

Suicide Risk Assessment: What Psychologists Should Know

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Recent increases in death by suicide in the United States have led to national calls for improvements in how suicide risk screening and assessments are conducted. As health care providers and leaders in mental health practice, psychologists should be immersed in cutting edge education and training in suicide assessment. In this article, we describe the limits of the traditional medical model approach and review modern developments in suicide risk assessment. Six important shifts in how contemporary psychologists formulate and approach suicide assessment are reviewed. These include: (a) acknowledgment that suicide risk factors are not especially helpful to psychologist-practitioners; (b) a movement away from medical model formulations and toward social constructionist and collaborative orientations; (c) progress in theoretical knowledge pertaining to suicidal individuals; (d) recognition that the clinical encounter and comprehensive suicide assessment interviews are essential to developing and maintaining a therapeutic relationship; (e) advancements in how clinicians question patients about suicide ideation; and (f) methods for monitoring suicide ideation over time. Psychologists who understand and apply these approaches to suicide risk assessment will be more capable of conducting competent suicide assessment and treatment and thereby contribute to national suicide prevention efforts.

Keywords: suicide, assessment, clinical interview

Suicide rates in the United States have steadily increased from 10.4 per 100,000 in 2000 to 13.4 per 100,000 in 2014 (Centers for Disease Control and Prevention & National Center for Injury Prevention & Control, 2016). This represents a 27.6% increase over 15 years and has contributed to persistent calls for medical and mental health responses. For example, in 2012 the Washington state legislature passed a law mandating that physicians, psychologists, mental health workers, and other care providers receive continuing education in suicide assessment, treatment, and management (Washington State Legislature, 2015). Also in 2012, the U.S. Surgeon General, in collaboration with the National Action Alliance for Suicide Prevention, published an updated version of the *National Strategy for Suicide Prevention*. This update emphasized the central role that physicians and mental health providers can play in suicide prevention efforts and tracked progress on the 2001 national goals (U.S. Department of Health and Human Ser-

vices Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012).

Psychologists routinely encounter situations that require initiation and implementation of suicide assessment procedures. These situations may occur across a wide variety of practice domains (e.g., hospitals, clinics, independent practice, residential treatment centers). Although psychologists arguably have more suicide assessment training than other health care providers, suicide risk assessment competencies are not consistently infused into graduate training and it is difficult for practicing psychologists to stay updated on continuing research in suicidology and related developments (Schmitz et al., 2012; Shea & Barney, 2015). The purpose of this article is to review theoretical, research-based, and clinically informed advances in suicide risk assessment.

Key Shifts in Suicide Assessment

Over the past 20 years there have been several significant changes in how mental health professionals think about and work with patients who are suicidal (Jobes, 2012; May & Klonsky, 2016; Nock, Kessler, & Franklin, 2016; Sommers-Flanagan & Sommers-Flanagan, 1995). Major modifications include: (a) an acknowledgment that suicide risk factors contribute little to clinicians' suicide prediction and prevention efforts (Large & Ryan, 2014; Tucker, Crowley, Davidson, & Gutierrez, 2015); (b) a movement away from the medical model and toward a social constructionist, collaborative orientation (Jobes, 2012, 2016; Konrad & Jobes, 2011); (c) developments in suicide-related theory; (d) an emphasis on the initial and ongoing clinical encounter, including use of comprehensive suicide assessment interviewing protocols (Simon, 2011; Sommers-Flanagan, 2016); (e) use of increasingly nuanced methods for clinicians to directly question patients about suicide ideation (Shea & Barney, 2015; Sommers-Flanagan

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& Sommers-Flanagan, 2014); and (f) methods for monitoring suicide ideation and risk over time (Jobes, 2016).

Limitations of Traditional Suicide Risk Factors

Traditional suicide assessment has overfocused on suicide risk factors (Large & Ryan, 2014; Nock, Kessler, & Franklin, 2016). These factors are often status or demographic variables (e.g., diagnosis of a mental disorder, previous suicide attempt, adolescent Native American demographic status, etc.). Unfortunately, risk factors are poor suicide predictors. This is because although many status, demographic, or diagnostic variables confer greater risk, the increased risk is relatively small. For example, even if suicide risk is 30 times the U.S. base rate among patients with a diagnosis of major depressive disorder (MDD), risk only increases from 13.4 per 100,000 to 402 per 100,000; this translates to an estimate that 0.00402% or one of every 249 patients with MDD dies by suicide. Renowned suicidologist Robert Litman wrote: "When I am asked why one depressed and suicidal patient commits suicide while nine other equally depressed and equally suicidal patients do not, I answer, 'I don't know'" (Litman, 1995, p. 135). Similarly, just because the 2014 CDC data indicate that males die by suicide at a 21.1 rate per 100,000 and females only at 6.0 per 100,000 does not change how providers should routinely deal with individual males or females in suicidal crisis.

