman et al., 2003; Smith et al., 1984), the degree of lethality should not supersede the first order of business—establishing the presence of intent as a defining factor (Denning, Conwell, King, & Cox, 2000).

Brown, Henriques, Sosdjan, and Beck (2004) found a minimal association between the degree of suicide intent and the extent of medical lethality for patients who attempted suicide, suggesting that suicidal intent and lethality are independent dimensions of suicide attempt behavior and that both of these char-
characteristics require careful assessment for accurate identification of suicide attempters. Their study supports the low validity of medical lethality as a measure of the seriousness of intent, given that over half of the patients had inaccurate expectations of the lethality of their attempt. Nevertheless, for most clinicians, high medical lethality suggests high intent, even though high intent doesn’t always suggest high lethality.

Many variables seem to be involved in the matter of lethality, among which are: availability/proximity of the method, personal knowledge about the lethal effects of the means and/or the dosage needed to achieve a certain outcome, familiarity with and/or comfort level in choosing and using a particular means, and contributory factors such as the presence of alcohol or other drugs/medications in the person (over-the-counter, illicit, or prescribed), discoverability, rescuability, timing, and sequencing (De Moore & Robertson, 1999; McIntosh, 1992). As previously noted, we accepted the clinical observation that an individual might not have a clear understanding or clear recall of their intent at the time they engaged in the suicidal act; however, the range of questions to determine the presence or absence of suicidal intent is fairly limited (“Did you intend to die?”). Developing a lethality score that would be more consistently and easily employed remains a challenge.

**Suicide Threat and Gesture**

Communication about a suicidal state can be through (1) ideation (“I’m thinking about killing myself”), (2) threats (with more of an emphasis to coerce—“I’m going to kill myself if . . .”), or (3) behaviors. While a threat may be verbal, nonverbal, or implied, there is a distinction between the expression of a suicide threat that might result in subsequent action at some unspecified time in the future, and a direct threat which carries with it a high likelihood of action in the very near future. This results in the use of modifiers such as imminent versus long-term, direct versus indirect, and acute versus chronic when describing threats. The assignment of a value (high vs. medium vs. low; acute vs. long-term; active vs. passive) involves an assessment of temporality, as well as the determination of the frequency, duration, intensity, and potential lethality of the threat. When a threat evolves into a condition with behavioral components, the lines between a threat, a gesture, and a suicide attempt become important clinically, as well as from the perspective of foreseeability.

Another reason for establishing a definition of suicide threat is that the literature is confused about whether a suicide threat is a precursor for a suicidal gesture, deliberate self-harm, a plan for a suicide attempt (i.e., self-destructive behavior not leading to death), or suicide. A threat implying self-harm or deliberate self-harm may be different than a threat to one’s life. A suicide gesture might be construed as a behavioral form of a suicide threat, in that this term has been meant to convey a low lethality suicidal act meant to influence others. In common parlance, the term suicidal gesture has been used to convey the notion of a physical act or behavior that is self-inflicted (with or without suicidal intent), but nonetheless of low lethality and low intent to die. The term has been also used to refer to suicide-related behavior that is preparatory to a suicide attempt; suicidal behavior with the intention to communicate or manipulate others or the social environment; and deliberate self-harm without the intent to die (Compton, Daniel, & Goldston, in press). Because the observed behavior is self-inflicted and because it “may be self-injurious” in nature, but seemed to others “half-hearted” or “minimally injurious,” the behavior has taken on a pejorative connotation (Aschkenasy, Clark, Zinn, & Richtsmeier, 1992; Daigle & Cote, 2006). Hence, we chose not to include this term in our nomenclature and incorporated such behaviors under the term self-harm.

**Additional Terms**

O’Carroll et al. tried to eliminate redundant phrases such as “completed suicide,”
fatal suicide,” and “fatal suicidal behavior.” In addition, O’Carroll et al. tried to resolve phrases such as “nonfatal suicidal behavior” and “parasuicide” (DeLeo et al., 2004, 2006). Similarly, we tried to distinguish between ideation (or thoughts) and intent. Although ideations, intent, and motivation are cognitions of one sort or another (as opposed to physical behaviors or actions), ideations are purely cognitive in nature, while intent assumes, in part, an emotional component to the cognitive process, as well as a higher degree of mental engagement.

