Empirically Informed Approaches to Topics in Suicide Risk Assessment

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The purpose of this article is to approach topics in suicide risk assessment from a scientifically informed standpoint. We summarize and elaborate a general framework for an empirically supported best practice recommendation in evaluating suicide potential and minimizing risk. This risk assessment framework provides a concise heuristic for assessment of suicidal symptoms, points the way to relatively routinized clinical decision-making and activity, and is compatible with best practices relevant to the legalities of suicide risk assessment. Having established a general and scientifically based framework for risk assessment, we go on to address the other questions noted above, with reference to the framework and to our ongoing scientific work. We conclude by summarizing all the work and providing clear and concise clinical recommendations based thereon. Copyright © 2004 John Wiley & Sons, Ltd.

Suicide is a leading cause of death in the United States, and worldwide well over a half a million people die by suicide each year. A large portion of the general population acknowledges suicidal ideation at some point during their lives, and a still higher portion of those presenting in mental health settings note at least some suicidal ideation (Paykel, Myers, Lindenthal, & Tanner, 1974). Although suicidal ideation is common, and many people die by suicide, the actual occurrence of suicide is relatively infrequent. The mere presence of some suicidal symptomatology, including thoughts of suicide, is not very discriminating. Because suicidal ideation occurs much more frequently than suicide, it is important to figure when the former may predict the latter. From a practical clinical standpoint, it would be...
useful to know which suicidal symptoms are particularly worrisome and which are less so.

Practitioners are routinely faced with the decision as to what to do when a patient reports suicidal ideation. In some settings, mental health professionals may take one of two extreme approaches, neither of which is recommended. Some take an approach of excessive caution, and assume that any patient who mentions the thought of suicide is at high risk for suicide. Research has shown that clinicians tend to take a “better safe than sorry” approach and over-estimate suicidality (Joiner, Rudd, & Rajab, 1999). This, of course, could have several negative consequences, including inappropriate deprivation of patients’ rights, and squandering of scarce clinical resources. Of course, the other extreme—a dismissive or inept approach to suicide risk assessment—carries risk to patients’ safety and clinicians’ liability.

The challenges do not end here. What to recommend when a colleague asks for a brief pencil-and-paper screening measure? What to think when a clinician’s view of risk is discrepant from the patient’s own view? What is the usual course of symptoms and risk following a suicide crisis? Is it true that there is a window of particular risk as deeply depressed patients begin to recover?

The purpose of this article is to approach each of these questions, and some others, from a scientifically informed standpoint based mostly on our group’s program of research. We begin by summarizing and updating the general framework for an empirically supported best practice recommendation in evaluating suicide potential and minimizing risk, put forth by Joiner, Walker, Rudd, and Jobes (1999). This risk assessment framework provides a concise heuristic for assessment of suicidal symptoms, points the way to relatively routinized clinical decision-making and activity, and is compatible with best practices relevant to the legalities of suicide risk assessment. Having established a general and scientifically based framework for risk assessment, we go on to address the other questions noted above, with reference to the framework and to our ongoing scientific work. We also address additional issues relevant to post-crisis assessment. We conclude by summarizing all the work and providing clear and concise clinical recommendations based thereon.

**A GENERAL FRAMEWORK FOR SUICIDE RISK ASSESSMENT**

A quick survey of the websites of organizations such as the American Association of Suicidology, the American Foundation for Suicide Prevention, and the American Psychological Association, among many others, shows that over 75 factors are listed as suicide risk factors or warning signs, including things as diverse as “loss of religious faith,” “neurotransmitters,” “accident-proneness,” “perfectionism,” and “loss of security.” Even without managed care pressures, it is unrealistic to imagine that clinicians can assess all or even many of these (and for the examples listed, as well as many others, it is questionable whether they should be assessed at all). Moreover, even if clinicians could cover so much ground, how are they to organize the resulting mass of data? What conclusions should they reach if a patient has a certain number or constellation of risk factors, versus some other number or constellation?

What is needed is an efficient, clear, and empirically supported method to assess for suicide risk. Such a method would not only serve as a guideline for professionals
in clinical work, but would also provide a benchmark against which clinicians’ activities can be evaluated in legal and other settings.

