CHAPTER 4

Accurate and Brief Risk Assessments

As has been discussed in previous chapters, several factors have converged to raise awareness of the need for competent suicide risk assessment in primary care settings. First, increasing numbers of psychologists and other mental health care providers have been positioned in primary care clinics in an effort to improve both the ease of access to mental health care and the efficiency of service provision (Blount et al., 2007). Second, almost half of those who die by suicide present to a primary care clinic during the month before their death (Luoma et al., 2002), and almost 20% contact their primary care provider (PCP) within a day of their suicide (Pirkis & Burgess, 1998). Finally, recognizing that primary care is the predominant source (and in most cases the only source) of mental health care in the United States, public health campaigns targeting suicide have identified primary care as a critical setting for frontline intervention (Blount et al., 2007). The result is a mounting need for straightforward, clinically applicable, and flexible approaches to assessing and managing suicide risk in primary care clinics. Critical to this need for approaches that acknowledge the unique clinical constraints of the primary care setting that differ markedly from the specialty mental health settings in which the general science and practice standards of suicide risk assessment and management have been developed.

Few would argue with the assertion that the assessment, management, and treatment of suicide risk are among the most challenging and stressful tasks for clinicians regardless of setting (cf. Jobes, Eyman, & Yufit, 1993). The unique constraints of the primary care setting (e.g., brief appointments, high patient volume, comorbid medical conditions, limited follow-up schedules, restricted management options) serve to further complicate an already complex task. Perhaps the most prominent and frequently occurring question from behavioral health providers practicing in primary care settings is "how do I complete an appropriate and accurate risk assessment within the contextual constraints of the primary care clinic?"
Before answering this question, it is useful to consider the typical diagnostic and evaluative approach to other medical or health complaints presented by a typical patient when meeting with his or her PCP. First, a patient comes in and reports symptoms and problems to the PCP, who asks evaluative questions designed to rule in potential causes for the symptoms and rule out other causes suspected to be unrelated to the problem. To aid in this process, the PCP conducts an examination and oftentimes orders tests to further refine their initial clinical impressions. The results of these tests generally serve to confirm or disconfirm suspected causes underlying the patient's complaints and are used to guide appropriate treatment. In some cases, the patient is referred to a specialist for more refined testing and/or treatment. In the meantime, the PCP initiates some form of treatment plan to manage the problem and provide symptom relief while the patient awaits this higher level of care. If a health issue requiring specialty care is identified, the specialist provides appropriate treatment and management, and when the issue has been adequately resolved, care for the patient is typically transferred back to the PCP for ongoing monitoring and preventative care.

This typical approach to primary care therefore consists of several steps. First, an initial screening that tends to be highly generalized and nonspecific occurs (e.g., patient self-report of symptoms, respiration, checking inner ears), followed by increasingly specific assessment strategies (e.g., laboratory work, throat swab, x-rays, physical manipulation of body parts) until a reasonable level of confidence regarding the cause for the problem is identified (i.e., diagnosis). Finally, an intervention is initiated by the PCP and, where indicated, a referral to a specialist is made for more advanced assessment and treatment (e.g., cardiology, endocrinology, oncology).

This same approach is recommended for the assessment and management of suicide risk in primary care: (1) screen for suicide risk, (2) for positive screens conduct a more specific suicide risk assessment, (3) arrive at a reasonable assessment of risk level, (4) initiate interventions and management strategies, and (5) refer to specialty mental health care where indicated. In this chapter, the first three steps of this approach (i.e., screening, assessment, and determination of risk) will be described in detail; intervention and referral will be discussed in subsequent chapters. A brief case vignette will be interspersed throughout the discussion during the next few chapters to serve as a reference point for illustrating concepts and steps involved in a clinical encounter for a suicidal patient. Case information will be revealed sequentially as we go through each step to mirror the chronology and process of a typical behavioral health consultant (BHC) appointment.

Mary is a 54-year-old married woman with two adult children. She is currently unemployed, with no previous employment outside the home. She lives with her husband, who is a retired military veteran. Mary is obese with several co-morbid medical issues, including hypertension and obstructive sleep apnea. She attended a routine follow-up appointment with her PCP today to go over the recent laboratory results, which point to a diagnosis of diabetes mellitus type 2. The PCP notified the BHC of Mary's upcoming appointment and requested a consultation with a specialist to address motivational and behavioral issues related to diet and exercise. As Mary has not always been adherent to treatments in the past. During the appointment, Mary agreed to meet with the BHC for recommendations regarding diabetes management, and she was checked in for a consult. As part of her practice, she was given a symptom checklist to complete before the BHC appointment while the PCP conferred with the BHC. The PCP stated that when he informed Mary of the diagnosis of diabetes, she “took the news hard” but overall seemed doing okay. The PCP stated that Mary was willing to engage with the BHC and she would be a good candidate for a collaborative treatment plan combining medication with behavioral treatment. The BHC agreed to evaluate Mary and follow up with the PCP afterward with specific treatment recommendations.

**ROUTINELY SCREEN ALL REFERRED PATIENTS FOR SUICIDE RISK**

Because suicide is such a low base-rate phenomenon, it is not possible to screen its occurrence with any realistic level of reliability or consistency. Screening of every referred patient for suicide risk during initial contact is therefore recommended for increasing the likelihood of identifying individuals who might be at elevated risk. Screening is a brief and straightforward strategy that allowed to identify individuals at risk for suicide, in contrast to assessment which a more thorough understanding of the nature and intensity of suicide risk is obtained following positive screenings (cf. Robinson & Reiter, 2007).