Furthermore, O’Carroll et al. tried to place the planning process on a continuum from a thought (“I thought about killing myself”), to an intent (“I want to die”), to a plan (“I have a plan to effect my death”). O’Carroll et al. reasoned that one cannot consciously make a plan to die without having thought about it (ideation) and having a desire or wish to act on it (intent). We subsequently needed to rethink this position, in part due to recent findings that, for some individuals, suggest the role of impulsivity in the suicidal process (Kessler, Borges, & Walters, 1999; Mann et al., 1999; Simon et al., 1991), although we think that ideation and intent remain very important components, even considering the potential influence of impulsivity. Ideation and intent are fluid and dynamic and so can change rapidly, and perhaps do change more rapidly in impulsive individuals.

Although we felt that O’Carroll et al.’s term, “instrumental suicide-related behavior” (ISRB), came very close to accurately identifying and defining the self-destructive behavior which is not intended to result in death, yet is potentially self-injurious and containing a communication component, we were persuaded by our colleagues that the term “ISRB” is a “mouthful” which can be easily misunderstood, and would be difficult to insert into the existing vocabulary of suicidology. We were offered alternatives, including “pseudosuicidal behavior,” “suicidiform behavior,” and “metasuicide” (Egel, 1999). Inasmuch as ISRB was intended to encompass such behaviors as suicide threat, we chose to adopt and adapt Dear’s (2001) expanded recommendation to change the concept to suicide-related communication to account for the presence of suicidal threats and suicidal plans.

We tried to avoid terms such as suicidality because it is used to encompass a wide range of thoughts and behaviors, including suicidal ideation, the act of suicide, and those behaviors associated with suicidal attempts, and as such loses its meaning, distinctiveness, and clarity. However, some authors utilize this term to describe the totality of suicide-related ideations and behaviors, and it has become a popular term (Rudd, 2006b; U.S. Department of Health and Human Services [DHHS], 2006), although it is not yet found in a dictionary. Possibly a better term to encompass all forms of suicidal behaviors would be suicidal activity, because an activity can have cognitive, emotional, or physical components, whereas the behavior only refers to an action that is observable (DHHS, 2001). Furthermore, “behavior” connotes an ongoing, continuous activity, whereas an “action” connotes a time-limited event (Wagner et al., 2002). Nevertheless, we chose to remain with the 1996 terminology: suicide-related ideations and suicide-related behaviors, but we added suicide-related communications.

**What Defines a Suicide Attempt?**

The existing literature consistently reports that the history of a prior suicide attempt is a statistically significant risk factor associated with future self-destructive behaviors, including death (Rudd, 2006a). A history of repeated attempts further increases the risk of death by suicide. Hence, understanding and labeling what is a suicide attempt, and what is not, is an important task that informs prognosis and the selection of interventions. For example, the distinction between attempted suicide and attempted homicide is that the latter has a very clear definition as an attempt to murder someone else (encompassing both intent and behavior), whereas the former encompasses a wide range of nonfatal self-inflicted behaviors. Al-
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though the O’Carroll et al. definition of a suicide attempt emphasized the importance of an intent to kill oneself and of self-injurious behavior, clinically it is sometimes difficult to determine whether an individual intended to kill themselves or whether an individual actually engaged in a self-injurious behavior (Brown et al., 2006). A clarification of what is a suicide attempt will lead to the development of specific, selective, and sensitive questions that clarify precisely whether the self-injurious behavior under investigation was intended to end one’s life (clear suicidal intention), or was secondary to other mitigating factors (Wagner et al., 2002).

Self-reported suicide attempts have limited validity due to inconsistent definitions and problems with recall bias (Kjoller, Norlev, & Davidsen, 2004). Freeman, Wilson, Thigpen, and McGee (1974) conducted a study that attempted to assess intention to die in cases of self-injury. They concluded that: “This study has shown that the vast majority of heretofore called ‘suicide attempts’ are in fact not that at all, but rather are, behaviorally speaking, events of self-injury or self-poisoning. The intent is, in nearly all cases, not that of dying, but of living” (p. 38). In the CDC’s Youth Risk Behavior Survey (2005), only 1 in 3 adolescents who reported a suicide attempt required any medical attention, leaving the investigator very unclear about what self-reporters are referring to when they report a suicide attempt. No study has yet to demonstrate the validity or reliability of adolescents’ or adults’ self-reported suicide attempts (Rosenbaum, 2006; Santa Mina & Gallop, 1998).