One of the most recent guidelines published, *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors* (American Psychiatric Association, 2003), is very thorough and attends to empirical data, but is quite lengthy. In fact, the document is 117 pages and it discusses in detail the assessment of patients with suicidal behavior, psychiatric management, specific treatment modalities, documentation, and risk management, as well as several other topics. The guideline is divided into three parts with several sections. In Part A, “Section I summarizes the key recommendations of the guideline and codes each recommendation according to the degree of clinical confidence with which the recommendation is made. Section II discusses the assessment of the patient, including a consideration of factors influencing suicide risk. Section III discusses psychiatric management, Section IV discusses specific treatment modalities, and Section V addresses documentation and risk management issues. Part B provides an overview of suicide, including general information on its natural history, course, and epidemiology. It also provides a structured review and synthesis of the evidence that underlies the recommendations made in Part A. Part C draws from the previous sections and summarizes areas for which more research data are needed to guide clinical decisions” (American Psychiatric Association, 2003). It would be beneficial to have a succinct guideline that is compatible with that and other best practice recommendations.

Joiner et al. (1999b) approached this issue with an initial question: Of all the numerous risk factors and warning signs, do any stand out on clinical, theoretical, or scientific grounds as particularly important? If so, then a risk assessment approach might be built around them. Studies have found that clinically important differences exist between suicide ideators, single attempters, and multiple attempters (see, e.g., Clark & Fawcett, 1992; Rudd, Joiner, & Rajab, 1996). Additionally, the results of a factor-analytic study of the Modified Scale for Suicidal Ideation (Joiner, Rudd, & Rajab, 1997) suggest that the two main factors “resolved plans and preparations” and “suicidal desire” summarize the factor space of suicidal symptomology (see also Steer, Rissmiller, Ranieri, & Beck, 1993; Mieczkowski, Sweeney, Haas, & Junker, 1993; Stoelb & Chiriboga, 1998). It emerges in various outpatient and inpatient samples; Joiner et al. (2003) among others have shown that “plans” predict death by suicide, “desire does not.” Based in part on the above empirical evidence, Joiner et al. (1999b) argued that two factors deserve particular weight: (1) history of multiple suicide attempts and (2) the specific nature of current suicidal symptoms, with specific reference to whether the symptoms include “resolved plans and preparations” versus “suicidal desire.”

Regarding history of multiple attempts, there is converging evidence that clinically important differences exist between three groups—suicide ideators, single attempters, and multiple attempters1 (see, e.g., Clark & Fawcett, 1992; Forman, Berk, Henriches, Brown, & Beck, manuscript under editorial review; Rudd et al., 1996). More specifically, there appear to be clear differences in overall baseline risk for multiple attempters, as opposed to others, even under the best of conditions. In

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1 Attempter, as used in this article, is defined as any individual who engages in a self-destructive act with the intention of committing suicide.
contrast to single attempters or ideators, the risk rating for multiple attempters is perpetually elevated, at least to a degree, as a result of the type, chronicity, and severity of psychopathology associated with multiple attempt status. In other words, when all other factors are held constant, or people are matched for all other factors (forming a baseline for comparison), multiple attempters are at an elevated risk compared with single attempters or ideators. One study that explored the relationships among suicide ideators, attempters, and multiple attempters among 332 psychiatric patients referred for suicidal ideation or behavior found that multiple attempters, when compared with attempters and ideators, presented a more severe clinical picture as well as elevated suicide risk (see Rudd et al., 1996, for further commentary on risk groups). Accordingly, Joiner et al. (1999b) concluded that risk assessment should differ, at least somewhat, for multiple attempters as compared to ideators and single attempters. We will describe how it should differ, but first, the other key variable in the framework—the nature of current suicidal symptoms—must be introduced.

In continuing education seminars on depression and suicide, we have polled over 100 audiences on the one most important suicide assessment question. Invariably, the audiences respond, “Do you have a plan?” and “Do you have suicidal ideas?” These are, of course, good questions, but they can be criticized nevertheless. Suicidal ideas are important, sure, but are all suicidal ideas alike? Are some more dangerous than others? Asking about a suicidal plan is crucial, of course, but what features of a suicidal plan make it particularly clinically worrisome?