Another way to conceptualize the differences between screening assessment is to consider them with respect to their ability to detect or diagnose the target construct. Screening approaches tend to maximize sensitivity at the expense of specificity because they are intended to positively identify as many suicidal individuals as possible. This expectedly results in a lower false-negative rate (i.e., nonsuicidal patients being identified as suicidal), while in contrast, emphasizes a more refined diagnostic specificity at the expense of potentially missing cases (i.e., suicidal patients being incorrectly classified as nonsuicidal). In other words, suicide screening serves to "rule in" the possibility of sui
risk, while risk assessment serves to “rule out” false-positives and better refine the clinician’s understanding of the true positive.

The two-stage approach of screening followed by more thorough risk assessment is therefore an effective strategy for balancing these two competing dimensions of identifying suicide risk. Screening can be accomplished in a variety of ways according to the needs and demands of each clinic, whether through clinician questioning during the appointment or through the use of brief, standardized measures that include screening items for suicidal ideation and/or behaviors.

Clinical Questioning Approaches

If using clinical questioning as the method for routine screening, BHCs should ensure that screening questions become a routine part of all patient evaluations, not just a subset of patients (e.g., the widespread practice of screening only those patients reporting depressed mood). Screening only subsets of patients, especially when designated by particular diagnoses, overlooks the well-established fact that suicide risk is not diagnosis-specific (Harris & Barraclough, 1997) and could result in missing many suicidal patients. Routine screening of all patients further ensures that BHCs do not succumb to using subjective indicators of risk or “gut feelings” to drive screening and assessment, a notoriously unreliable method for decision-making (Grove & Meehl, 1996). Routine screening of all patients therefore requires BHCs to screen for suicide even among patients who present with issues that seem to be completely unrelated to suicide risk (e.g., tobacco cessation). This position may initially seem to be unnecessarily extreme, but given the low base rate of suicidality and the data indicating that patients are unlikely to voluntarily report suicidality during medical appointments (e.g., Bryan, Corso, et al., 2009), it becomes clear that screening of all patients is the optimal method for increasing the likelihood of detection.

There are a number of ways to incorporate screening questions into one’s routine evaluation, the most widely recommended being a hierarchical approach in which the BHC transitions from the patient’s current symptom picture to hopelessness, and then to suicide-specific questioning (Bryan & Rudd, 2006; Rudd, Cordero, & Bryan, 2009). This hierarchical approach sequences increasingly specific questions that are more specific to the issue of suicide. For example, a straightforward screening approach might entail the following two questions:

1. It is not unusual for someone who is feeling depressed/agitated/lonely to feel hopeless. Do you ever feel hopeless about life or feel that things are never going to get any better?

2. Many times when people feel hopeless they also think about death or have thoughts about suicide. Do you ever wish you were dead or think about killing yourself?

The initial screening question probing for hopelessness is highly sensitive will therefore “catch” a very large number of suicidal patients because hopelessness is so common among suicidal patients. However, screening for hopelessness is not very specific and will result in a lot of false-positives because the overwhelming majority of patients who are hopeless are not suicidal. Second question is therefore designed to further narrow the field while remaining broad enough to catch as many suicidal patients as possible. Starting with a question about hopelessness, the BHC provides a bridge to the current topic of conversation to the ultimate goal of screening for suicide risk. By “easing in” to the suicide screening in this way, the BHC provides a contextual basis by which it “makes sense” to ask about suicidality, reducing the patient’s anxiety about discussing the issue and increasing their willingness to honestly self-disclose any such thoughts.

Another important point to emphasize is that effective screening requires the BHC to specifically probe for the target construct—in this case, risk of suicide. Using hopelessness as the sole screening for suicide risk is inadequate because it is too nonspecific. Effective suicide screening requires direct, unambiguous inquiry about suicide risk in the same way that effective depression screening requires direct inquiry about mood. Asking patients if they are having “thoughts about hurting themselves” is not the same as asking patients if they are having “thoughts about suicide” or “thinking about killing yourselves.” As demonstrated in the second question, suicide screening should specifically ask about suicide during each clinical encounter. In the same way that FPE checks vital signs at every appointment regardless of complaint or reason visit, so should BHCs routinely check this vital sign for psychological holistic care.

Checklist and Questionnaire Approaches

Use of screening measures such as symptom checklists or self-report questionnaires is a simple and straightforward alternative screening method. There is a number of symptom checklists that can be used for the purposes of suicide screening such as the 9-item depression subscale of the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) or the 20-item Behavior Health Measure (BHM-20; Kopta & Lowry, 2002). If BHCs choose to use checklist or survey screeners, they should ensure that the screening item directly about suicide in clear, easy-to-understand language. The PHQ-9, for example, asks patients to rate how often they have been bothered by “thoughts that...
would be better off dead or of hurting yourself in some way" during the previous 2 weeks. The BHM-20 similarly asks patients to rate how much they have been distressed by "thoughts of ending your life" in the past 2 weeks as well as rating their subjective level of suicide risk from "extremely high risk" to "no risk."

Both of these measures have demonstrated the ability to improve detection rates of suicide ideation. For example, Bryan et al. (2009) found in a primary care clinic that 12.4% of all patients referred for a BHC evaluation screened positive on the BHM-20's suicide ideation item (i.e., "thoughts of ending your life" during the previous 2 weeks). In comparison, only one in six of these positive screens (2.1% of the entire sample) disclosed suicide ideation to their PCP during the previous medical visit occurring anywhere from 48 hours to just minutes before the screening, indicating a sixfold increase in detection of suicidal patients as compared with usual care. Unfortunately, this study was not designed to determine what proportion of patients had been explicitly asked by their PCPs about suicide risk but denied it and what proportion was not asked about suicide risk by their PCPs at all, which would further clarify the survey's ability to improve detection. In another study investigating suicide screening in primary care, inclusion of the suicide item from the PHQ-9 significantly improved detection of patients with thoughts about death or suicide (Corson, Gerrity, & Dobscha, 2004). Follow-up risk assessments of positive screens revealed that one third had confirmed suicide ideation, demonstrating the value of the two-stage process of screening (maximal sensitivity) followed by risk assessment (maximal specificity). For positive screenings, the BHC should therefore conduct a more thorough risk assessment to better understand the nature and content of the endorsed items.

