ASSESSMENT, TREATMENT, AND PREVENTION OF SUICIDAL BEHAVIOR

Edited by
ROBERT I. YUFIT and DAVID LESTER

John Wiley & Sons, Inc.
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Change is a constant in life. By building coping strengths the clinician can help the more vulnerable person cross the therapy bridge and prevent the extreme failure of adaptation: suicide.

We dedicate this book to the mental health clinicians who help suicidal patients build the therapy bridge from hopelessness to wellness, from vulnerability to successful coping with change.
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Foreword

It doesn’t seem too long ago that the best answer to the question “How do you know if someone is suicidal?” was (only half-jokingly) “Just ask him/her.” Often, it was the only answer in those early years when the first suicide prevention centers and crisis centers were established and the field of suicidology was just beginning. First efforts turned to those most used psychological tests and scales, such as the Rorschach, the TAT, and the MMPI, but these were repeatedly unsuccessful or only minimally helpful. Accordingly, clinicians called on their own resources and made up their own scales using feelings, behaviors, family history, psychosocial factors, medical status, epidemiological and demographic aspects drawn from their own contacts with suicidal individuals along with already existing sociological studies. While these first scales and questionnaires were helpful, they were drawn primarily from clinical experiences with suicidal callers and patients that featured an assessment of immediate short-term risk or the probability of a lethal acting out occurring within the next 24 hours. Kaplan and Lindemann’s crisis theory that was developing at about the same period provided a handy theoretical underpinning for the responses that developed.

The difficulty has been that in the intervening years, as studies multiplied and information about the vagaries of suicide increased, its complexity and its multidimensional aspects became more and more apparent. Treatment had to expand to include chronic and long-term suicidal behavior, direct and indirect suicidal behavior, intentional planned and impulsive unplanned behavior, and so on. It became apparent that no one theory and no one therapy could fit all the many manifestations of self-destructive feelings and behaviors. It was increasingly recognized that suicide encompassed a complex, complicated, wide-ranging network of conditions, and that its assessment could only be partial with
any one scale or questionnaire. Supplemental procedures and additional sources were necessary to understand more completely the presenting situation. This important fact is repeatedly noted in many chapters in this book, especially in the section on assessment.

This book plays a vital role in helping the reader keep pace with the many changes in assessment that have occurred since those early days. In some instances, it brings the reader up to date with familiar tests by giving their history and indicating its current status, whether useful applicability (Beck scales), or reaffirmations of doubtful help (MMPI, Rorschach in part). But even with unconfirmed scales, there are indications of ways in which they might be useful, as in providing information about specific aspects like impulsivity, handling of guilt feelings, or management of anger and similar conditions that contribute to evaluating suicide status.

A comprehensive view of the major areas of assessment, treatment, and prevention in suicide prevention since its beginnings in the 1950s reveals an uneven development, with studies of treatment of the suicidal individual at first lagging behind the studies of assessment. Within the area of treatment itself, activity was unequal with the majority of the studies focusing on the critical area of crisis response and management as suicide prevention centers appeared throughout the United States and the world. However, as reflected in this book, the focus has shifted and many studies have appeared on individual therapies and long-term treatments, with at least two of the therapies reporting success in working with people at risk of suicide—cognitive behavior therapy and dialectical behavior therapy. For those who still prefer to work with dynamics, there is voice therapy and transactional analysis with their specialized features for providing insights, along with gestalt therapy, interpersonal therapy, insight therapy, and others. Neurobiological aspects and the development of medications specifically targeting the feelings and attitudes most often found in suicide now play an increasingly important role. Guidelines have been formulated specifically for treating the suicidal patient that provide both short-term and long-term procedures and goals, increasing confidence in achieving positive outcomes. Regardless of the kind of therapy practiced, the summaries and conclusions of the chapters in Part Two—the Treatment section of this book—will help every therapist in providing effective and efficient practice with suicidal
patients. Like an added special treat in an 18-course intellectual dinner, there is a thoughtful, considered report on the re-emergence of suicide as a weapon of terrorism.

This book provides an invaluable update on the current status of assessment, treatment, and prevention of suicidal behavior.