We and others (e.g. Beck, Brown, & Steer, 1997) have shown that the factor space containing suicidal symptoms can be adequately explained by two factors, which, while of course correlated (approximate \( r = 0.50 \)), are discernible, and which we named “resolved plans and preparations” and “suicidal desire and ideation.” Beck et al. (1997) studied suicidal ideation in a group of 4063 outpatients. They explored the psychometric properties of the Scale for Suicide Ideation—Current (SSI-C) and the Scale for Suicide Ideation—Worst (SSI-W). These are 19-item scales that measured current suicide ideation (SSI-C) as well as suicide ideation at its worst point in the patient’s life (SSI-W). Factor analyses identified comparable Preparation and Desire dimensions underlying both scales.

The “resolved plans and preparation” factor is made up of the following symptoms: a sense of courage to make an attempt; a sense of competence to make an attempt; availability of means to and opportunity for attempt; specificity of plan for attempt; preparations for attempt; duration of suicidal ideation; and intensity of suicidal ideation. The “suicidal desire and ideation” factor was comprised of the following symptoms: reasons for living (when absent or minimal indicate a higher risk); wish to die; frequency of ideation; wish not to live; passive attempt (e.g. driving recklessly with the thought of possible death); desire for attempt; expectancy of attempt; lack of deterrents to attempt; and talk of death/suicide.

Although the presence of symptoms corresponding to either factor is of clinical concern, the symptoms of “resolved plans and preparation” are, relatively speaking, of more concern than the symptoms of “suicidal desire and ideation.” For example, “resolved plans and preparation” was more related than “suicidal desire and ideation” to worrisome indicators such as status as a multiple suicide attempter. As another example, the “plans” dimension was particularly related to subsequent
completed suicide, as well as a lifetime history of suicide attempts, among psychiatric outpatients experiencing suicidal ideation at the time of assessment (Joiner et al., 2003).

Returning to the overall risk assessment framework presented by Joiner et al. (1999b), it was argued that assessment of two domains—multiple attempt status and whether symptoms are more in the domain of “resolved plans and preparation” or “suicidal desire and ideation,”—when combined with evaluation of other key risk factors, produces a relatively objective categorization scheme. The framework can be summarized as follows: For multiple attempters, any noteworthy finding from the domains of current suicidal symptoms, significant life stressors (but their role is complex; see below), general Axis I symptoms, hopelessness, social isolation, and Axis II symptoms/impulsivity translates into at least moderate suicide risk. For non-multiple attempters, the combination of notable suicidal symptoms from the “resolved plans and preparation” factor and at least one noteworthy finding from the other domains translates into at least moderate suicide risk. For non-multiple attempters who display no suicidal symptoms from the “resolved plans and preparation” factor but who do display symptoms from the “suicidal desire and ideation” factor, the presence of two or more noteworthy findings from the other domains translates into at least moderate suicide risk. The framework is not a completely automated statistical prediction rule, but provides a relatively objective starting point for clinical decision-making in risk assessment. Figure 1 provides a visual representation of our general approach, with some updates in italics to be discussed later.

Regarding clinical decision-making, Joiner et al. (1999b) made the following recommendations for risk severity ratings. (a) Nonexistent: no identifiable suicidal symptoms; no past history of suicide attempt; no or very few other risk factors. (b) Mild: a multiple attempter with no other risk factors or a non-multiple attempter with suicidal ideation of limited intensity and duration, no or mild symptoms of the Resolved Plans and Preparation factor, and no or few other risk factors (both the nonexistent and mild risk severity ratings are consistent with Low Risk in Figure 1). (c) Moderate: a multiple attempter with any other notable finding or a non-multiple attempter with moderate to severe symptoms of the Resolved Plans and Preparation factor or a non-multiple attempter with no or mild symptoms of the Resolved Plans and Preparation factor, but moderate to severe symptoms of the Suicidal Desire and Ideation factor and at least two other notable risk factors. (d) Severe: a multiple attempter with any two or more other notable findings or a non-multiple attempter with moderate to severe symptoms of the Resolved Plans and Preparation factor and at least one other risk factor. (e) Extreme: A multiple attempter with severe symptoms of the Resolved Plans and Preparation factor or a non-multiple attempter with severe symptoms of the Resolved Plans and Preparation factor and two or more other risk factors.

For those in the nonexistent and mild risk categories, Joiner et al. (1999b) suggested that some variant of the following statement be regularly made. “In the event that you begin to develop suicidal feelings, here’s what I want you to do: First, use the strategies for self-control that we have discussed, including seeking social support. Then, if suicidal feelings remain, seek me out or whoever is covering for me, or call 1-800-SUICIDE. If, for whatever reason, you are unable to access help, or, if you feel that things just won’t wait, call 911 or call or go to the ER—here is
their phone number.” That some variant of this statement was made should be clearly documented in progress notes. Continued risk assessment activities of this sort are necessary because suicidality can suddenly increase for an array of unpredictable reasons.