Large and colleagues have conducted empirical research focusing on the utility of risk factors in clinical work with patients at risk for suicide or violence (Large & Ryan, 2014; Ryan, Nielssen, Paton, & Large, 2010). Although counterintuitive and at odds with what many psychologists learn during clinical training, they concluded that categorizing patients as high- or low-risk is contraindicated; they recommended that:

... clinical care ... be delivered on the basis of observable clinical need and, as much as possible, the patient's own preferences for their path to recovery. Estimates of the probability of particular and rare events such as suicide ... are of no assistance in this most fundamental of clinical tasks. (Large & Ryan, 2014, p. 416)

Thinking about risk factors in an effort to understand individual patients may be helpful, but focusing on risk factors as predictors to guide treatment is not recommended (Konrad & Jobes, 2011; Large & Ryan, 2014; Tucker et al., 2015). There are many reasons for this, including: (a) the overwhelming number of risk factor and warning sign lists available; (b) the extremely low base rate of death by suicide; (c) the fact that even the strongest risk factors and warning signs do not effectively distinguish suicidal from nonsuicidal individuals (Bolton, Spiwak, & Sareen, 2012; Lester, McSwain, & Gunn, 2011; Tucker et al., 2015); and (d) repeated empirical observations that some low-risk patients die by suicide and many high risk patients do not (Large & Ryan, 2014; Ryan et al., 2010). Instead, effective approaches to suicide assessment and treatment begin with establishing a collaborative working relationship between psychologist and patient (Sommers-Flanagan, 2016). This involves showing empathy, communicating genuine interest, and working to facilitate trust (Ganzini et al., 2013). In addition, Large and Ryan (2014) recommended that clinicians directly discuss the potential risks and benefits of treatment or no treatment with the patients themselves. This recommendation is consistent with moving away from the medical model and toward a collabora-

orative and social constructionist approach to suicide risk assessment.

Moving Away From the Medical Model

Historically, mental health professionals and physicians have viewed suicide ideation as deviance (Szasz, 1986). This perspective led to an emphasis on medically driven evaluation, diagnosis, and intervention strategies. Interventions typically included medications, psychotherapy, or hospitalization, with a strong focus on eliminating suicide ideation.

Psychological reactance. There is little evidence that viewing suicide ideation or behavior as deviance or psychopathology is helpful to patients (Silverman & Berman, 2014). In fact, if patients perceive psychologists or other health care providers as judgmental and as applying coercive medical treatments to take away suicide as a behavioral alternative, they may respond with psychological reactance instead of openness and cooperation (Brehm & Brehm, 1981; Konrad & Jobes, 2011). Psychological reactance is a well-documented phenomenon that can be applied to psychotherapy in general and to individuals who present with suicide ideation in particular (Lester & Schaller, 2000; Linehan, 2011). Reactance is likely to emerge in situations where individuals perceive their freedom threatened. A reactance-based response involves individuals having increased motivation to restore their freedom. In cases of suicidality, patients who feel coerced to keep living may experience motivation to "prove" their freedom to have suicidal thoughts or act on suicide impulses (Lester & Schaller, 2000).

Empirical evidence that reactance (as an alternative term for resistance) operates in psychotherapy is significant. In a meta-analysis of 12 studies involving 1,102 patients, Beutler, Harwood, Michelson, Song, and Holman (2011) reported a large effect size ($d = .82$) for the "fit of directiveness to patient resistance" (p. 139). Specifically, patients with high reactance appear to benefit from treatments that are less directive. Consistent with recently developed suicide treatment models, these findings imply that psychologists should use less directive strategies with patients who are suicidal and reactive (Jobes, 2012; Konrad & Jobes, 2011). Otherwise, psychologists may contribute to "inducing noncompliance" (Beutler et al., 2011, p. 133).