Upon completion of the symptom checklist, the BHC walks Mary to his examination room. During this walk down the hallway, the BHC quickly scanned the symptom checklist, making sure he checked the suicide screening item. Mary's responses indicated a moderate level of distress and a positive endorsement of the suicide ideation item. Once in the examination room, the BHC introduced himself and explained his services and informed Mary that her PCP had requested consultation regarding diabetes management. The BHC spent a few minutes assessing Mary's perceptions about diabetes, during which Mary described a sense of failure, shame, and self-disgust:

MARY [M]: It's all my fault because I'm so fat. I did it to myself. Look at me, I'm a whale.

BHC [B]: Those are pretty negative things to think about yourself. I'm wondering if that has anything to do with the depressed mood, anxiety, stress, and low energy you reported on this checklist.

M: They are. I get so depressed when I think about my weight. I just hate myself and how I look.

B: You know, sometimes people who don't think highly of themselves have all these other problems going on in life like feeling stressed, hungry, less, and low in energy also think about things like death or even kill themselves. I see on this form that you say you've been having some thoughts about ending your life.

In this segment of the clinical encounter, the BHC opened the conversation in the standard format, which in this case was related to diabetes management. He did not immediately open with a question about the suicide screening because he did not yet have any sense of the context within which Mary would endorse suicidality. Instead, the BHC obtained basic information related to the presenting complaint (diabetes) and very quickly started uncovering clues about Mary's suicide risk. The BHC was able to guide the conversation toward the eventual issue of suicidality in such a way that the issue of suicide came up naturally and was an expected part of the overall evaluation at conversation.

FOR POSITIVE SCREENINGS, CONDUCT A BRIEF BUT THOROUGH RISK ASSESSMENT

Based on our experience as BHC trainees, we have found that a frequent asked question surrounds how to accurately assess suicide risk and appropriately manage that risk within the brief window of the typical BHC appointment. As with any other aspect of BHC clinical work, the BHC should approach risk assessment in a manner that accounts for the greatest amount of suicide risk with the least amount of variables. In other words, BHCs should emphasize gathering information about those factors that have the strongest empirical association with suicidal behaviors. It is therefore recommended that BHCs sequence their risk assessment questions in particular order to minimize patient anxiety and obtain more accurate self-report leading to optimal clinical decision-making (Shea, 2002). Appropriately sequencing further maximizes the information gained from patients in a most practical, efficient, and clinically useful manner. A suggested format for sequencing of questions within primary care, along with sample queries is presented in Figure 4.1 and will be discussed in detail next. With practical experience, it is quite feasible to complete an accurate and high-quality risk assessment within the typical 25- to 30-minute window allotted for BHC appointments.
Differentiate Nonsuicidal Morbid Ideation From Suicide Ideation

Because most suicide screening items assess for the presence of suicide ideation, the BHC should clarify if the patient is experiencing suicide ideation or nonsuicidal morbid ideation. Nonsuicidal morbid ideation includes thoughts about death or wishing one were dead without suicidal content (e.g., “If I didn’t wake up tomorrow, that would be okay” or “I just wish it would all be over”). This differentiation is key since suicide ideation has a much stronger association with suicidal behaviors than nonsuicidal morbid ideation (Joiner, Rudd, & Rajab, 1997), thereby implicating different clinical responses.

The notion of a spectrum of suicide-related thoughts has a firm foundation in both the clinical and empirical literature. Joiner’s (2005) interpersonal psychological theory of suicide posits that not only is the desire for death an aspect of suicide behavior, but also that an individual must develop the capability to overcome the fear of death and subsequent the fear of suicide, the latter of which can take either the form of decreased levels of fear about death (i.e., “fearlessness”) and/or increased tolerance for the fear of death (i.e., “courage”). One study has specifically tested the possibility of a spectrum of suicidality from life weariness at the least severe end, through death wishes, suicide ideation, suicidal planning, and suicide attempt at the most severe end (Renberg, 2001). This study found general support for a hierarchical organization of these constructs, with more severe forms of thinking generally including less severe forms of thinking, but not vice versa. Suicidal planning, for example, typically was associated with suicide ideation, desire for death, and life weariness; desire for death was associated with life weariness but not necessarily associated with suicide ideation or planning.

From a clinical perspective, research among populations across the entire lifespan has supported differences between individuals with nonsuicidal morbid ideation and individuals with suicide ideation. Among older persons, higher levels of suicide ideation are related to greater psychological symptomatology when compared with individuals with nonsuicidal morbid ideation (Socieco & De Leo, 2002). Among adult patients with major depressive disorder, severity of depressive symptomatology has likewise been found to be higher in patients with suicide ideation than patients with nonsuicidal morbid ideation with the lowest levels of depressive symptoms being among patients denying either thought process (Fountoulakis et al., 2004). Among adult chronic pain patients, the highest levels of depression, trait anxiety, pain severity, pain-related functional impairments, and catastrophizing thought processes are found among suicide ideators, followed by nonsuicidal morbid ideators and then controls (Edwards et al., 2006). Similar patterns have been found in pediatric populations. Children and adolescents who report nonsuicidal morbid ideation...
have fewer depressive symptoms (i.e., irritability, depressed mood, psychomotor agitation, sadness, feelings of worthlessness, and guilt) and are less likely to have comorbid anxiety and conduct disorders as compared with those reporting suicide ideation (Liu et al., 2006). In general, this pattern of data indicates that much higher levels of psychological distress are associated with suicide ideation when compared with nonsuicidal morbid ideation, implicating different levels of clinical response and management strategies.