For those in the moderate risk category, the following actions were recommended by Joiner et al. (1999b): consideration of increase in the frequency or duration of outpatient visits to address specific, identified stressors, and facilitate symptom resolution; active involvement of the family and supportive others if possible; frequent re-evaluation of treatment goals (e.g. symptom remission, reduction in the frequency, intensity, or specificity of suicidal ideation, reduced hopelessness, improved problem-solving, adaptive coping, improved hopefulness, improved self-control, establishing or mobilizing an available or accessible support system); 24-hour availability of emergency or crisis services for the patient; frequent re-evaluation of suicide risk, noting the specific changes that elevate or reduce risk (e.g. no further suicidal ideation); if not already in use, consideration of medication for symptom relief; consideration of use of telephone contacts for monitoring purposes; professional consultation as indicated or needed for risk assessment and treatment planning; consideration of input from family members with respect to risk indicators (e.g. instituting a suicide watch at home). Again risk designation, and the attendant clinical decisions and activities, should be regularly documented in progress notes.

For those in the severe and extreme risk categories, many of the activities recommended for the moderate category also apply, as does immediate evaluation for psychiatric hospitalization (including involuntarily depending on the circumstances, especially for those in the extreme risk group). As before, clear documentation of risk
category and attendant decisions and actions is necessary. Importantly, for patients in
the moderate, severe, and extreme risk categories, the variable and time limited nature
of risk must be noted (even for those making multiple attempts), and subsequent
progress note entries will eventually need to indicate resolution of risk, or at least
clinical activity aimed at such.

UPDATING THE FRAMEWORK

The Complex Role of Negative Life Stress

We noted earlier that significant life stressors could be a significant finding in the
rubric of our risk assessment framework, but that their role is complex. Recent
studies from our research program indicate that negative life stress predicts the
duration but not the severity of a suicidal crisis among multiple attempters (Joiner &
Rudd, 2000; Joiner, Rudd, Rouleau, & Wagner, 2000). That is, even in the absence
of precipitant life stress, a person with a multiple attempt history may develop a
relatively acute suicidal crisis, but one that should resolve relatively rapidly. When
stress is present, the crises of multiple attempters tend to be of longer duration, and
similarly, when stress is absent, the crises tend to be of shorter duration. Given that
many of the pernicious symptoms from the Resolved Plans and Preparation factor
involve enduring processes (e.g. duration of ideation, planning), a stress-dependent
suicidal crisis among multiple attempters is reason for particularly serious concern
and a designation of serious risk.

The Relevance of a New Theory of Suicidal Behavior

Joiner’s (manuscript under editorial review) interpersonal–psychological theory of
attempted and completed suicide states that serious suicidal behavior requires each
of three interpersonal–psychological precursors: (1) the acquired capability to enact
lethal self-injury; (2) the sense that one is a burden on loved ones; and (3) the sense
that one does not belong or is not connected with a valued group or relationship. An
individual cannot die by suicide even if s/he wants to if the acquired capability for
suicide is absent. If a person feels a sense of belongingness or feels that s/he
contributes to a group (is not a burden), the individual will be protected from
suicide, even if the acquired capability for suicide is present. These three precursors
were specifically identified because they are theoretically sound and are supported
with representative data from several sources, ranging from the anecdotal to the
controlled experiment. The three precursors have repeatedly been associated with
increased risk for suicide and in light of these consistent and repeated associations
are likely to have a good degree of predictive utility. The interpersonal–psychological
theory, with the inclusion of the three precursors, is able to “address, and at least
partially explain, various key facts, including prevalence of completed suicide, the
associations of completed suicide with age, gender, race, neurobiological indices,
previous suicide attempts, mental disorders and substance abuse, impulsivity, and
childhood adversity, as well as such issues as the clustering and ‘contagion’ of
suicide” (Joiner, manuscript under editorial review).
The theory argues that each of these factors is a necessary, but not sufficient, antecedent of serious forms of suicidal behavior, including completed suicide. According to the theory, it is through repeated experience with painful or provocative stimuli, especially (but not limited to) deliberate self-harm, that a person acquires the ability to enact lethal self-injury. When this ability is combined with desire for suicide, risk is very high. The desire for suicide, according to the theory, occurs when basic needs for competence and connectedness are thwarted. Feelings of incompetence contribute to the desire for suicide, and moreover, feeling incompetent to the degree that others are burdened is among the strongest sources of all for the desire for suicide (Brown, Comtois, & Linehan, 2002; Brown, Dahlen, Mills, Rick, & Biblarz, 1999; Joiner et al., 2002a). The need to belong is also a key aspect of the theory. The need to belong is a basic human drive and when it is frustrated negative effects, including suicide, are more likely to occur (Baumeister & Leary, 1995). Social isolation is a powerful predictor of serious suicidal behavior, including death by suicide (e.g. Motto & Bostrom, 1990).