Norman L. Farberow, PhD
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ASSESSMENT, TREATMENT, AND PREVENTION OF SUICIDAL BEHAVIOR
CHAPTER 1

Introduction

Robert I. Yufit and David Lester

The scourge of suicidal behavior touches many lives and knows few boundaries. About 30,000 people are known to take their own lives in the United States each year. In addition, many of those deaths recorded as accidental or undetermined by coroners and medical examiners may have been motivated by suicidal intent. Suicide is the eighth leading cause of death in this country and, among young people 15 to 19 years of age, suicide is exceeded in frequency as a cause of death only by accidental deaths. Suicide occurs in every country in the world and among all racial and ethnic groups. Being destitute and alone increases the risk of suicide, but suicide occurs in all groups of the population, the young and the old, the rich and the poor, the famous and those who remain unnoticed.

For each suicidal death that occurs, there are many more nonfatal suicidal acts ranging in seriousness from mild overdoses and superficially inflicted cuts to potentially lethal acts such as jumping from a high place or ingesting a corrosive poison. It is estimated that there are about a quarter of a million nonfatal suicide attempts each year in the United States. Among people who have made a suicide attempt, about 15 percent will eventually take their own lives; among those who kill themselves, about one-third have previously attempted suicide.

These facts attest to the importance of assessing suicidal risk accurately, providing effective treatment for people who have attempted suicide or who appear to be likely to do so, and implementing preventive strategies that can minimize the emergence of suicidal impulses. Since suicide is unique among causes of death in that it is entirely the result of decisions and actions made by the deceased person, it should
be preventable by helping people cope with the chronic predispositions that increase their risk of suicide and the temporary stressors with which they are confronted.

To help clinicians who work with suicidal clients, this book provides a current and comprehensive source of information and guidelines for assessing, treating, and preventing suicidal behavior.

The book consists of three sections: Part One, “Screening and Assessment,” examines empirically based assessment techniques that measure important mood states, personality traits, and attitudes that are associated with suicidal behavior. These assessment methods help define the dimensions of vulnerability to becoming self-destructive and also assess the risk of such behavior occurring.

In Chapter 2, James Rogers and Kimberley Oney examine those scales that measure the suicidality of clients. The diversity of these scales means that each clinician and each researcher may use a different scale. As a consequence, their definitions of and judgments about the suicidality of clients may differ considerably. Rogers and Oney discuss the empirical evidence for the reliability and validity of these scales but, more importantly, they discuss how the nature of the relationship between the psychologist and the client can affect this reliability and validity. They propose a model for the clinician to follow that may increase the usefulness of these scales in clinical practice.

One of the most thoughtful and prolific developer of scales to assess the suicidality, mood, and cognitive functioning of clients is Aaron Beck. His scales are based on his theory of psychiatric disorder and the techniques of cognitive therapy that he has proposed. These scales have been used in hundreds, if not thousands, of empirical studies, and so their reliability and validity has been well established. In Chapter 3, Mark Reinecke presents current data on these scales that are of immense value to clinicians working with depressed and suicidal clients.

Several assessment techniques have been used for more than 50 years with suicidal clients. In Chapter 4, Alan Friedman, Robert Archer, and Richard Handel review the use of the old MMPI and the more recent MMPI-2 and MMPI-A with suicidal clients. Not only are these measures still used extensively with potentially suicidal clients, there are also large sets of archival data that have included these measures. Thus, the MMPI in its various forms remains useful for the evaluation of clients, and it
also enables archival data sets to be re-examined as new findings on the MMPI become disseminated.

In Chapter 5, Ronald Ganellen reviews research on the use of the Rorschach Ink Blot Test with suicidal clients. Although projective tests such as the Rorschach are not favored by all clinicians, some clinicians still use them and, again, there are large archival data sets from the Rorschach.

Robert Yufit has been involved in research on the assessment of suicidal clients for many years, and he has developed his own approach to assessment based on Karl Menninger’s concept of the Vital Balance, a balance between the strengths and weaknesses of the client. He presents assessment techniques to evaluate both vulnerability and coping skills in his approach in Chapter 6.

