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Suicide Assessment: Strategies for Determining Risk

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Abstract:

Suicide constitutes an international health crisis. The World Health Organization estimates that approximately one million people per year commit suicide, and suicide is now among the top three leading causes of death for persons aged 15-34 in every country in the world. Counselors encounter suicidal persons in schools and agencies with alarming frequency and often express concerns about handling these clients. This manuscript overviews suicide risk factors and then discusses suicide risk assessment, as assessment is the critical foundation for both suicide prevention and treatment. The assessment of suicide risk is a difficult and complex task. Suicide risk assessment helps identify acute, modifiable, and treatable risk factors and helps clinicians to recognize when clients need more concrete methods to help clients manage their lives. Suicide risk assessment requires knowledge, training, and experience.

Suicide Assessment: Strategies for Determining Risk

According to the World Health Organization (WHO), approximately one million people each year commit suicide, more than all homicides and war-related deaths combined. Suicide rates are on the rise, increasing more than 60% in the last half century. In 1950, the worldwide suicide rate was 10 per 100,000, and it has now reached 16 per 100,000. If this trend continues, by 2020, there will be more than 1.5 million suicides in the world each year (World Health Organization, 2006).

Suicide represents a major health concern in Australia. The suicide rate for Australia is 13 per 100,000, higher than many industrialized countries, including the United States, France, Britain or Italy (WHO, 2006). More than 2,200 Australians a year commit suicide, averaging about seven suicide deaths per day. Suicide in Australia represents one-third of all injury deaths, and there are almost nine suicides for every homicide, and 1.5 suicides for every road accident death.

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In 2003, there was a very slight downward trend in suicide deaths in Australia, although it is too early to determine whether this represents an ongoing trend or is simply an artifact of the data (Australian Bureau of Statistics, 2006).

Mental health professionals in all types of career paths encounter suicidal persons in their practice. More than 30% of adults in the general population admit to feeling suicidal during at least one point in their lives (Goldney, Winefield, Tiggemann, & Winefield, 1989), and more than 70% of mental health professionals state that they have worked with at least one suicidal individual (Rogers, Gueulette, Abbey-Hines, Carney, & Werth, 2001). Nearly one-quarter of counselors have experienced a client suicide (McAdams & Foster, 2000). In general, mental health professionals who experience a client suicide describe it as “the most profoundly disturbing event of their professional careers” (Hendin, Lipschitz, Maltzberger, Haas, & Wynecoop, 2000, p. 2022).

This paper is intended to assist clinicians in their efforts to recognize persons at elevated risk for suicide. Several of the major risk factors and warning signs associated with elevated risk are discussed, followed by an overview of suicide assessment protocols and techniques.

Suicide Risk Factors, Warning Signs, and Protective Factors

There are numerous risk factors for suicide, many of which have been articulated in the literature. In fact, a recent study found more than 75 risk factors in the suicide literature (Wingate, Walker, Joiner, Rudd, & Jobes, 2004), clearly suggesting a broad range of risk. Several major categories of risk factors are identified in the following paragraphs.

Suicide and Gender

For every completed suicide in Australia, there are approximately 30 suicide attempts, although this differs by gender. Just as in all developed countries, there are more suicide attempts by females in Australia and more completions by males. For every completion by an Australian male, there are five attempts. For every completion by an Australian female, there are 35 attempts. Thus, the gender breakdown in Australia is very similar to the U.S., where females are seven times more likely to attempt and males are four times more likely to complete suicide. For Australian males, the 2003 suicide rate was 17.7 per 100,000, and for females, it was 4.7 per 100,000 (Australian Bureau of Statistics, 2006). For the most part, this distinction is made because of the lethality of chosen methods, with males tending to use more lethal means for their suicide attempts.

Suicide and Age

Worldwide, suicide is the third leading cause of death among young people between ages 18-24. In general, among males, suicide rates increase with age, with men in the oldest age categories (over age 85) having the highest rates. In Australia, men over age 80 have rates that are six times that of women in the same age bracket, and males over age 65 account for 20% of all suicides. Additionally, the young adult years appear to hold a high level of risk for males, with a suicide rate of over 30 per 100,000 for males between 30-34 years old (Australian Bureau of Statistics, 2006).