An implication of the theory is that a suicide risk assessment framework should emphasize acquired capability for serious self-injury, burdensomeness, and thwarted belongingness. The theory thus suggests a broadening of the focus in suicide risk assessment from multiple attempters to anyone who has, through various means, acquired the capability for lethal self-injury. This capability is acquired by means of repeated practice, or repeated exposure to self-injury. Practitioners should assess for instances in which a patient may have been able to practice self-harm, including “aborted” suicide attempts (an event in which an individual comes close to attempting suicide but does not do so and thus sustains no injury; Barber et al., 1998) and other self-harm behaviors such as cutting, burning, and eating harmful objects. Various forms of exposure to violence, as well as other provocative experiences such as self-injecting drug use, are other possible areas of investigation (Conner et al., 2001; Darke & Ross, 2002). This assessment can be conducted in an unstructured interview format, and information can also be gathered from other sources including medical records and reports from friends and family.

Another implication of the theory is that the “suicidal desire” factor may be most pernicious when it contains themes of both burdensomeness and thwarted belongingness. If suicidal desire in general is endorsed, it should be explored as to whether burdensomeness and thwarted belongingness undergird it. If so, risk may be more elevated; if not, risk may be more moderate. In order to assess for burdensomeness and belongingness, the practitioner can assess relevant information through an informal interview. Practitioners can assess the client’s ability to care for him/herself, dependency on others, and general ineffectiveness in daily living. Practitioners should also assess for recent separations from relationships and other groups as well as social involvement and integration. In addition to self-report, much of this information can be provided by friends and family. The theory-based amendments to the risk assessment scheme are consistent with the original risk assessment scheme and serve to elaborate on the scheme and provide more specific detail as to particular, theoretically important areas of inquiry. The italicized parts of Figure 1 incorporate these theory-based amendments to the risk assessment scheme.
Axis II Symptoms: The Interesting Case of Antisociality

Self-destructive behavior, including suicide, has been linked to antisocial personality disorder (ASPD; see, e.g., Repo-Tiihonen, Virkkunen, & Tiihonen, 2001). In a masterful work on ASPD phenomena, Cleckley (1941) reserved the term psychopath for those with the cardinal feature of emotional detachment (i.e. low anxiety, fake or shallow emotions, immunity to guilt and shame, callousness, and incapacity for love, intimacy, and loyalty). Empirical work has demonstrated that the factor space occupied by antisociality consists of two, separable factors (Hare, 1991) — that currently emphasized by DSM and corresponding to “antisocial behavior” (i.e. impulsive, reckless, under-controlled behaviors) and that formerly emphasized in DSM to some degree and corresponding to Cleckley’s emphasis on “emotional detachment” (coined by Patrick, Bradley, & Lang, 1993). According to this perspective, the two dimensions may possibly correspond to two kinds of person with antisocial personality—those who are emotionally detached (and who are also prone to poor behavioral control, in part because of their emotional detachment) and those who are primarily impulsive, aggressive, and irresponsible but who are not emotionally detached (and actually may be especially emotionally reactive).

Verona and colleagues (Verona, Patrick, & Joiner, 2001; Verona, Sachs-Ericsson, & Joiner, 2004) predicted that this latter type of individual would be prone to suicidal behavior (due to the combination of impulsivity and emotional reactivity), but that emotionally detached, Cleckley psychopaths would not be (due in part to low emotional reactivity). Their studies (of 313 inmates and of 4745 community participants) supported this prediction: “antisocial behavior” was associated with history of suicide attempts; “emotional detachment” was not. Moreover, the Verona et al. (2001) study on inmates found that the link between “antisocial behavior” and suicidality was mediated by personality traits such as negative emotionality and impulsivity.