A collaborative, social constructionist approach. The provider-patient relationship within the medical model has typically emphasized clinicians as experts who deliver diagnostically based decisions about treatment in a top-down manner (Jobes, 2000). Newer approaches to suicide assessment and treatment conceptualize provider-patient interactions from a social constructionist perspective (Ellis, Green, Allen, Jobes, & Nadorff, 2012; Jobes, 2016; Linehan et al., 2015). This perspective includes a de-emphasis on diagnosis. Additionally, suicide ideation is framed as a naturally developing symptom of distress (Silverman & Berman, 2014; Smith et al., 2013). Using a social constructionist model allows for a more natural conversation to develop between provider and patient wherein disclosure of suicide ideation is regarded as a valuable communication and an invitation for collaborative problem-solving (Jobes, Lento, & Brazaitis, 2012; Sommers-Flanagan & Sommers-Flanagan, 2014).

In addition to stimulating reactance, when patients sense they are being judged or stigmatized as deviant, they are likely to

become less open with providers about their suicide ideation and impulses (Ganzini et al., 2013; Linehan, Comtois, & Ward-Ciesielski, 2012). Consequently, psychologists should exhibit a welcoming, less diagnostic, and more compassionate attitude toward patients with suicide ideation. This attitude can lead to patients speaking more honestly about suicide-related thoughts and plans. As Nietzsche claimed, it may be comforting to individuals to contemplate suicide as an alternative to a life of continuing painful misery (Lester & Schaller, 2000). In fact, some patients with a borderline personality disorder (BPD) diagnosis experience increased distress when psychologists or other health care providers try to get them to stop thinking about suicide (Linehan et al., 2012). This paradoxical dynamic may emerge because patients with BPD use suicide ideation as a Nietzschean coping strategy that relieves their distress (Lester & Schaller, 2000).

Provider anxiety and judgment. Working with patients who are suicidal is emotionally challenging (Kleespies & Dettmer, 2000). Patients who are suicidal are often irritable; they exhibit mental constriction, dichotomous thinking, as well as other characteristics of impaired problem-solving (Ghahramanlou-Holloway, Bhar, Brown, Olsen, & Beck, 2012; Shneidman, 1985). Given that suicide assessment and treatment involves a two-person psychology where psychologists and patients interact and affect one another, patient characteristics and psychologist anxieties can easily intermingle and lead to suboptimal outcomes (Geltner, 2006). For example, when psychologists experience anxiety, they might react to patients with their own version of dichotomous thinking and impaired problem-solving. This can lead to a narrow focus on psychiatric diagnosis and nomothetic data regarding suicide predictors and result in a less nuanced understanding of the patient's subjective experience (Jobes, 2000; Large & Ryan, 2014). In contrast, a collaborative model involves a less pressured provider-patient interaction, reduces anxiety about addressing suicide immediately, and is a strategy for containing countertransference. Ideally, psychologists will embrace a collaborative frame beyond the consulting hour and solicit feedback, guidance, and consultation from peers and supervisors.

Progress in the Theoretical Understanding of Suicide Risk

Many theories of suicidal behavior exist. Although it can be difficult to directly translate theory into actionable skills, knowledge of theory is helpful in several ways. At the least, knowledge of theory can help (a) alleviate clinician anxiety, (b) inform clinicians regarding important assessment domains, and (c) provide a framework for deeper understanding of patients who present with suicide-related thoughts and behaviors.

Shneidman's mentalistic theory. Edwin Shneidman, the father of modern suicidology, described himself as a "21st-century mentalist" (Shneidman, 2001, p. 201). His suicide theory included three primary dimensions. First, he viewed suicidal individuals as suffering from intense psychological pain and referred to this pain as "psychache." For example: "... the suicidal drama is almost always driven by psychological pain, the pain of negative emotions—what I call psychache. Psychache is at the dark heart of suicide; no psychache, no suicide" (p. 200).

Shneidman called his second factor "constriction." He observed suicidal patients as having lost their ability to think about loved

ones or consider viable alternatives to suicide. He described constriction as "the primary thought disorder in suicide" and "a pathological narrowing of the mind's focus . . . which takes the form of seeing only two choices: either something painfully unsatisfactory or cessation" (Shneidman, 1984, pp. 320–321). In recent years, researchers have affirmed this dimension of Shneidman's theory. There is substantial evidence that many highly distressed individuals with suicidal impulses suffer from problem-solving deficits (Ghahramanlou-Holloway et al., 2012; Lau, Haigh, Christensen, Segal, & Taube-Schiff, 2012).