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Psychiatric Disorders and Mood States

About 90% of people who commit suicide have a diagnosable mental or addictive disorder at the time of death, making this a central risk factor for suicide and suicidal behaviors. In fact, a psychiatric disorder is the strongest observed risk factor for attempted suicide in all age groups, and mental and addictive disorders provide the major context for suicide and suicidal behaviors. In adolescents, the major mental disorders that are associated with suicide are affective disorders, conduct disorder, antisocial personality disorder, and substance abuse. In adults, mood disorders (primarily depressive disorders & bipolar disorder), substance abuse, and aggressive behaviors are associated with elevated suicide risk. For example, persons with schizophrenia have 40 times the risk (Potkin, Anand, Alphas, & Fleming, 2003), and those with chronic alcoholism are at 60 times greater risk for suicide (Hufford, 2001) than those in the general population.

Although most mental health professionals understand the importance of screening for depression in suicide risk, most research indicates that hopelessness, rather than general depression, is an even greater risk factor for suicide. Whereas depression involves a strong negative affect, hopelessness is typically more about the lack of positive affect. Persons who are hopeless cannot generate images of positive outcomes for the future. Hopeless people attempt suicide because they cannot foresee an end to their psychological pain.

Impulsivity also has been linked to increased risk. Persons whose judgment is impaired through impulsivity – either by the use substances or because of an impulsive temperament – are more likely to attempt or complete suicide as an immediate reaction to an immediate stressor. Impulsivity is a key feature of several psychiatric disorders, including conduct disorder, some of the personality disorders, substance use disorders, and bipolar disorder. Impulsivity – whether occurring within the context of a diagnosable mental disorder or as personality trait that does not meet the criteria for a mental health diagnosis, significantly increases suicide risk. Taken together, hopelessness and impulsivity can serve as a very dangerous combination.

Cognitive Dysfunction

Individuals who have their thinking constricted by cognitive limitations may find themselves more likely to fixate on suicide as the only possible option. Thus, cognitive rigidity is a major risk factor for suicide. Cognitive distortions (e.g., over-generalizations, preoccupation with a single thought or idea, all or nothing thinking) are often present in those who attempt or commit suicide. A study of suicide notes of adolescents who completed suicide found a high incidence of cognitive constriction, including rigidity in thinking, narrowing of focus, tunnel vision, and concreteness. Other cognitive distortions that have been associated with elevated risk are limited problem-solving ability (inability to generate options or alternatives), an external locus of control (perceived inability to control one's destiny), impulsivity (inability to defer gratification of needs) and perfectionism (inability to tolerate perceived violations of internalized standards for behavior).

Environmental or Situational Stressors

Poor coping and/or problem-solving ability are exacerbated by environmental or situational stressors that push people beyond their ability to manage. Stressors such as job loss, divorce, financial concerns, and legal difficulties all have been linked to higher suicide rates (Weyrauch, Roy-Byrne, Katon, & Wilson, 2001). Among suicidal adolescents, there is a higher incidence of

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family dysfunction of all types compared to their non-suicidal peers. Common familial risk factors for adolescent suicide include coming from highly conflicted families that are unresponsive to the adolescent's needs, families with parental alcoholism or substance abuse, and families with physical or sexual abuse. Families of suicidal teens also have higher levels of medical and psychiatric problems (Garfinkel, Froese, & Hood, 1982). Social isolation and poor peer relationships are two additional environmental risk factors. Suicidal adolescents often feel alienated, both within the family and with their peers (Stillion & McDowell, 1996). They are more likely to have poor social skills, ineffective peer relationships, to be non-joiners, and to be generally unpopular. Finally, families who have had a suicide completion are at higher risk for another.

Warning Signs

Individuals who attempt or commit suicide often express their intent to others, either directly or indirectly. In fact, more than 90% of adolescents who commit suicide give clues (either verbal or other warning signs) before they attempt. About one-third of people who attempt suicide will have another attempt within the year, and about 10-12% of those who threaten or attempt go on to complete suicide, typically within 5-10 years of the first attempt (Runeson, 2001). Thus, recognizing warning signs for what they are when they occur can be an important component of suicide prevention.

There are many warning signs listed in the literature, but some of the most common include: suicide threats (direct or indirect), obsession with death, poems, essays and/or drawings that refer to death, dramatic changes in personality or appearance, irrational and/or bizarre behavior, overwhelming guilt or shame, changes in eating or sleeping patterns, changes in school or work performance, and giving away possessions (National Mental Health Association, 2006). It is clear that warning signs must be taken seriously and investigated to determine whether or not they are associated with elevated risk.