Part Two, “Intervention and Treatment of Suicidality,” compares several different approaches for conducting psychotherapy with suicidal clients. The classic systems of psychotherapy have rarely addressed suicidal clients, but in Chapter 7, David Lester brings together the few suggestions that these classic systems (such as psychoanalysis, person-centered therapy, and Gestalt therapy) have made.

Most suicide prevention centers are based on a crisis intervention approach to treating the suicidal client. They do this partly because the suicidal clients they encounter are in crisis, but also because the centers are set up to deal with clients only on a short-term basis and use telephone counseling, both of which limit the techniques that the counselor can use. In Chapter 8, John Kalafat and Maureen Underwood discuss the principles of crisis intervention for suicidal clients.

Having suicidal clients sign contracts that they will not commit suicide has become a common but controversial tactic for psychotherapists. Lillian Range reviews the opinions on this tactic, as well as the research on its usefulness, in Chapter 9.

There are three systems of psychotherapy which have addressed the suicidal client in detail. Mark Reinecke and Elizabeth Didie present cognitive-behavioral therapy in Chapter 10, Lisa Firestone presents voice therapy in Chapter 11, and David Lester presents dialectical behavior therapy approach in Chapter 12.

For many years, Joseph Richman has been the lone therapist advocating the relevance of family therapy for suicidal clients, and he presents
his approach in Chapter 13. Suicidal clients have been placed into group therapy since the 1960s when the Los Angeles Suicide Prevention Center first tried this approach. Robert Fournier discusses current practices for group therapy with suicidal clients in Chapter 14.

The final part presents special issues that have relevance today. First, discussions of rational suicide and physician-assisted suicide have become common in recent years, but few psychotherapists have explored how they might become involved in these decisions. In Chapter 15, David Lester discusses the role that counselors and psychotherapists might play in helping the suicidal client come to a decision and in helping the significant others come to terms with the decision.

There is great concern with suicidal behavior in adolescents and students, particularly because many nations have experienced a rise in the suicide rates of young people in recent years and because suicide is one of the leading causes of death for the youth. Antoon Leenaars, David Lester, and Susanne Wenckstern discuss suicide prevention in schools in Chapter 16, while Morton Silverman discusses tactics for helping suicidal college students in Chapter 17.

Finally, we hear much about suicide terrorists who blow themselves up with bombs in their efforts to bring about political change in nations as disparate as Iraq, Chechnya, and Sri Lanka. Ariel Merari concludes this volume by discussing the problems and issues that suicide terrorists present.

This compilation of information concerning the assessment, treatment, and prevention of suicidal behavior is addressed to nurses, psychiatrists, psychologists, social workers, and other mental health professionals, who will find it useful in providing services to patients and clients who have been or may become suicidal or who indulge in self-harm behavior. In addition to its primary audience of mental health professionals, this book will prove valuable to educators, school counselors, and others who are actively engaged with young people and in a position to help them learn improved coping skills. These readers are likely to appreciate the guidance provided for structuring programs to promote coping skills in adolescents that can reduce their potential for suicide. We hope that this book will provide the needed advances in information to help us cross the bridge to a better understanding of how to help suicidal people.
PART ONE

Screening and Assessment
CHAPTER 2

Clinical Use of Suicide Assessment Scales: Enhancing Reliability and Validity through the Therapeutic Relationship

James R. Rogers and Kimberly M. Oney

The search for suicide assessment measures that can reliably and validly inform the clinical assessment of suicide risk or potential has a long history in suicidology (e.g., Farberow, 1981; Jobes, Eyman, & Yufit, 1995; Lester, 1970; Lewinsohn, Garrison, Langhinrichsen, & Marsteller, 1989; Maris, 1992; Range & Knott, 1997; Rothberg & Geer-Williams, 1992; Westefeld et al., 2000). While this search over time has led the field away from its prior focus on the prediction of suicide by means of psychological measures to the more reasonable goal of assessment (Maris, 1992), the ability to inform accurately the clinical assessment of suicide risk or potential using suicide assessment scales remains an elusive goal (Westefeld et al., 2000).