Third, Shneidman identified a suicide-related physical-emotional state that he referred to as "perturbability." Although the term perturbability is not in popular use, researchers have consistently reported that patient arousal or agitation is linked to suicidal behavior (Ribeiro, Silva, & Joiner, 2014). For example, one explanation for why recent serotonin-specific reuptake inhibitor (SSRI) use is linked to suicidal behavior is because SSRIs cause the side effect of akathisia (Healy, 2009).

Shneidman's theory, although dated, has significant research support. However, contemporary suicide researchers and practitioners tend not to use his terminology. Distress is used instead of psychache; problem-solving impairment instead of mental constriction; and agitation or arousal instead of perturbability.

Joiner's interpersonal theory of suicide. Thomas Joiner (2005) and colleagues developed an interpersonal theory of suicide (Van Orden et al., 2010). This theory is built on the following foundational hypothesis: "... serious suicidal behavior . . . is most likely to occur in the context of thwarted belongingness, perceived burdensomeness (and hopelessness regarding both), reduced fear of suicide, and elevated physical pain tolerance" (p. 581).

Thwarted belongingness is defined as an unmet need for social connection. This unmet need to belong can lead to an increased desire for death (Van Orden et al., 2010). Thwarted belongingness is empirically linked to numerous other suicide risk factors such as social withdrawal and lack of openness to experience (Van Orden et al., 2010), impaired executive functioning (Campbell et al., 2006), lack of prosocial behaviors (Twenge, Baumeister, DeWall, Ciarocco, & Bartels, 2007), and an internal experience of numbness (Twenge, Catanese, & Baumeister, 2003). Perceived burdensomeness refers to beliefs about being flawed, a burden on others, and holding thoughts of self-hatred (Van Orden et al., 2010). This perceived burden upon others is also related to specific suicide risk factors such as liability (i.e., belief that "It would be better for others if I were dead") and self-hatred (Van Orden et al., 2010). Thwarted belongingness and perceived burdensomeness are conceptualized as dimensional cognitive-affective variables that exist on a continuum of severity. They have interpersonal and intrapersonal components and vary considerably based on individuals and their interpersonal environment. For example, thwarted belongingness varies based on interpersonal context, mood, and activated intrapersonal schemata (Van Orden et al., 2010).

Thwarted belongingness and perceived burdensomeness can stimulate the desire for suicide, but, "... desire to die by suicide is not sufficient for lethal suicidal behavior to result because, simply put, dying by suicide is not an easy thing to do" (p. 589). Joiner and colleagues posit that fear of death is a natural, evolutionary-based factor that must be overcome for individuals to die by suicide. Additionally, because suicide frequently involves intense physical pain or the expectation of great pain, individuals

who die by suicide must have or must develop tolerance for physical pain. Joiner and colleagues refer to this phenomenon of pain tolerance as “acquired capability” and identify it as a third factor contributing to death by suicide. One empirical example of how acquired capability contributes to increased suicide risk is the finding that some individuals who engage in repeated and progressive self-harm eventually die by suicide (Zahl & Hawton, 2004).

Research supporting the interpersonal theory of suicide is substantial. This is partly because the theory represents an effort to integrate previous research on risk and protective factors. In their 2010 review of the literature, Van Orden et al. (2010), identified well over 50 empirical studies that implicate social isolation or disconnection as a factor contributing to suicide risk (e.g., Thoresen, Mehlum, Roysamb, & Tonnessen, 2006; Wyder, Ward, & De Leo, 2009). Additionally, Joiner has a research team actively publishing new studies that evaluate components of his theory (Bernert, Turvey, Conwell, & Joiner, 2014; Hagan, Podlogar, Chu, & Joiner, 2015).

Klonsky and May’s three-step theory (3ST). Klonsky and May’s (2015) 3ST is rooted in an “ideation-to-action” framework. In this framework they describe the development of ideation and “progression from ideation to suicide attempts” as “distinct processes with distinct explanations” (p. 114). Their theory includes three steps.

Step 1 focuses on the development of suicide ideation. Similar to Shneidman’s formulation, psychological or emotional pain drives individuals toward suicide ideation (Klonsky & May, 2015). However, Klonsky and May add that pain alone does not lead to suicide ideation, but when pain is combined with hopelessness regarding whether the pain will ever abate or remit, then ideation is likely.