BHCs can differentiate suicide ideation from nonsuicidal morbid ideation by asking one or more probes or questions such as: "Tell me exactly what you've been thinking. What is it specifically that goes through your mind when thinking about this? Tell me the words that you use or say when thinking about this or describe the images that you see in your mind." In some cases, patients will still answer with unclear or ambiguous responses that do not clearly differentiate suicide from nonsuicidal morbid ideation. A patient might say, for instance, "I just wish I were in a fatal car accident" or "I just see myself dying, and I'm okay with that." BHCs can further refine this distinction by directly asking about a desire or intent toward self-infliction. For example, "When you wish you were in a fatal car accident, do you see yourself causing that accident? When you see yourself dying, is it because you killed yourself?"

As can be seen, the primary aim of initial screening is not to confirm the presence of nonsuicidal morbid ideation, but rather to rule in or rule out suicide ideation, as this ultimately drives the remainder of the risk assessment. Patients who report suicide ideation should be further assessed for suicide risk. Patients who endorse nonsuicidal morbid ideation but deny any suicide ideation generally do not require a detailed suicide risk assessment unless they report a previous history of suicidal behaviors. This difference in clinical response is due to the fact that nonsuicidal morbid ideation alone does not include an active motivation or desire to kill oneself and is a common feature of many psychiatric conditions (especially depression).

Because Mary positively endorsed the suicide screening item, the BHC begins a suicide risk assessment by attempting to clarify the nature of her suicidal thoughts. The following exchange occurs between the BHC and Mary:

B: You know, sometimes people who don't think highly of themselves and have all these other problems going on in life such as feeling stressed, hopeless, and low in energy also think about things like death or even killing themselves. I see on this form that you say you've been having some thoughts about ending your life.

M: Yeah, sometimes.

B: Can you tell me what, exactly, you've been thinking about?

M: Sometimes I think about just ending it all.

B: So you've been thinking about killing yourself?

M: Yeah.

In this segment, the BHC asks about suicide ideation and receives a somewhat ambiguous response. As a result, he follows up with a highly specific question signed to either rule in or rule out the likelihood of suicide ideation. In this his clarifying question results in a positive endorsement of suicide ideation.

Assess Past Suicidal Behavior

Suicide ideation is generally the most common method of screening for suicide risk. Using suicide ideation as the primary screener for suicide is ideal in many ways, since thinking about suicide generally precedes emergence of suicidal behaviors. Furthermore, during the typical BHC point-in-time, the self-report of suicide risk is almost always disclosed by patients in terms of current or recent suicidal thoughts or urges (as opposed to past suicidal episodes). It is imperative, however, for BHCs to quickly transition into obtaining a brief history of the patient's suicidal behaviors. Of the many risk factors that have been empirically associated with increased risk for suicide, the single most significant and robust predictor of future suicide attempts and death by suicide across the entire lifespan is a history of previous suicide attempts (Clark, Gibbons, Fawcett, & Scheffner, 1989; Mann et al., 2004; Joiner et al., 2005; Ostamo & Lonqvist, 2001). This has been confirmed in numerous studies. In one particularly impressive study referred to as the "kitchen sink" study (after the paper's title: "Four Stages of How Past and Current Suicidality Relate Even When 'Everything but Kitchen Sink' Is Covaried"), Joiner and colleagues (2005) conducted a series of analyses on four separate populations with varying degrees of suicide risk to determine if the magnitude of the relationship between past suicidal behaviors and current suicidal symptoms or future suicidal behaviors was held even when a staggering list of well-established suicide risk factors were simultaneously considered: age, sex, functional impairment level, hopelessness, depression, personality disorder diagnosis, psychosis, problem-solving impairment, current suicide ideation, family history of depression, and family history of suicide. In all cases, past suicidal behavior maintained a robust relationship with current or future suicide risk that was not significantly diminished even when these other variables were factored in. When these researchers repeated their procedures with the other suicide risk factors,
other variable (not even hopelessness) demonstrated the ability to maintain the magnitude of their relationship with suicidality in the presence of other risk factors.

These results provide a powerful demonstration of the "resilience" of past suicidal behaviors in predicting current and future suicide risk even in the presence of an impressive array of covariates and unambiguously highlight the importance of assessing for past suicidal behaviors when conducting risk assessments. No other risk factor for suicide has yet been identified that shares this unique characteristic. As such, history of suicide is a critical component of the BHCs risk assessment and should be evaluated as early as possible in the risk assessment to obtain the information that will most significantly drive their eventual risk formulation and clinical response.

When asking about past suicidal behaviors, BHCS should again implement appropriate sequencing and wording of questions to reduce the patient's discomfort in talking about suicide and to enhance the likelihood of obtaining an accurate historical report. This can be accomplished by gradually increasing the intensity and specificity of each question:

- Have you ever had thoughts of suicide like this before?
- Have you ever tried to kill yourself before?