Thus, just as all suicidal symptoms are not alike in conferring high risk for suicide, not all Axis II symptoms relate similarly to suicide risk. In judging whether Axis II symptoms should be viewed as a significant risk factor within the framework described above and shown in Figure 1, the findings of Verona and colleagues, as well as those of others (e.g. Soloff, Lynch, Kelly, Malone, & Mann, 2000) suggest an emphasis on behavioral and emotional dyscontrol.

Self-Report versus Clinicians’ Judgment

Ideally, there is concordance between patients’ self-report and clinicians’ judgment regarding suicide risk. However, discrepancies regularly occur (Coombs, Miller, Alarcon, & Herlihy, 1992; Hawton, Cole, O’Grady, & Osborn, 1982; Kaplan, Benbenishty, Waysman, & Solomon, 1992). Perhaps surprisingly, there is evidence that, all things being equal, patients’ self-ratings may outperform clinicians’ ratings in important ways. For example, Jobes, Jacoby, Cimbolic, and Hustead (1997) tracked patients who had initially presented with suicidal symptoms, and, based on the later course of the suicidal symptoms, classified patients into “acute resolver” and “chronic non-resolver” outcome categories. Patients’ initial self-ratings were better than clinicians’ ratings at predicting eventual group membership. Similarly,
among a large group of suicidal young adults, Joiner et al. (1999a) reported that patients’ self-ratings were more telling than clinicians’ ratings regarding recurrence of suicidal symptoms at 6, 12, and 18 month follow-up sessions. This result was recently affirmed in a sample of psychiatric outpatients in Brazil (Berlim et al., manuscript under editorial review).

Two sources may account for clinicians’ over-estimates of suicidality. First, clinicians may treat a past history of a single suicide attempt in the same way as a history of multiple attempts, whereas we argue that only the latter group deserves special categorization. Second, clinicians may be particularly sensitive to patients’ personality traits, particularly those in Axis II’s Cluster B, which may serve to somewhat artificially inflate actual risk estimates.

Importantly, we do not suggest that clinicians ignore key prognostic indicators such as Cluster B symptoms (which are clearly important); nor do we suggest that self-report methods replace clinician ratings. We are suggesting that patients’ own self-report of suicidal symptoms deserves considerable attention within frameworks such as that presented in Figure 1. Unless there are clear reasons to the contrary (and there may often be; e.g., motivation to dissemble, malingering, and cognitive impairment), self-report regarding suicide potential should be a major—perhaps the major—data source.

In this connection, a reasonably well studied and inexpensive self-report instrument should be mentioned. Based on a study of approximately 2,800 adolescents and young adults accessing primary care, Joiner, Pfaff, and Acres (2002) presented the Depressive Symptom Index Suicidality Subscale (see the appendix). It is a very brief screening tool for suicidality for use in general health settings. The scale was clearly unitary, cohesive, and internally consistent. Moreover, it evinced construct validity by relating to several demographic and clinical indices in predicted ways. For example, the scale was highly related to depressive symptoms and to general emotional distress, and as predicted was more related to the former than to the latter.

Joiner et al. (2002b) noted that a cut-off score of 2 or above would designate approximately 20% of the sample as at risk; 3 or above would designate approximately 15% of the sample as at risk; and 4 or above would designate approximately 10% of the sample as at risk. Although local adjustments should be made according to clinicians’ needs (as base rates of suicide-related behavior will differ among various populations), we find the cut-point of 3 and above appealing, in that it is relatively selective (1 or 2 in 10 patients will achieve this score or higher). It should be noted that level of risk falls on a continuum and the cut-point of 3 is suggested because those who obtained a score of 3 or above in the Joiner et al. study showed a high risk profile (e.g. substantial depression). Because the scale is very brief and contains questions relevant to both the “resolved plans” and “suicidal desire” facets, it can be used as a very efficient prelude to the more in-depth risk assessment scheme described above and in Figure 1.

