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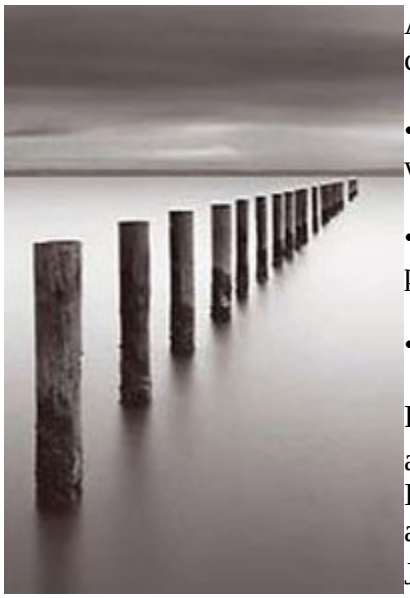
Suicide Assessment

Part 1: Uncovering Suicidal IntentA Sophisticated Art

By Shawn Christopher Shea, MD | December 3, 2009
Dr Shea is director of the Training Institute for Suicide Assessment and Clinical Interviewing (www.suicideassessment.com) and adjunct assistant professor in the department of psychiatry at the Dartmouth Medical School in Hanover, NH. He reports no conflicts of interest concerning the subject matter of this article.



A sound suicide assessment approach or protocol is made up of 3 components:

• Gathering information related to risk factors, protective factors, and warning signs of suicide.

• Collecting information related to the patient's suicidal ideation, planning, behaviors, desire, and intent.

• Making a clinical formulation of risk based on these 2 databases.

Practical approaches to integrating these 3 aspects of a suicide assessment have been well delineated for adults and adolescents.[1-8] Innovative systematic approaches, such as the Collaborative Assessment and Management of Suicidality (CAMS) approach created by David Jobes,[9] have also been developed for integrating all 3 tasks while providing collaborative intervention, which may help lay the foundation for a more evidence-based protocol for suicide assessment. Recently, Joiner and colleagues[10] have delineated a promising approach based on the interpersonal theory of suicide, which gracefully integrates all 3 components necessary for a suicide assessment.

In the clinical and research literature, much attention has been given to the first and third tasks (gathering risk/protective factors/warning signs and clinical formulation). Significantly less attention has been given to the second task—the detailed set of interviewing skills needed to effectively elicit suicidal ideation, behaviors, and intent. But in many respects, it is the validity of the information from the second component that may yield the greatest hint of imminent suicide. Moreover, as any clinical supervisor will testify, there is little doubt that 2 clinicians, after eliciting suicidal ideation from the same patient, can walk away with surprisingly different information.

The importance of uncovering suicidal ideation

Some patients who are seriously suicidal may actually share their real intent, secondary to their own ambivalence and/or the effective interviewing skills of the clinician. Such information subsequently serves to sculpt safe triage, whether offered in an emergency department (ED), outpatient clinic, or on the telephone with a crisis counselor.

CHECK POINTS

- ✓ Patients who have the most serious suicidal intent may be the most likely to withhold it.
- ✓ The actual suicidal intent of the patient may be a combination of what the patient tells the interviewer is his or her intent, what plans and actions may reflect the patient's actual intent, and what intent the patient consciously or unconsciously withholds.
- ✓ Motivational theory suggests that in some instances, reflected intent—amount of ideation, extent of planning, and actions taken on planning—may be a more accurate indicator of actual intent than what a patient states is his intent.

This information may also be useful in a prospective sense if accurately documented; a thorough record of suicidal ideation and action provides subsequent clinicians with a baseline of the patient's suicidal activity at a specific point. This reference point can be used by future clinicians—such as crisis intervention clinicians or inpatient staff contemplating a pass for a patient—to determine whether the patient's current suicidal ideation is increasing or decreasing.

Not all dangerous patients relay suicidal ideation to clinicians.[11] One could argue that many dangerous patients—those who truly want to die and see no hope for relief from their suffering—would have little incentive to do so. Even if their ambivalence about attempting suicide leads them to voluntarily call a crisis line or go to an ED, they may be quite cautious about revealing the full truth, for a large part of them still wants to die. Such patients may be predisposed to share only some of their suicidal ideation or action taken on a particular plan, while hiding their real intent or even their method of choice (such as a gun tucked away at home).