By first asking about suicide ideation, which the patient has already endorsed and begun to discuss, the BHC can begin the historical review on "familiar ground." Regardless of the patient's response to the question about past suicide ideation, the BHC should ask about past suicide attempts, since previous suicidal behavior (not suicide ideation) is the target variable for assessment. In this context, although questioning about past suicide ideation serves a clinical purpose (i.e., frequency of previous suicidal episodes), it more importantly serves as a bridge to a higher level and more emotionally intense component of the risk assessment. If the patient responds negatively, the BHC should follow up with a third question that directly probes for specific methods of self-harm, preparatory or rehearsal behaviors, and suicide attempts that may have occurred in the past:

- So you've never cut yourself, burned yourself, held a gun to your head, taken more pills than you should, or tried to kill yourself in any other way?

This third and highly specific question in response to a denial of past suicidal behavior is important for a number of reasons and warrants further discussion. First, patients will occasionally withhold information about their suicidal thoughts and behaviors but will respond honestly if directly asked (Rudd et al., 2001). Consider the patient who, for the past few weeks, has driven to an isolated location on four occasions and held a loaded gun to his head but after several minutes puts the gun down and drives home and never mentions these actions to his wife or anyone else. When asked if he has ever tried to kill himself before, he might answer negatively because he has not yet pulled the trigger and therefore not yet "tried" to kill himself. When asked about specific methods and preparatory behaviors, however, he is much more likely to admit to this highly dangerous behavior because although he does not necessarily want to disclose his actions, he also does not necessarily want to lie. Second, asking about suicidal history in a repeated and increasingly specific manner minimizes the likelihood of missing episodes that the patient has inadvertently dismissed or overlooked. This often occurs among patients with repeated instances of suicidal episodes or self-harm behaviors, as well as among patients who have forgotten about instances in the distant past. In these cases, the highly specific question can prompt or jumpstart memories of relevant episodes. Finally, listing off multiple methods for self-harm and suicide further demonstrates to the patient that the BHC is comfortable discussing such issues in detail, which increases the likelihood of self-disclosure.

Screen for Multiple Attempeter Status and Assess Attempt History

In most cases, patients will not report a history of past suicidal behaviors, in which case, the BHC should move to assessing the current suicidal episode. In the event of a positive endorsement, however, the BHC should quickly screen for multiple attempter status and obtain some basic information about key past attempts. Identifying multiple attempters (i.e., patients with two or more previous suicide attempts) is important because this subpopulation is at much greater risk for suicide than nonmultiple attempters (i.e., patients with zero or one previous suicide attempt) (Rudd, 2006). Multiple attempters tend to be chronically suicidal, with frequent suicidal episodes that are easily triggered and maintained over time. If a patient endorses previous suicidal behaviors, the BHC should therefore ask how often and when these behaviors occurred. When working with multiple attempters, it is useful to identify patterns in behavior and intent over time. This can understandably be a daunting prospect within the primary care setting, especially with patients who report a very high frequency of past attempts. For many multiple attempters, it is simply not feasible for BHCS to conduct a thorough assessment of each and every suicidal episode that has occurred in their lives. The BHCS goal therefore should not be to obtain a detailed history of every suicide-related behavior that has
ever occurred but rather to establish a snapshot of the patient's behavioral pattern and intent over time in order to better understand the patient's current risk and to map out the general trajectory of suicidal behaviors over time.

This snapshot of the patient's suicidal history can be achieved by starting with the first episode, then jumping forward in time to the "worst" or "most serious" episode, then moving forward again to the current episode. BHCs can begin the historical assessment by asking patients to briefly describe the first attempt: "Tell me a little bit about the first time you tried to kill yourself. What's the story of what happened there?" Asking patients to "tell the story" of the suicide attempt as opposed to asking a series of questions to uncover details of the attempt (akin to an interrogation) is a collaborative strategy the BHC can use to enhance patient honesty and mitigate fears about self-disclosure. As the patient begins to relate the story of their first suicide attempt, the BHC should pay attention to several key features of the suicidal episode: when it occurred, methodology, context or location of the attempt, and intended or desired outcome. These variables provide BHCs with information about the "facts" of the suicidal episode that can guide management strategies and possible interventions. For example, does the patient attempt suicide when alone and the likelihood of rescue is low or does the attempt occur in a situation with high probability of survival (e.g., taking a handful of medication then immediately telling someone who is also in the house)? Identifying contextual variables also provides clues as to the types of situations that are likely to trigger suicidal behavior (e.g., relationship failures, arguments with family, job stressors) and are critical for developing management strategies and interventions. Developing a crisis response plan, for instance, in which a suicidal patient seeks out support during a crisis from a family member whose critical and abusive behavior contributes to suicidal thinking and urges is unlikely to be effective.

Assessing for these features of each episode is also important because they serve as indicators of behavioral intent. The behavioral intent associated with each episode should be assessed for two reasons. First, understanding the behavioral intent associated with each episode enables the BHC to more accurately classify the behavior as a suicide attempt or self-harm—an important differential, given the scientific evidence supporting increased risk for suicide associated with previous suicide attempts as compared with self-harm. Second, suicidal intent is considered one of the most important and robust predictors of suicidal behavior. There are two dimensions of suicidal intent for BHCs to assess: subjective and objective. Subjective intent entails what the patient reports to have been the motivation underlying the behavior. The BHC can clarify subjective suicidal intent by asking the patient one or more questions such as:

- Did you hope you would die, or did you hope something else would happen?
- What did you hope would happen when you [method]?
- Did you expect to die as a result of [method]?

The objective dimension of suicidal intent includes circumstantial features of the episode, such as isolation, likelihood of intervention, and preparation for the attempt and/or death. If the patient does not relate these details as part of their description of the suicide attempt, BHCs can quickly assess these variables with clarifying questions such as:

- Where were you when you [method]?
- When did this occur?
- Did you practice or rehearse [method] in any way or prepare for you death at all?