Much of the difficulty in the prediction and assessment of suicidality has been attributed to psychometric weaknesses in suicide assessment scales (e.g., Jobes et al., 1995). Specifically, there has been notable concern about the reliability (i.e., stability and replicability) of scale scores and the validity (i.e., meaningfulness, appropriateness, and usefulness) of the interpretations of those scores vis-à-vis suicidal behavior (Jobes et al., 1995; Maris, 1992; Rothberg & Geer-Williams, 1992).

Conspicuously missing from these discussions, however, has been a consideration of the impact of the relational context of assessment on the psychometric characteristics of reliability and validity at the clinical level. In this chapter, we argue that accurate assessment for clinical work involves not only a consideration of the general psychometric properties
of assessment measures based on aggregate data, as has been the pri-
mary focus in the past, but also attention to the impact of the context of
assessment on the reliability and validity of information collected via
those measures at the clinical level. Thus, we posit a two-tiered consid-
eration of reliability and validity, with the first tier consisting of an
evaluation of those characteristics at the aggregate level and the second
tier focused on issues of reliability and validity at the clinical or phe-
nomenological level.

In keeping with this two-tiered model, we first provide a brief overview
of three major reviews of suicide assessment scales published in the past
12 years focusing on reliability and validity based on group or aggregate
data. Next, we present an argument supporting the importance of the re-
lational context as a mechanism for enhancing the reliability and validity
of data collected via suicide assessment scales in clinical work. Finally,
we offer an example of a clinical assessment protocol that incorporates
the relational context in the assessment process and, thereby, increases
the potential to derive reliable and valid data from suicide assessment
scales at the individual level.

TIER ONE: RELIABILITY AND VALIDITY BASED ON
AGGREGATE DATA

Three major reviews of suicide assessment scales have appeared in the
literature over the past decade. Rothberg and Geer-Williams (1992) re-
viewed 18 published suicide risk scales and evaluated those scales in
terms of their psychometric properties. Similarly, Range and Knott
(1997) evaluated 20 suicide assessment instruments, and Westefeld et al.
(2000) reviewed 12 suicide assessment scales. Authors of these reviews
focused primarily on the psychometric issues of scale reliability and va-

didity derived from aggregate data in their evaluations of the scales and
subsequent recommendations. As defined by the Joint Committee on
Standards for Educational and Psychological Testing (1999), validity is
“the degree to which evidence and theory support the interpretations of
test scores” (p. 9) while reliability refers to the consistency of measure-
ment when “the testing procedure is repeated on a population of individ-
uals or groups” (p. 25) or the extent to which measurement is free from
error (Crocker & Algina, 1986). Thus, from a psychometric perspective,
the characteristics of validity and reliability are assessed based on the responses of groups of individuals. This information is then used to evaluate the appropriateness of using those instruments at the individual or clinical level.

**Rothberg and Geer-Williams**

Rothberg and Geer-Williams (1992) reviewed 18 suicide prediction scales in terms of their psychometric properties. These authors categorized the scales into those relying on the direct self-report of the test-taker (six scales) and those relying on a second party, such as documentation from hospital records as the source of information (12 scales). Seventeen of the scales reviewed by Rothberg and Geer-Williams are presented in Table 2.1 along with their original citations. Because it is imbedded in a projective measure of personality and, therefore, not specifically a suicide assessment measure, the Rorschach Suicide Constellation (Exner & Wylie, 1977) is not included in the table.

In summarizing their review, Rothberg and Geer-Williams lamented the general absence in the literature of attention to the psychometric properties of the suicide assessment scales that they included in their work. In an interesting conclusion to their chapter, however, the authors attempted to apply nine of the second-party scales in their review to five case vignettes characterized as ranging from low risk to high risk for suicide (see Berman, 1992, for case summaries). Their application of the scales to the cases resulted in a wide range of risk estimates across four of the five cases. The one case that was rated in a relatively consistent fashion using the nine scales was uniformly identified as a low-risk case. This result suggests that, while the scales may have value in assessing suicide risk as a dichotomous variable (i.e., no risk versus risk), their ability to discriminate across various levels of suicide risk is questionable.