Many reasons exist why patients, even with various ranges of intent, may be hesitant to openly share, including the following:

- The impulsive patient may lack extensive suicidal ideation before his or her attempt. (This is one reason it may be necessary to hospitalize a patient who denies suicidal ideation.)
- The patient has had marked suicidal ideation and is serious about completing the act but is purposely not relaying suicidal ideation or is withholding the method of choice because he does not want the attempt to be thwarted (another reason to hospitalize a patient who may be denying or minimizing suicidal ideation).
- The patient feels that suicide is a sign of weakness and is ashamed to acknowledge it.
- The patient feels that suicide is immoral or a sin.
- The patient feels that discussion of suicide is, literally, taboo.
- The patient is worried that the clinician will perceive him as crazy.
- The patient fears that he will be locked up if suicidal ideation is shared or, if during a crisis call, that the police will appear at his door.

- The patient fears that others will find out about his suicidal thoughts through a break in confidentiality.

- The patient does not believe that anyone can help.

- The patient has alexithymia and has trouble describing emotional pain or material.[12]

It is sometimes easy to believe that if we ask directly about suicide, the patient will answer directly—and truthfully. From the above considerations, it is apparent that this is not necessarily the case. The real suicidal intent of a patient can be more accurately conceptualized by the following "Equation of Suicidal Intent":

Real Suicidal Intent = Stated Intent + Reflected Intent + Withheld Intent

Thus, a patient's actual intent may equal his stated intent, reflected intent, and withheld intent; any one of these 3; or any combination of the 3. The more intensely a patient wants to proceed with suicide, the more likely he is to withhold his true intent. In addition, the more taboo a topic is (eg, incest and suicide) the more one would expect a patient to withhold information. In such instances, both conscious and unconscious processes may underlie the withholding of vital information.

From a psychodynamic perspective, a curious paradox can arise. If a patient believes that suicide is a sign of weakness or a sin, unconscious defense mechanisms (such as denial, repression, rationalization, or intellectualization) may create the conscious belief that the patient's intent is much less than it actually is. When asked directly about his suicidal intent, this patient may provide a gross underestimate of his potential lethality even though he is genuinely trying to answer the question honestly.

From a phenomenological perspective, it is not surprising that some seriously suicidal patients may relay their actual intent in stages. Whether evaluating such patients in an ED or on a crisis line, one would expect that the patient would share some information, see how the clinician responds, then share some more information, reevaluate "where this session is going," and so on.

Indeed, patients with serious suicidal intent who are trying to decide how much to reveal may share information about a mild overdose while consciously withholding their main method of choice (such as a gun, for they are well aware that once they share information about the gun it may be removed) until they arrive at a decision during the interview that they do not want to die. At this point, they may feel safe enough to share the full truth with the clinician.

Reflected intent: one of the master keys to unlocking real intent

Reflected intent is the quality and quantity of the patient's suicidal thoughts, desires, plans, and extent of action taken to complete the plans, which reflect how much the patient truly wants to commit suicide. The extent, thoroughness, and time spent by the patient on suicidal planning may be a better reflection of the seriousness of his intent and the proximity of his desire to act on that intent than is his actual stated intent.

Such reflections of intent may prove to be life-saving pieces of the suicide assessment puzzle. The work of Thomas Joiner[10,13] has provided insight into the importance of acquired capability for suicide (eg, intensive planning, multiple past attempts) as a reflection of the seriousness of intent and the potential for action.

A wealth of research and theory from an unexpected source—motivational theory—can help us better understand the importance of reflected intent. Prochaska and colleagues'[14,15] transtheoretical stages of change—precontemplation, contemplation, preparation, action, and maintenance—helped lay the foundation from which Miller and Rollnick's[16,17] influential work on motivational interviewing arose. When it comes to motivation to do something that is hard to do but good for oneself (eg, counseling), the extent of the patient's goal-directed thinking and his subsequent actions may be much better indicators of intent to proceed than his stated intent. In short, the old adage "actions speak louder than words" appears to be on the mark in predicting recovery behavior.

A patient in alcohol(Drug information on alcohol) counseling may tell the counselor all sorts of things about his intent to change. Nevertheless, it is the amount of time he spends thinking about the need for change (reading the literature from Alcoholics Anonymous [AA]), arranging ways to make the change (finding out where the local AA meetings are), and the actions taken for change (finding someone to drive him to the meetings) that, according to Prochaska's theory, may better reflect the intent to change than the client's verbal report.

Motivational theories are usually related to initiating difficult-to-do actions for positive change. But they may be equally effective for initiating a difficult-to-do action that is negative, such as suicide. (Joiner [10,13] has pointed out that suicide can be quite a difficult act with which to proceed.) Once again, the amount of time spent thinking, planning, and practicing a suicide attempt may speak louder about imminent risk than the patient's immediate words about his intent.