These objective indicators of suicidal intent differentiate fatal from nonfatal suicide attempts (Beck et al., 1974) and predict eventual death by suicide (Beck, Brown, & Steer, 1989; Harriss et al., 2005; Hawton & Harriss, 2006). Suicidal intent is an important variable for nonfatal suicidal behaviors as well based on findings that suicide attempters with high levels of suicidal intent are very similar to individuals who die by suicide (Lester, Beck, & Mitchell 1979). In general, objective indicators of intent are better predictors of death by suicide than subjective indicators (Beck, Brown, & Steer, 1989), indicating that BHCs should place more emphasis and weight on situational or objective features of past episodes than a patient's self-report of behavioral intent. BHCs should additionally probe patients about their reactions to surviving these suicide attempts by asking a question such as, "Afterward, were you glad to be alive or disappointed that you weren't dead?" Gauging a patient's survival reaction is a brief and straightforward method for determining suicidal intent and is an empirically supported method for estimating risk of reattempt. Suicide attempters who report disappointment about survival (i.e., wishing they had died) following an attempt are significantly more likely to attempt suicide again than those who were glad to be alive (Henriques, Wenzel, Brown, & Beck, 2005).

Upon concluding the assessment for the first suicide attempt, the BHC should transition to the patient's "worst point" suicide attempt: "Next I'd like to talk about the time you most wanted to kill yourself and attempted suicide. When was that worst point in your life? Tell me the story about that suicide attempt." The reason for jumping ahead to the worst-point suicide attempt even if this skips other suicidal episodes or attempts is because the worst-point
suicidal episode is much more strongly associated with future suicidal behavior than current suicidal crises among patients with multiple suicidal episodes (Joiner et al., 2003). Specifically asking about the patient's worst-point suicide attempt is therefore a useful and efficient strategy for maximizing risk assessment decisions with chronically suicidal patients.

BHCs should repeat the assessment steps described earlier to obtain information about methodology and objective indicators of intent during the worst-point suicidal episode before transitioning to the assessment of the current suicidal episode. In some cases, the patient will indicate that the worst-point episode is the same episode as the first suicide attempt or current crisis (e.g., "The first time was the worst time" or "Right now is the most suicidal I've ever felt"). If this arises, BHCs should simply note this and ask patients to identify and describe the second worst suicidal episode in their lives. Once the assessment of the worst-point suicide attempt is complete, the BHC transitions to the current suicidal episode: "Next I'd like to talk a little bit more about what's been going on recently with your suicidal thoughts and feelings. You said you've been thinking about [content of suicide ideation]. Could you tell me a little bit more about what you've been thinking?"

Having confirmed the presence of suicide ideation, the BHC briefly assesses for Mary's past suicidal behaviors:

B: Have you ever had thoughts like this before, or is this the first time you've ever thought about killing yourself?
M: It's not the first time.
B: When's the first time in your life you thought about killing yourself?
M: It was a long time ago, like in high school.
B: Have there been any other times?
M: A bunch of times. It just comes and goes when things are going really badly in life.
B: Have there ever been any times in your life when you've intentionally injured yourself?
M: Yeah, a few times.
B: And how many of these times would you say you were trying to kill yourself or hoping you would die?
M: Maybe seven times.
B: Let's start with the first time you tried to kill yourself. Tell me the story about what happened.

At this point, Mary described an incident around the age of 15 in which she used a razor to cut her wrists following an argument with her mother. She described it as highly critical and demeaning. She made this attempt in the bathroom while her parents were downstairs. She locked the door, filled the bathtub with water, broke open her razor to pull out the blade, got into the bathtub, and sliced her wrists several times with the blade. Upon questioning by the BHC, Mary reported that she had imagined herself dying in the bathtub, although now she doubts that she really wanted to die. After several minutes, her bleeding stopped and she decided that she was "just being stupid" and wrapped up her wrist. Mary reported wearing long sleeves for approximately a week to hide the wounds. When asked if she was glad to be alive or wished she were dead afterward, Mary answered:

M: I'm not really sure, but I don't think I really wanted to die. I didn't wish I had died, but I don't know that I was exactly glad to be alive.
B: Okay, I understand. Let's jump forward in time a bit. You said you attempted suicide about seven times in your life. I want you to think about the time you felt the worst, when you most wanted to kill yourself.
M: Okay.
B: When was that worst time in your life that you tried to kill yourself?
M: About 2 years ago.
B: I'd like you tell me the story about that time 2 years ago.

Mary described a period of several months in which she experienced a significant depressive episode. She felt that her husband was disconnected from her and seemed indifferent about her and therefore experienced intense loneliness. At the peak of her distress, Mary took "a handful" of over-the-counter sleep medications and prescription pain killers, hoping she would "fall asleep and just not wake up." She took the pills at night after her husband had fallen asleep, then got into bed next to her husband and fell asleep. When she did not wake up in the morning, her husband called an ambulance to transport her to the hospital, where she was treated and then admitted to the inpatient unit for 2 weeks. When asked about her reaction to surviving this attempt, Mary answered:

M: I didn't feel anything. I guess I was disappointed.
B: I see. Well I appreciate you sharing that with me; it must have been difficult to talk about.
M: It wasn't so bad. I've never really talked about this before.
B: Well I'm glad you're able to talk about it now. Why don't we spend a little
bit of time now talking about what's been going on recently to make you
want to kill yourself.

M: Okay.