Step 2 involves social connectedness factors. Klonsky and May (2015) posit that social connectedness is protective and can buffer individuals from their pain and hopelessness. They define social connectedness broadly; it might include connection to important people, a job, a project, or a role. Higher connectedness protects or insulates patients from pain and hopelessness and consequently can prevent progression to Step 3.

Step 3 focuses on the progression from suicide ideation to suicide attempts. Factors that move individuals to suicide attempts can be dispositional, acquired, and practical. Dispositional factors are largely biogenetic. Examples include pain sensitivity and blood phobia (Klonsky & May, 2015). Acquired factors are similar to Joiner’s model, in that they involve individual life experiences that, over time, have resulted in habituation to pain, fear, and/or death. Practical factors refer to the concrete environmental variables, such as whether or not an individual has access to lethal means and the knowledge and ability to utilize those means.

Based on an integration of the three preceding theories, the crucial factors that should guide psychologists in their empathic efforts and evaluation include: (a) substantial psychological or emotional pain; (b) social disconnectedness, thwarted belongingness, and/or a sense of being burdensome; (c) hopelessness about the psychological, emotional, or interpersonal angst ever resolving; (d) problem-solving deficits; (e) agitation or arousal; (f) diminished fear of suicide or increased pain tolerance that push individuals toward (g) an accessible lethal means. Also, given that social connection protects against suicide, psychologists should make efforts to establish an empathic and supportive interpersonal

connection with patients who report suicide-related thoughts and behaviors (Konrad & Jobes, 2011; Sommers-Flanagan & Sommers-Flanagan, 2014).

A Comprehensive Approach to Suicide Assessment Interviewing

The clinical interview is the universal starting point for psychotherapy (Sommers-Flanagan, 2016). Although psychologists may or may not have extensive training in evidence-based approaches to suicide treatment, they should have training and experience in clinical or intake interviewing; part of this training should include knowledge and skills for conducting a comprehensive suicide assessment interview (Shea & Barney, 2015; Sommers-Flanagan & Sommers-Flanagan, 2014). Suicidality is a ubiquitous phenomenon that requires psychologists to be constantly prepared to conduct risk assessments across a wide range of practice settings. For example, suicide risk assessment may be integrated into a standard intake interview, ongoing psychotherapy, and repeated contacts within short-term psychiatric units or long-term residential treatment settings.

Contemporary psychologists should integrate cutting-edge suicide knowledge into traditional suicide assessment interview protocols. This involves establishing a collaborative therapeutic relationship, accepting suicide ideation as an expression of distress and not a sign of pathology, embracing new theoretical advancements, and using risk and protective factor information to deepen understanding rather than categorizing suicide risk. Based on this knowledge, components of a comprehensive state-of-the-art suicide assessment interview include: (a) exploration and analysis of pertinent risk and protective factors (with an emphasis on empathizing with and evaluating psychological pain, social connection, and hope or hopelessness); (b) using clinical strategies to ask directly about current and past suicide ideation; (c) evaluating, as needed, the nature of current and past suicide plans, including previous attempts; (d) assessment of patient self-control and agitation; (e) habituation to pain, fear, and/or death; (f) assessment of suicide intent and reasons for living; and (g) implementation (as needed) of a collaborative safety plan or alternative suicide intervention strategy that assists patients with concrete problem-solving and addresses unique patient issues, including lethal means restriction (Sommers-Flanagan & Sommers-Flanagan, 2014). Conducting an initial comprehensive suicide assessment interview can provide a framework for simultaneously evaluating for suicide risk and beginning a therapeutic process. In many cases and settings, practice standards not only involve an initial suicide assessment, but also an ongoing and collaborative process of monitoring and understanding suicide risk for unique individual patients.

Strategies for Directly Questioning Patients About Suicide Ideation

When it comes to suicide risk assessment interviewing, the universal mantra is: Ask directly about ideation. But how should psychologists go about asking patients directly about suicide ideation? In this section we review evidence-based and clinically informed strategies for asking about and exploring suicide ideation. These approaches are likely to fit individual psychologist-practitioners more or less depending on individual setting and

clinical style. To be competent in this area, psychologists should go beyond simply asking direct questions like, “Have you been thinking about suicide recently?” (Silverman & Berman, 2014). Instead, using one or more of the following four strategies is recommended.