Meehan, Lamb, Saltzman, and O’Carroll (1992) found that for every ten self-reported attempts, only one resulted in hospitalization. Only two others resulted in medical attention. The intent and lethality of the other 70% is unknown, thus seriously compromising the validity of self-reported suicide attempts. Since suicide means intentional self-injury that results in death, any meaningful definition of suicide attempt should also incorporate a high likelihood of death as well as a true intent to kill oneself. The fact that Meehan et al. (1992) found that the great majority of self-reported suicide attempts did not even result in medical attention strongly indicates that the term is vastly overused to describe other forms of distress or self-injury. Thus, as O’Carroll et al. noted, “Because the term ‘attempted suicide’ potentially means so many different things, it runs the risk of meaning almost nothing at all” (p. 238).

Freeman, Wilson, Thigpen, and McGee (1974) advocated for eliminating the term suicide attempt, a recommendation that we felt we could not abide, because, in part, the term is too well ingrained in the language of suicidology. Instead, we decided to more narrowly define the term (which invokes intention) and, in so doing, clearly distinguish it from other terms, such as self-harm (which lacks intent to die). The behavioral consequence of self-harm is to change the circumstances of one’s environment or internal state in a meaningful way (albeit through a self-injurious act). This term held great appeal to us, because it served as a conceptual juxtaposition to suicide attempt (where the hoped-for or intended outcome is to remove oneself from one’s environment forever) and as an alternative to “low lethality attempt with uncertain intent.”

Meehan et al. (1992) suggested that to assess a suicide attempt, a series of questions are needed with independent verification from a knowledgeable source, such as an emergency room physician, in addition to self-reports from the individual. This series of questions should elicit a description of the injury that occurred, if any, so that independent raters may judge the potential lethality of the event; whether medical attention or hospitalization followed; and whether the self-initiated behavior was indeed intended to cause one’s own death or injury. We would add that an investigation of the context of the suicidal attempt (environmental, psychological, ecological) would also assist in defining the behavior and potentially classifying it.

Overlap Between Suicide and Nearly Lethal Suicide Attempts

A number of recent studies have looked at the degree to which there is a distinction
between suicide and nearly lethal suicide attempts (or “medically serious suicide attempts”) (Beautrais, 2001; Silverman & Simon, 2001). Beautrais concluded that suicides and medically serious suicide attempts are two overlapping populations that share common psychiatric diagnostic and historical features (current mood disorder; previous suicide attempt; prior outpatient psychiatric treatment; admission to psychiatric hospital within the previous year; low income; a lack of formal educational qualifications; exposure to recent stressful interpersonal, legal, and work-related life events), but are distinguished by gender (males were more likely to kill themselves) and patterning of psychiatric disorder (attempts were more likely than those dying by suicide to have a current diagnosis of anxiety disorder and to be socially isolated).

The Houston Case Control Study found that up to 24% of nearly lethal suicide attempters had spent less than 5 minutes between the decision to attempt suicide and the actual nearly lethal attempt (5% reported spending just one second) (Simon et al., 2001). For 52.6% of the nearly lethal suicide attempters, it was their first suicide attempt. Male gender and a history of involvement in physical fights differentiated impulsive attempters from non-impulsive suicide attempters. Although some would argue that “impulsivity” may have a proximal causal role in the suicidal process for some individuals (Mann, Waternaux, Haas, & Malone, 1999), what may look like an impulsive act may actually be a culmination of a thinking and planning process that had developed over time but had not yet reached the “tipping point” (Goldney, 1998).

CONCLUSION

The publication of the O’Carroll et al. (1996) nomenclature sparked a revitalization in addressing the language of suicidology and its conceptual foundations (Andriessen, 2006; De Leo et al., 2004, 2006; Silverman, 2006). The Denver Veterans Administration VISN 19 Mental Illness Research, Education, and Clinical Care (MIRECC) Nomenclature Workgroup reviewed the critiques and recommendations made in response to the O’Carroll et al. paper, and proceeded to address as many as possible in their revision. In the article that follows, Silverman, Berman, Sanddal, O’Carroll, and Joiner (this issue) present the revised nomenclature.

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