In this segment, the BHC skillfully obtains a brief history of Mary's
suicidal history by engaging her in a conversation about two critical suicide
attempts in her history. He does not interrogate or interview Mary but rather
facilitates a guided discussion that quickly and efficiently obtains the most
relevant clinical information needed and smoothly transitions from one point
in time to another.

Assess the Current Suicidal Episode

As can be seen in the discussion up to this point, the structure of suicidal
symptoms is multidimensional in nature, with different factors demonstrating
differing magnitudes of association with suicidal behaviors. When considering
current suicidal episodes, similar patterns emerge in the scientific literature.
As a specific example, Joiner, Rudd, and Rajab (1997) showed that current
suicidal symptoms can be explained by two primary dimensions termed “re-
 solved plans and preparation” and “suicidal desire and ideation.” Resolved
plans and preparation consist of subjective courage to attempt suicide, avail-
bility of means and opportunity for an attempt, specificity of plan for at-
tempt, preparatory and rehearsal behavior, duration of suicidal ideation, and
intensity of suicidal ideation. Suicidal desire and ideation, in contrast, consist
of a lack of reasons for living, wish for death, frequency of suicidal ideation,
desire and expectancy for a suicide attempt, lack of deterrents to attempt,
and suicidal communication. Similar two-factor structures for current suicidal
symptoms have been reported in several other studies (Beck, Brown, & Steer,
1997; Joiner et al., 2003; Mieczkowski et al., 1993), indicating that this is
a reasonable method for understanding varying dimensions of suicide risk.
Although the presence of both symptom dimensions are of clinical concern,
the resolved plans and preparation factor is more significantly related to re-
cent and future suicide attempts than the suicidal desire and ideation factor
(Joiner, Rudd, & Rajab, 1997; Joiner et al., 2003). BHCs seeking to maximize
accuracy in their risk assessments within the temporal and situational con-
straints of the primary care setting should therefore emphasize these symp-
toms and dimensions of current suicidal episodes.

The relative importance of the resolved plans and preparation factor as
compared with the suicidal desire and ideation factor is due to the relationship
of these factors to the two dimensions of suicidal intent. As suicidal intent
emerges during the suicidal crisis, the patient spends an increasing amount
time thinking about the specifics of suicide and how to accomplish the act.
Noted earlier, objective indicators of intent include behaviors such as taking
precautions against discovery, preparing for death, and rehearsing or practicing
the method; these behaviors overlap with the construct of resolved plan and
preparation. Components of suicidal desire and ideation (e.g., desire for dea-
spections about suicide), however, overlap with the subjective indicators
intent that are much less robustly associated with suicidal behaviors. Focus on
resolved plans and preparation is therefore a preferable method for asse-
sing suicide risk because it incorporates an assessment of the patient's level
suicidal intent. As part of the risk assessment, BHCs should aim to elicit infor-
mation about the presence of a specific plan, the intensity of current sui-
cial ideation, preparatory or rehearsal behaviors, and access to lethal means.

Assess for the Presence of a Specific Plan

Once the patient has transitioned to an account of the current suicidal epis-
ode, the BHC should determine if the patient has started to formulate a spe-
cific plan to kill themselves by asking questions such as “Have you thought
about how you might kill yourself? Do you know how or when you intend
do this?” Eliciting information about the suicide plan or “blueprint for sui-
cide” can provide critical clues for risk management. For example, a patient
who plans to shoot himself with his personal handgun should have firear-
restriction enacted as a risk management precaution. Similarly, a patient who
takes plans to overdose on medications should have her medications moni-
tor and should only be prescribed nonlethal amounts of medications. In gen-
eral, patients with well-thought-out and highly specific plans are at much greater
risk for suicide than those who have not considered the details of the intended
act because planning generally entails mental rehearsal of the act (e.g., “I set
myself doing it after I get home from work”), which serves to escalate the
patient's fearlessness about death and their capability for engaging in the ac-
tion.

It is not uncommon for patients to be reluctant to disclose the detail
about their suicide plan due to fear of being hospitalized or otherwise thwarted
in their intentions. This reluctance could signal greater levels of suicide ris-
(k American Psychiatric Association, 2003) and therefore warrants a brief dis-
ussion. BHCs assessing patients reluctant to provide detailed information
about their suicide plan should resist the temptation to confront this resistanc
e and attempt to “pry” these details out of the patient. Instead, BHCs should
seek to maintain a collaborative stance by moving on with the risk assessmen
in order to elicit additional information that might be less "threatening" to the patient. The BHC should continue to build a collaborative alliance with the patient then return to the issue of specific plans later in the interview. Asking a patient to describe their expectations about the consequences of honest disclosure (e.g., “What do you think might happen if you were to tell me the specifics of your plan?” or “How do you think I’ll respond if you tell me fully what you’ve been thinking about?”) is a useful strategy for quickly identifying the source of the patient’s hesitation and any barriers to full disclosure.

If, for instance, the patient is afraid that the BHC will automatically recommend hospitalization following disclosure of specific plans (a common fear for many suicidal patients, especially those who have disclosed suicide risk in the past and have been referred for hospitalization as a result), the BHC can engage the patient in a discussion of how and when such a decision is made, which provides a natural transition for the BHC to discuss steps that can be taken to reduce the likelihood of this disposition.