Using a normalizing frame. Wollersheim (1974) noted that questions about suicide should be framed so patients feel normal about disclosing suicide ideation. For example, when working with adolescent patients, a normalizing frame might sound like this: “I’ve read that between 10% and 50% of teenagers are bothered by thoughts about suicide. Would you say that’s true for you?” A similar normalizing strategy can be used with adults: “It’s not unusual for people who are down or depressed or feeling miserable to think about suicide. Have you had any thoughts about suicide?”

Asking “Have you had thoughts about suicide” without a normalizing frame may sometimes stimulate an open disclosure. This straightforward approach is preferable to not inquiring about suicide ideation. However, given the tendency of suicidal patients to feel isolated and alienated, offering a normalizing frame should be viewed as standard practice.

Gentle assumption. Shea (2004) recommended using an alternative framing strategy referred to as “gentle assumption.” He described this strategy: “. . . clinicians assume potentially embarrassing or incriminating behaviors are [already] occurring and frame their questions accordingly, using gentle tones of voice” (p. 389). An example of gentle assumption when working with patients who may be suicidal is: “When was the last time when you had thoughts about suicide?” The point is to ask directly in a manner that assumes suicidal thoughts have been present. Gentle assumption should be used in combination with a normalizing frame.

A common fear related to the normalizing frame and gentle assumption is that asking about suicide will somehow put suicidal ideas in patients’ heads. There is no evidence to support this fear (Jobes, 2016). More likely, when psychologists invite patients to share suicidal thoughts, patients will feel reassured to be working with a professional who is comfortable with the subject and capable of dealing with the problem. Further, using a normalizing frame in psychotherapy can reduce patient self-criticism and catastrophizing (Nystul, 1994).

Using mood ratings with a suicide floor. It can be helpful to imbed suicide ideation assessment within a mood-based scaling procedure. This process involves evaluating mood in a manner similar to an extended mental status examination (Sommers-Flanagan & Sommers-Flanagan, 2014). The procedure involves using scaling questions to assess current mood, worst mood, and best mood. Psychologists should ask the following questions, taking care to show empathy and gently explore multidimensional components of the patient’s responses.

1. Is it okay if I ask you some questions about your mood? (This is an invitation for collaboration; patients can say “no” but rarely do.)
2. Please rate your mood right now, using a 0 to 10 scale, with zero being the worst mood possible. In fact, 0 means you’re totally depressed and so you’re just going to kill yourself. At the top, 10 is your best possible mood. A 10 means you’re as happy as you could possibly be. Maybe

you would be dancing or singing or doing whatever you do when you’re very happy. Using that 0 to 10 scale, what rating would you give your mood right now? (Each end of the scale must be anchored for mutual understanding; the key is that the clinician includes “kill yourself” or “die by suicide” as naturally associated with a rating of 0.)

3. What’s happening now that makes you give your mood that rating? (This links the mood rating to the external situation.)
4. What’s the worst or lowest mood rating you’ve ever had? (This informs the interviewer about the lowest lows.)
5. What was happening back then to make you feel so down? (This links the lowest rating to the external situation and may lead to discussing previous attempts.)
6. What would be a normal mood rating for you on a normal day? (Patients define their normal.)
7. Now tell me, what’s the best mood rating you think you’ve ever had? (The process ends with a positive mood rating.)
8. What was happening that helped you have such a high mood rating? (The positive rating is linked to an external situation.)

Although structured interviewing protocols aid psychologists in systematic and comprehensive suicide-related questioning, they can also result in a stilted process wherein many negatively worded questions are asked consecutively (e.g., “Over the past day or two have you thought about wanting to die? Do you want to die now?” from the Modified Scale of Suicide Ideation, (Rudd & Rajab, 1995). In contrast, the preceding protocol is a flexible frame for exploring (a) specific triggers linked to low mood and/or suicide ideation and (b) conditions associated with positive mood and/or the reduction suicide ideation. This can flow into a more balanced assessment, where reasons for dying and reasons for living are both explored (e.g., “You’re saying that being alone at night is when you feel like killing yourself . . . what helps you live through the night?”). The deliberate assessment of protective factors such as social support, cognitive abilities, hopefulness, and spirituality/religion can be woven into the interview at moments when their discussion seems natural (Breton et al., 2015). The purpose of this approach is to smoothly initiate suicide-related questioning and then to integrate, as needed, questions and empathic responding to the patient’s psychological pain, risk and protective factors, suicide ideation, suicide plans, hopelessness, agitation or self-control, and suicide intent. Subsequently, suicide interventions can be introduced that best fit with the individual patient’s current state and life situation. Scaling questions can also be used to evaluate patient experiences of other suicide risk factors (e.g., hopelessness or intent; Bryan & Rudd, 2006).