**TWO ADDITIONAL ISSUES RELEVANT TO POST-CRISIS ASSESSMENT**

Much of what is described above—and indeed much of the literature as a whole—is focused on assessment to determine whether a suicidal crisis is imminent,
deepening, dangerous, and so forth. But what about post-crisis? It is clear from work on multiple attempters that risk can persist even when crises subside. A legitimate answer is that the risk assessment procedure described above and in Figure 1 is appropriate for ongoing risk assessment.

We would point to two studies, however, that further inform issues related to post-crisis risk assessment. The first issue involves a well known piece of clinical lore that cautions that there is a window of heightened suicide risk when people become more energetic in the context of continued depressive symptoms. According to this view, individuals may acquire energy to act on continued suicidality, and/or may gain cognitive clarity to act on their suicidal intentions. This perspective confers a special status on particular symptoms such as energy—when the energy symptom remits and other symptoms do not, the window of vulnerability opens, according to this view. But is this special status deserved? What happens regarding suicide risk if, for example, the sadness symptom remits and other symptoms do not? Relatedly, it is clear that persistence of subclinical depressive symptoms—any depressive symptoms, not just the energy symptom—can be a negative prognostic sign (Judd, 1997). Perhaps those who experience persistence of depressive symptoms in the context of increased energy represent just one of many patterns of incomplete remission, and perhaps it is incomplete remission (an index of illness severity), and not increased energy, that confers heightened suicide risk.

In fact, Joiner, Pettit, and Rudd (2004) studied 109 suicidal young adults; among those who initially reported substantial depression, they identified a subgroup whose energy was increasing in the context of continued depressive symptoms. They were compared to others with regard to suicidality one month later. Results suggested that those who have incomplete remissions (of any sort) may be more ill to begin with, and this may account for their higher suicide risk.

Importantly, Joiner et al. (2004) did not recommend that the role of increased energy with sustained depression in suicidality be rejected. Rather, they recommended that it be subsumed within a more general view that extends to other clinical profiles, not just improved energy within sustained depression. Specifically, our data, combined with work on incomplete remission (e.g. Judd, 1997), suggest that clinicians should be attentive to any situation in which a substantially depressed person’s symptoms (any of them) continue after sufficient treatment. Continued depressive symptoms can serve as a risk factor for re-instantiated full-syndrome depression, and can serve as a marker for illness severity. Recurrent depression and severity of depression, in turn, are associated with serious suicidality. Clinicians who are attentive to incomplete symptom responses (and who factor them into the risk assessment framework elucidated above and displayed in Figure 1) will detect those who have improved energy but little improvement in other symptoms, and will also detect those with other incomplete recovery profiles who might also be at substantial risk.

A second issue has to do with the course of post-crisis suicidal symptoms. Walker and colleagues (2001) compared two views of improvements in the wake of a suicide crisis—“catharsis” or “blowing off steam” versus the gradual accretion of post-crisis interpersonal support. They doubted traditional views of catharsis (i.e. blowing off steam or emotional venting), and reasoned that if such views possessed explanatory power, then attempt-related symptom reductions should be immediately apparent. By contrast, if a more gradual process such as accretion of
interpersonal support were involved, post-crisis symptom reductions may emerge, but only after the passage of a substantial amount of time. Furthermore, drawing on the literature on multiple attempters, Walker et al. (2001) predicted that long-term course of suicidal symptoms may differ for multiple attempters versus others, in that multiple attempters may undo any gains, and thus display signs of symptom relapse.

Results were generally in line with expectations. Specifically, immediately post-crisis, attempters had somewhat higher symptom scores than ideators, at odds with the view that attempters gain immediate symptom relief through catharsis. Over a one month follow-up, however, attempters did display a slightly steeper rate of symptom improvement, partially consistent with the view that a gradual process, such as accrual of interpersonal support, was involved. At 12 month follow-up, non-multiple attempters maintained low suicidality, whereas multiple attempters displayed signs of symptom relapse.

A key implication of these findings for suicide risk assessment is that post-crisis social support should be monitored. A social environment that mobilizes in support of someone post-crisis appears to be a positive prognostic sign for reductions in suicidality over 12 months. This is one reason that encouraging these kinds of interpersonal connection is a major emphasis of the categorization-based clinical activities summarized above. An additional implication of these findings is that multiple attempters may benefit less than others from the mobilization of social support, in part because they may engage in help negation (the active thwarting of offered help, including therapeutic help; Rudd, Joiner, and Rajab (1995) documented this phenomenon among multiple attempters)—still another reason to highlight multiple attempt status as a key variable in risk assessment frameworks such as that presented above and in Figure 1.