Protective Factors

Just as some behaviors or beliefs elevate suicide risk, others have a protective effect. Examples of protective factors include: appropriate and effective clinical care for persons with psychiatric problems, easy access to interventions, support for help-seeking, family and community support, and learned skills in problem-solving, conflict-resolution, and non-violent dispute resolution. However, only 38% of Australian adults with mental health problems access health care, with that care being provided primarily by general practitioners. Additionally, only one in four young people with mental health problems receive help, and even among those with most severe mental health problems, only 50% receive professional help (Parliament of Australia, 2006). Thus, although protective factors can clearly be important in reducing risk, there is little evidence that they are prevalent among those who need them most.

Suicide Risk Assessment

The assessment of suicide risk is a complex and challenging task that requires training, education, and experience. Mental health professionals who are new to the field or who assess suicide infrequently should always work under supervision. Even those with years of experience, however, find that consultation with peers is important. In fact, Edwin Shneidman (1981), often called the Father of Suicidology, cautioned that there is no instance in a therapist's professional

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life when consultation with a colleague is more important than in the case of a highly suicidal person. Because of the highly complex nature of suicide assessment, and the consequences of “false negative” assessments (e.g., believing someone is not suicidal when, in fact, they are), it must be underscored that this brief article does not contain all the necessary information to complete a comprehensive suicide risk assessment. It is merely an overview of some of the most essential information. Readers are referred to more comprehensive texts for more thorough discussions of suicide risk assessments (e.g., Shea).

A foundational principle of suicide assessment is that it must take into account the uniqueness of each individual. It may be tempting to review risk factors and warning signs, which are based on aggregate data, and then make individual determinations of risk. This is never appropriate. Risk assessment instruments and protocols focus on known risk factors. Although it is true that, in general, the more risk factors a person has, the higher their risk, clearly, clinical judgment must prevail. In other words, a person with very few risk factors and very low scores on assessments of suicide risk may, in fact, be at high risk. Another person with many risk factors may have protective factors (e.g., a relationship with the mental health professional, religious injunctions against suicide) that mitigate the risk. Thus, according to the American Psychiatric Association’s practice guidelines for suicide, suicide assessment remains “the quintessential clinical judgment” (Jacobs & Brewer, 2004, p. 373).

A comprehensive suicide risk assessment involves several different types of assessment as well as consultation, collaboration, and corroboration of information (Granello, 2006). A complete psychiatric history and examination of both demographic and individual risk factors are always part of a comprehensive assessment (Cochrane-Brink, Lofchy, & Sakinofsky, 2000). In addition, many mental health professionals use risk assessment instruments. There are many different informal checklists, interview protocols, and formal assessments that are available to assist the clinician in determining risk. However, the most common method to assess suicide risk is simply to ask. Sometimes beginning practitioners get so caught up in all the complexity of the risk assessment that they forget to ask the question (something like, “have you thought about suicide?” or “are you considering killing yourself?”). Other times clinicians let their assumptions, rather than their clinical judgment, interfere with assessment. Finally, there is evidence that a standard clinical interview, with one or two questions regarding suicide, may not be sufficient. In one study, as many as 44% of persons with past histories of suicide attempts answered “no” to a general gatekeeping question regarding past attempts and therefore would have been missed for follow-up questioning (Barber, Marzuk, Leon, & Portera, 2001).

Interview Protocols: A comprehensive suicide risk assessment interview does more than just ask a simple question. Clients are led through a series of topic areas that should include (at a minimum):

Suicidal intent – present/recent thoughts about killing oneself

Details of the suicide plan – the more specific, the more dangerous

The means by which s/he plans to commit suicide (gun, hanging, overdose, etc.). Be sure to consider the lethality of the means (a gun is more lethal than ingesting several over the counter aspirin)

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Accessibility of those means to the suicidal person (how easy is it for the person to obtain the means. In other words, saying they will shoot themselves is less of an immediate threat if they don't have access to a gun, versus someone who says, "I will shoot myself using my dad's pistol, which is in his dresser drawer and the bullets that are in the garage.")

History of suicidal thoughts and attempts (including parasuicidal attempts)

Stability of the current mood (e.g., did the person feel suicidal yesterday? Last week? This morning?)

Family history of suicide attempts or completions as well as family history of mental disorders

Client's mental state (through a mental status exam)

Assessment of warning signs and specific risk factors

Acronyms. Sometimes, counselors use acronyms to help them remember the basic components of suicide risk assessment. Commonly-used acronyms are:

S.L.A.P.

S – what are the *specific* details (S = specificity)

L – how *lethal* is the plan (e.g., guns, pills, rope) (L = lethality)

A – how *available* is the method of choice? Where is it? (A = availability)

P – what is the *proximity* to help? Who will find him/her? How long will it take to be found? (P = proximity)

P.L.A.I.D.