Pitfalls of an incomplete elicitation of suicidal ideation

Premature crisis resolution. Arguably, the single most important task in a suicide assessment, whether in a face-to-face interview or on the phone, is to estimate the immediate risk of suicide and to triage safely with appropriate follow-up. Much of this determination of risk is contingent on an accurate estimate of the patient's suicidal intent. However, significant errors can be made, whether a clinician is in an ED or manning a crisis line.

Picture a patient who mentions suicidal thought and openly admits to a plan (eg, overdosing) yet is withholding much of his intent because of a strong desire to die. The clinician explores the ideation related to overdosing and then prematurely (before carefully eliciting other suicidal ideation and planning that may better reflect the patient's true intent and method of choice) begins crisis transformation. Being a skilled clinician, the crisis is effectively resolved. The client reports feeling much better. The clinician makes a recommendation for follow-up such as, "Sometime in the near future, I urge you to seek out a therapist."

Because the clinician did not do a thorough assessment of reflected intent before beginning crisis transformation (he or she prematurely assumed that the method first supplied by the client—overdosing—was the method of choice), the clinician is unaware that the client has been thinking about shooting himself for weeks; has gotten the gun out on several occasions (loaded it once); and was in need of much more careful follow-up, including the fact that the patient's mother could have removed the gun. Unfortunately, three days after the "successful" crisis intervention, the patient's girlfriend leaves him, he begins drinking, and his suicidal intent returns with a vengeance and the sound of a gunshot.

Lost data for the receiving clinician. A clinician who helps a patient to open up about his suicidal ideation and who uses effective interviewing techniques **(described in Part 2 of this article online)** may have an unusually good opportunity to obtain an accurate picture of both stated and reflected intents during the initial crisis intervention. The patient may be affectively charged at the time and such

emotional turmoil may make the client's unconscious and conscious defenses less active so that it is easier for the truth to emerge.

It is of great value for a triage clinician, such as a school counselor, primary care physician, or crisis line counselor to gather as much information as possible at this time because during the trip to the ED a surprising number of patients undergo a "miraculous cure" during transport. In short, they clam up. It is important for professional gatekeepers to gather as much information as possible regarding reflected intent because the receiving mental health professional, whether in an ED later that night or in a community mental health center 2 days later, may be dependent on this relayed information when making a formulation of risk.

The power of a thorough elicitation of suicidal ideation, behavior, and intent to save a life

The issue of credibility. Especially in situations in which the patient is not known to the interviewer, such as may occur in EDs and during consultation and liaison assessments following a suicide attempt, a determination of the credibility of the patient's self-report is of vital importance. In such situations, one can compare the validity of what is being reported with what has been documented in the past. Although previous charts are not always available (electronic records may diminish this problem), when they are, information documented on reflected intent may be invaluable in assessing the reliability of the patient's current self-reporting.

A marked discrepancy between what the patient reports about past suicidal ideation and what is actually documented may be the best indicator of whether the patient is telling the truth. Such a contradiction may guide the clinician to seek collaborative sources of information and/or to discuss the discrepancies with the patient. It also emphasizes the need to reevaluate the patient's immediate safety.

Reaching for life. Regarding future safety, the act of eliciting a thorough database on suicidal ideation and actions may be of value not only in the content of the database obtained but in the therapeutic fashion in which this information is garnered. Clinicians who have been trained to use an engaging strategy for eliciting suicidal ideation, such as the **Chronological Assessment of Suicide Events–CASE Approach (see online article),**[1,18-20] may often create a positive interpersonal experience during the initial assessment. Such a patient may remember the sense of safety and comfort he felt talking with this clinician who neither overreacted nor underreacted to the patient's description of his suicidal thought. If, in the future, that patient becomes dangerously suicidal—and is debating whether to call for help or proceed with the attempt—the patient may decide to reach for the phone, not for a gun.

Closing comments

In **Part 2** of this series on suicide assessment, we will look at a flexible approach for uncovering suicidal ideation and intent that addresses the concerns described above. The CASE Approach is an interviewing strategy designed to increase the likelihood that the patient's stated intent is accurate, that the reflected intent is comprehensive and valid, and that the amount of withheld intent is minimized or absent.

But before we leave the topic of the importance of eliciting a thorough history of suicidal ideation and action, it cannot be overemphasized that collaborative sources, such as family members, therapists, and police, may play a defining role in gathering the pieces of the risk assessment puzzle. One study of completed suicides showed that 60% of the patients had communicated suicidal thoughts to a spouse and 50% to a relative.[21] Fortunately, the interviewing strategy described in the online article may prove to be equally useful in obtaining valid information from collaborative sources, who may have their own hesitation about sharing the patient's suicidal ideation.

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