Using standardized suicide self-report instruments. Some psychologists find it useful to have patients complete standardized self-report instruments. Common instruments focusing on suicide, risk factors, or reasons for living include, but are not limited to the Beck Scale for Suicide Ideation (Beck, Kovacs, & Weissman, 1979), Positive and Negative Suicide Ideation Inventory (Muehlenkamp, Gutierrez, Osman, & Barrios, 2005), Geriatric

Suicide Ideation Scale (Heisel & Flett, 2006), Beck Hopelessness Scale (Beck & Steer, 1988), and the Reasons for Living Inventory (Linehan, Goodstein, Nielsen, & Chiles, 1983). Although these instruments are efficient for obtaining information, they must be thoroughly reviewed and discussed in detail with individual patients. At most, we recommend them as suicide conversation starters.

Interview protocols and self-report questionnaires are typically designed to categorize or rank suicide risk. However, as noted previously, categorizing risk has little or no clinical or predictive utility. Consequently, psychologists' use of standardized interview protocols and self-report questionnaires should be in the service of a deeper understanding of patients' unique suicidal state (Large & Ryan, 2014).

Using suicide assessment interviewing protocols. Simon (2011) distinguished between suicide assessment forms or checklists versus suicide-risk scales with established psychometric properties. Informal checklists and forms created for institutional needs can help clinicians remember to ask about specific suicide risk factors (e.g., insomnia, hopelessness, social isolation). However, Simon lamented their use, noting: "Mechanical, obligatory form completion ill serves the patient and the clinician" (Simon, 2011, p. 154).

In contrast, there may be benefits associated with using psychometrically established assessment interview protocols or schedules. Commonly used interview protocols include the Columbia Suicide Severity Rating Scale (Posner et al., 2011), the Modified Scale for Suicide Ideation (Rudd & Rajab, 1995), and the Suicide Status Form (SSF; Jobes, 2016). These protocols provide specific wording for asking difficult suicide-related questions. This can help psychologists and patients cope with the emotionally challenging nature of asking and answering questions about suicide.

The SSF, in particular, is designed to stimulate ongoing suicide-related communications between patient and clinician. Jobes (2016) described the SSF as a "multipurpose engagement, assessment, treatment-planning, tracking, updating, and outcome/disposition clinical tool" (p. 13). It is used to gather quantitative and qualitative assessment data in six core areas: psychological pain, stress, agitation, hopelessness, self-hate, and overall risk (Conrad et al., 2009).

The SSF has evolved over the past 25 years and is now in its fourth revision (SSF-4). Jobes (2016) considers it "indispensable" to his evidence-based Collaborative Assessment and Management of Suicide (CAMS) treatment model (p. 58). The SSF is also a prototype for how psychologists can regularly use suicide assessment as a process to monitor ongoing suicidality. It is an eight page document designed to guide clinicians through three CAMS treatment phases. The first phase (index assessment and treatment planning; pp. 1–4) is typically, but not always, used during the first session with actively suicidal clients. The second phase (tracking the risk and updating the treatment plan; pp. 5–6) provides a process through which psychologist and client can continually track suicide risk. The third phase (clinical outcomes and disposition; pp. 7–8) is used in the last session of CAMS treatment (Jobes, 2016).

Following an established interview protocol can result in a more organized, systematic, and thorough exploration of suicide ideation, behavior, and other risk factors. However, as Simon (2011) implied regarding the use of forms, interview protocols should not

be used in ways that interfere with interpersonal connection, rapport, and the development of a working alliance. Instead of rigidly sticking with an interview protocol, if a structured or semistructured interview is used, it is important to (a) pause after hearing the patient's response to each question, (b) use paraphrasing and feeling reflections to communicate empathic understanding, and (c) ask additional questions that pursue or track the patient's unique experience.