CONCLUSIONS

Our purpose was to summarize and update a general and scientifically based framework for risk assessment, and to address several other related issues, with reference to the framework and to our ongoing scientific work. The conceptual model presented is unique because it provides a concise heuristic for assessment of suicidal symptoms that is based on scientific theory and evidence, and it points the way to relatively routinized clinical decision-making activity. This guideline provides a scheme for designating risk level and advises the necessary actions at each level of risk. We close by offering bulleted summaries and recommendations.

- It is crucial to routinely use an objective and efficient risk assessment framework, one that balances attention to the scientific literature, speed, coverage, clarity, and utility. Doing so minimizes both risk to patients’ safety and legal liability of clinicians.
- The framework proposed by Joiner et al. (1999b), and summarized here, meets these criteria adequately. Within that framework, several key issues should be highlighted:
  - Multiple attempters are a unique group with regard to suicide risk assessment. Among important features of multiple attempters are the fact that their crises may occur in the absence of obvious precipitants, and that they may engage in
“help negation.” Additionally, a stress-dependent suicidal crisis among multiple attempters is reason for particularly serious concern and a designation of serious risk.

- Multiple attempters are also particularly likely to experience Axis II symptoms, and among these symptom, those having to do with pronounced emotional and behavioral dyscontrol are highly relevant to suicide risk assessment.
- The features of the “resolved plans and preparations” facet of suicidality are more pernicious and clinically worrisome than those of the “suicidal desire” facet, and risk assessment should proceed accordingly.
- The point of any objective risk assessment framework is categorization, and categorization, in turn, facilitates clinical decision-making.
- Documentation of risk assessment procedures, categorization, and categorization-based clinical decisions and activities should be a regular routine, informed by legal concepts such as foreseeability and causation.
- Such concepts as the various ways to acquire the ability to enact lethal self-injury, perceived burdensomeness, and thwarted belongingness elaborate on the “resolved plans” versus “suicidal desire” distinction.
- Brief self-report approaches (see the appendix) may be an efficient prelude to more in-depth risk assessment techniques.
- Patients’ own self-report of suicidal symptoms deserves considerable attention within the suicide assessment framework. Unless there are clear reasons to the contrary, self-report regarding suicide potential should be a major source of data.
- Regarding post-crisis course of suicidal and depressive symptoms as well as suicide risk, two issues were highlighted.
  - The clinical lore that there is a window of heightened suicide risk in which individuals may acquire energy to act on continued suicidality may be one instance of a larger principle: Those with other incomplete depression recovery profiles may be at substantial suicide risk.
  - Work on post-crisis course of symptoms and risk suggests that post-crisis symptom improvements appear to occur as a function of increased social support. Post-crisis social environment should thus be monitored as part of ongoing risk assessment, and positive interpersonal connections should be encouraged as part of categorization-based clinical activities summarized above.

APPENDIX. DEPRESSIVE SYMPTOM INDEX—SUICIDALITY SUBSCALE

Instructions: On this questionnaire are groups of statements. Please read all of the statements in a given group. Pick out and circle the one statement in each group that describes you best for the past TWO WEEKS. If several statements in a group seem to apply to you, pick the one with the higher number. BE SURE TO READ ALL OF THE STATEMENTS IN EACH GROUP BEFORE MAKING YOUR CHOICE.

A) 0 I do not have thoughts of killing myself.
    1 Sometimes I have thoughts of killing myself.
    2 Most of the time I have thoughts of killing myself.
    3 I always have thoughts of killing myself.
B) 0 I am not having thoughts about suicide.
1 I am having thoughts about suicide but have not formulated any plans.
2 I am having thoughts about suicide and am considering possible ways of doing it.
3 I am having thoughts about suicide and have formulated a definite plan.

C) 0 I am not having thoughts about suicide.
1 I am having thoughts about suicide but have these thoughts completely under my control.
2 I am having thoughts about suicide but have these thoughts somewhat under my control.
3 I am having thoughts about suicide but have little or no control over these thoughts.

D) 0 I am not having impulses to kill myself.
1 In some situations I have impulses to kill myself.
2 In most situations I have impulses to kill myself.
3 In all situations I have impulses to kill myself.

Note. Scores for the scale are obtained by summing item ratings.

REFERENCES