As a result of the dearth of published reliability and validity information on the 18 scales in their review and the lack of agreement among the nine scales used to rate the risk for suicide for four of the five case summaries, the authors refrained from recommending any of the reviewed scales for clinical purposes. Rothberg and Geer-Williams concluded that much more work was needed in developing clinically useful suicide assessment measures but did not make specific recommendations in that regard.
Table 2.1 Suicide Prediction Scales

<table>
<thead>
<tr>
<th>Title of Measure</th>
<th>Original Citation</th>
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<tbody>
<tr>
<td><strong>Suicide Measures</strong></td>
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<tr>
<td>Hopelessness Scale</td>
<td>Beck, Weissman, et al., 1974</td>
</tr>
<tr>
<td>Brief Reasons for Living Inventory (RFL-B)</td>
<td>Ivanoff et al., 1994</td>
</tr>
<tr>
<td>Clinical Instrument to Estimate Suicide Risk (CIESR)</td>
<td>Motto et al., 1985</td>
</tr>
<tr>
<td>Fairy Tales Test (FT) aka Life and Death Attitude Scale or Suicidal Tendencies Test</td>
<td>Orbach et al., 1983</td>
</tr>
<tr>
<td>Index of Potential Suicide</td>
<td>Zung, 1974</td>
</tr>
<tr>
<td>Instrument for the Evaluation of Suicide Potential (IESP)</td>
<td>Cohen et al., 1966</td>
</tr>
<tr>
<td>Intent Scale</td>
<td>Pierce, 1977</td>
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<td>Lethality of Suicide Attempt Rating Scale (LSARS)</td>
<td>Smith et al., 1984</td>
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<td>Life Orientation Inventory (LOI)</td>
<td>Kowalchuk &amp; King, 1988</td>
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<td>Los Angeles Suicide Prevention Center Scale (LASPC)</td>
<td>Beck, Resnik, et al., 1974</td>
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<tr>
<td>Modified Scale for Suicide Tendency Scale (MAST)</td>
<td>Miller et al., 1986</td>
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<td>Multiattitude Suicide Tendency Scale (MAST)</td>
<td>Orbach et al., 1991</td>
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<tr>
<td>Neuropsychiatric Hospital Suicide Prediction Schedule</td>
<td>Farberow &amp; MacKinnon, 1974</td>
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<tr>
<td>Prison Suicidal Behaviors Interview (PSBI)</td>
<td>Ivanoff &amp; Jang, 1991</td>
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<tr>
<td>Reasons for Living Inventory (RFL)</td>
<td>Linehan et al., 1983</td>
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<tr>
<td>SAD Persons (SP)</td>
<td>Patterson et al., 1983</td>
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<td>Scale for Assessing Suicide Risk</td>
<td>Tuckman &amp; Youngman, 1968</td>
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<td>Scale for Predicting Suicidal Behavior (SPSB)</td>
<td>Buglas &amp; Horton, 1974</td>
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<tr>
<td>Scale for Suicide Ideation (SSI)</td>
<td>Beck et al., 1979</td>
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<tr>
<td>Self-Rated Scale for Suicide Ideation (SSI-SR)</td>
<td>Beck et al., 1988</td>
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<tr>
<td>Short Risk Scale (SRS)</td>
<td>Pallis et al., 1982</td>
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<tr>
<td>Suicidal Death Prediction Scale, Long (SDPS-L) and Short Forms (SDPS-S)</td>
<td>Lettieri, 1974</td>
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<td>Suicidal Ideation Questionnaire (SIQ)</td>
<td>Reynolds, 1987</td>
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<td>Suicidal Ideation Scale (SIS)</td>
<td>Rudd, 1989</td>
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<tr>
<td>Suicide Behaviors Questionnaire (SBQ)</td>
<td>Linehan, 1981</td>
</tr>
<tr>
<td>Suicide Behaviors Questionnaire for Children (SBQ-C)</td>
<td>Cotton &amp; Range, 1993</td>
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<tr>
<td>Suicide Intent Scale aka Suicidal Intent Scale (SNS)</td>
<td>Beck, Schuyler, et al., 1974</td>
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