Monitoring Suicide Risk Over Time

Client suicide risk is often identified during an initial clinical interview. In such cases, psychologists are tasked with conducting a single-session suicide assessment and providing individualized recommendations for outpatient or inpatient treatment. However, in many cases, suicide risk assessment is not a single-session clinician activity. For example, if, at baseline, a clinician and patient identify suicide risk as a problem, develop a treatment plan, and continue working together, some form of ongoing assessment is necessary. Over time, suicide risk may diminish, remain the same, or intensify and clinical interventions can be modified as needed to address the patient's unique psychological dynamics and living environment (Konrad & Jobes, 2011).

For some patients, suicide ideation is a chronic condition and consistent suicide ideation and risk will continue across many sessions (Bryan & Rudd, 2006). In such situations, interventions can often continue as planned, or be modified slightly in an effort to address the patient as a unique individual. In contrast, when suicide risk emerges later in treatment, psychologists should initiate a gentle, empathic, and collaborative exploration of patients' suicidal thoughts and impulses (Jobes, 2016). As described previously, more or less formal assessment procedures can then be implemented to monitor suicide risk over time. Initiating suicide monitoring as a consistent therapeutic process can provide individualized information; this information should be used to reexamine and modify the patient's treatment plan.

As an example, Jobes (2016) recommends using the SSF within the first 5 to 10 min of a session if suicide risk is identified. Jobes advises listening for "key words of despair, desperation, a desire to escape, or hopelessness" (p. 58) using empathic responding ("Your situation sounds really overwhelming and emotionally painful") a normative statement ("You know it is not uncommon for some people going through what you are going through to consider suicide") and then initiating use of the SSF, with a statement like "There is an assessment process that we can go through together that really helps me understand your situation in much better depth. May I take a seat next to you so that we can work through this assessment together?" (p. 58).

There will also be clinical situations when suicide ideation or risk declines or disappears over time. Although this may signal progress, when clients stop reporting suicide ideation toward the end of treatment can indicate increased risk (Links et al., 2012). In particular, patients who show improvement may appear improved partly because they have resolved to die by suicide. This is a perplexing clinical problem. There are no clear clinician guidelines for determining the veracity of patient claims to improvement. Guidelines in this situation include focusing on the therapeutic relationship, continuing to be work to reduce psychological pain

and build social support, and being wary when patients improve too suddenly or seem especially eager to end treatment.

Concluding Comments

For many psychologists, suicide risk assessment is challenging, and possibly aversive. It involves asking hard questions, engaging patients who are sometimes ambivalent about treatment, making difficult decisions based on uncertainty, and facing the possibility of patient death. No wonder that working with suicidal patients is often considered the most stressful of all psychologist activities (Kleespies & Dettmer, 2000).

Modern advances in suicide risk assessment have underscored the importance of viewing suicidality as a response to distress and not a sign of deviance. When psychologists embrace this perspective and adopt a collaborative model, the stress of working with patients who are suicidal may be lessened. From there, suicide assessment can be viewed as embedded within a clinical encounter or interview, where empathic listening is combined with gentle exploration of each patient's unique risk and protective factors, psychological pain, social connectedness, hope or hopelessness, agitation, habituation to pain, and access to lethal means. This involves being able to directly and calmly inquire about suicide ideation, plans, and collaboratively assist in problem-solving designed to decrease distress, increase connectedness, and promote safety.

Although this article provides information about suicide risk assessment, working knowledge and training in suicide risk assessment is not the same as competence. The Suicide Prevention Resource Center (SPRC) has identified 24 suicide risk assessment and management competencies (Schmitz et al., 2012). These competencies are broad, challenging, and difficult to master. The information in this article will not produce competence across these 24 dimensions, and the path to suicide risk assessment competence, like the path to many competencies, involves a commitment to ongoing education and training along with an acknowledgment that, given client diversity, psychologists never arrive at a final destination of complete competence (Hook, Davis, Owen, Worthington, & Utsey, 2013).

Some of what constitutes suicide risk assessment and management is art. Marsha Linehan (2011) articulated this:

I describe the suicidal person as trapped in a small, dark room with no windows and high walls . . . The room is excruciatingly painful. The person searches for a door out to a life worth living but, alas, cannot find it . . . The task of the therapist in this situation . . . is to somehow find a way to . . . see the person's world from his or her point of view; to get inside the person, so to speak, and then together search again for that door to life that the therapist knows must be there. (pp. xi–xii)

It is hoped that the content of this article will aid psychologists in conducting suicide risk assessments in ways that help patients find the unique location of their particular door to life.

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