P – Previous attempts

L – Lethality

A – Access

I – Intent

D – Drugs/alcohol

P.I.M.P.

P – Plan

I – Intent

M – Means

P – Prior attempt

M.A.P.

M – Mental state for suicidality (thinking)

A – Affective state for suicidality (emotions)

P – Psychosocial state for suicidality (circumstances)

N.O. H.O.P.E. (Shea, 2002).

N – No framework for meaning

O – Overt change in clinical condition

H – Hostile interpersonal environment

O – Out of hospital recently

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P – Predisposing personality factors

E – Excuses for dying are present and strongly believed

Suicide Checklists

There are many checklists that are available to guide questioning around suicide risk. Again, just as with the acronyms, these checklists are intended only as a guide for the interview, not as a definitive suicide risk assessment. A caution is necessary: the “objective” scoring of some of the checklists can encourage inappropriate use. Remember, these are *general guidelines only*. Nevertheless, research has shown that clinicians who are trained in the use of suicide checklists have improved ability to evaluate risk than those who have not (Juhnke, 1994). Counselors have a variety of checklists to choose from, such as SAD PERSONS (Patterson, Dohn, Bird, & Patterson, 1983), Adapted SAD PERSONS for Adolescents (Juhnke, 1996), the Suicide Assessment Checklist (Rogers, Lewis, & Subich, 2002), and the Clinician Suicide Risk Assessment Checklist (King, Lloyd, Meehan, O’Neill, & Wilesmith, 2006).

Formal or Commercially Available Assessments

There are dozens of published standardized suicide risk assessments, and hundreds of unpublished questionnaires and assessments. Standardized assessments can be useful in providing adjunctive information that helps get a clearer picture of the situation. Research has shown that standardized assessments are especially helpful for professionals with limited psychiatric training (Patterson et al., 1983). However, at best they can only provide an estimate of suicide risk. Standardized assessments that are used for suicide risk assessment come in two major categories: those that measure suicidal risk directly and those that measure emotional states (e.g., depression, hopelessness, anxiety) that correlate with suicide risk. Some of the more common standardized assessments are listed below. For a more comprehensive review, see the National Institutes of Mental Health by Dr. Gregory Brown (nd).

Beck Scale for Suicidal Ideation (Beck & Steer, 1991)

Inventory of Suicidal Ideation (King, & Kowalchuk, 1994.)

Suicide Probability Scale (Cull & Gill, 1995)

InterSePT Scale for Suicidal Thinking – (ISST; Lindenmayer et al., 2003)

Reasons for Living Inventory (Ivanoff, Jang, Smyth, & Linehan, 1994)

Suicide Behaviors Questionnaire – Revised (Linehan, 1996)

Child-Adolescent Suicide Potential Index (Pfeffer, Jiang, & Kakuma, 2000)

Columbia Teen Screen (Shaffer et al., 1996)

When conducting suicide risk assessments, it is not necessarily important that all counselors select the same specific checklist, assessment, interview protocol, or acronym. What is important is that each counselor select a method of assessment that he or she actually will use. All of the assessment methods have overlap in their content because they are all trying to measure the same thing. What is most important is that counselors pick one (with advice and guidance from more seasoned practitioners, if applicable), keep a copy of it someplace where it is easily accessible, and use it. Whether it is an acronym written on a notecard that is taped to the desk or a formal checklist that is included in a file, the most important thing to do when assessing suicide risk is to conduct a thorough and comprehensive interview. The first step is to ask.

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Conclusion

Counselors who work with suicidal clients must have training, experience, and supervision to ensure that they have the necessary skills. Assessment of suicide risk is an important first step in working with suicidal persons, and assessing risk is a complex and challenging task. Clients who are at risk seldom fully understand their own risk level. They may not know whether they will be able to stay safe, and suicidal thoughts can change dramatically from day to day, hour to hour. The complexity of the task requires a careful and thorough assessment, ideally grounded in a strong therapeutic relationship, with consultation and collaboration with family members and other practitioners. Although knowing and understanding the risk factors is essential, suicide risk assessment of each person is unique and is based on clinical judgment. A real danger is that a formulaic plan for suicide risk assessment will lead to decisions that are inappropriate, or even deadly. Because of the likelihood that all counselors, regardless of setting, will encounter suicidal persons, everyone in the field of mental health is strongly encouraged to receive training and supervision to extend their knowledge in this very important area of clinical work.

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