Assess the Intensity of Suicide Ideation

Suicide ideation can be measured according to multiple dimensions, the most common of which are frequency (how often the thoughts occur), intensity (how severe the thoughts are experienced), and duration (how long the thoughts last). Importantly, these three dimensions of suicidal thinking relate differentially to suicidal behaviors. Frequency of suicide ideation has consistently been linked with the suicidal desire and ideation factor (Beck, Brown, & Steer, 1997; Joiner, Rudd, & Rajab, 1997; Joiner et al., 2003; Mieczkowski et al., 1993), whereas intensity of suicide ideation is associated with the resolved plans and preparation factor (Joiner, Rudd, & Rajab, 1997). Duration of suicide ideation has also been found to relate more strongly with the suicidal desire and ideation factor in some studies (Beck, Brown, & Steer, 1997; Joiner et al., 2003) and more strongly to the resolved plans and preparation factor in others (Joiner, Rudd, & Rajab, 1997). This suggests that of these three dimensions of suicidal thinking, it is the severity or intensity of these suicidal thoughts that are most relevant to suicidal behaviors and therefore should be emphasized.

This research has important implications for suicide screening procedures in primary care (and any other clinical setting) that warrant particular attention by BHCs. Most suicide screening methods ask patients to report on their suicide ideation, asking about the frequency with which they experience thoughts of suicide. Frequency of suicide ideation loads onto the suicidal desire and ideation factor of suicidal symptoms (Beck, Brown, & Steer, 1997; Joiner, Rudd, & Rajab, 1997), whereas the intensity dimension of suicide ideation load onto the more pernicious resolved plans and preparation factor (Joiner, Rudd, & Rajab, 1997). Consistent with the purpose of screening to maximize detection at the expense of specificity, measuring frequency of suicide ideation might be an ideal approach to suicide screening, although as a part of the more refined risk assessment process, BHCs should be sure to emphasize the intensity of suicide ideation. To demonstrate the clinical difference between the frequency a intensity dimensions of suicide ideation, consider the following two cases:

- John reports thinking about suicide “only once per day” while working alone on the night shift. During this daily episode, he spends “hours at a time” thinking about shooting himself with his firearm, during which “I can’t think about anything else; it’s all-consuming.”
- Dave reports thinking about suicide “off and on all day, every day” for the past few years, typically when he gets frustrated or angry. “They’re just passing thoughts that only last a second or two,” he adds.

If using a suicide screener that measures frequency of suicide ideation, it quite possible that Dave will score higher than John since Dave has more frequent discrete episodes of suicide ideation. However, when we consider the intensity dimension of suicide ideation, it is clear that John is at much greater risk for suicide than Dave. BHCs must understand the distinction between frequency and intensity of suicide ideation and be able to accurately assess each.

Assess for the Presence of Preparatory or Rehearsal Behaviors

Perhaps the most indisputable indicators of elevated suicidal intent are preparing for death and rehearsing suicidal acts. Preparing for death can entail activities such as settling final financial or legal issues, making funeral arrangements, writing a suicide note, purchasing a gun, or hoarding medications. Rehearsal behaviors are even more pernicious and include “practice” activities such as driving to the site of the planned suicide, tying knots and weighting ropes, holding a firearm to one’s head, counting medications, or aborting suicide attempts at the last minute. The reason these behaviors are so dangerous is because they serve to develop the individual’s capability for lethal self-injury through acquired fearlessness about death and increased tolerance to pain (Joiner, 2005). The fact that intensity of suicide ideation is related so highly to the resolved plans and preparation factor is accounted for by the mental rehearsal that
underlies both constructs. As suicide ideation becomes more intense, the suicidal individual finds it increasingly difficult to disengage from these thought processes (as in the case of John briefly presented in the previous section). This repeated mental rehearsal of the suicide attempt results in overlearning of the sequence of steps required to enact the action. Through preparation and rehearsal, suicidal individuals increase their courage and competency to carry out suicidal acts. BHCs should therefore assess for the presence of preparatory or rehearsal behaviors by asking, "Have you practiced [method] in any way, or have you done anything to prepare for your death?"

**Access to Lethal Means**

Up to this point, the discussion of suicide risk assessment has focused primarily on the nature of the patient's suicidal thinking, especially as it relates to the concept of suicidal intent. Because of the clear and consistent link between suicidal intent and eventual suicidal behaviors, many BHCs understandably spend most of the time in their risk assessments attempting to gauge the severity of intent, quite possibly due at least in part to the considerable amount of attention given to intent in the literature. An interesting and notable caveat to some of the research on the relationship between suicidal intent and death by suicide has demonstrated conflicting results, however, arguably due to the confounding variable of availability of means. Some studies have found that intent has little relationship with the lethality of a suicide attempt (Brown, Henriques, Sosdjan, & Beck, 2004; Plutchik et al., 1988; Swahn & Potter, 2001), for example, most likely because many patients have inaccurate expectations about the lethality of their chosen method (Beck, Beck, & Kovacs, 1975; Brown, Henriques, Sosdjan, & Beck, 2004). Availability of means, however, demonstrates a strong association with the lethality of chosen method (Eddleston et al., 2006; Peterson et al., 1985). It is therefore recommended that BHCs routinely ask about access to lethal means of suicide (e.g., "Do you have a firearm at home?" or "How much medication do you have in the medicine cabinet at home?").

Regular and repeated questioning about availability of means over the entire course of care is paramount because suicide attempts almost always occur during short-term peaks in distress. For example, among patients who survived life-threatening suicide attempts, 24% made the decision with 5 minutes preceding the attempt and 70% made the decision within the preceding hour (Simon et al., 2001). Of those who attempt suicide, 90% do not go on to die by suicide at a later time, due in large part to the fact that 75% never make another attempt (Owens, Horrocks, & House, 2002). This low reattempt rate by suicide attempters further supports the notion of suicidal behavior as a response to an acute (vs. chronic) stressor, although it is important to note that a full one quarter of all suicide attempters will eventually reattempt and consequently become multiple attempters.

Data have also supported a strong association between suicide at a length of time from firearm purchase, with suicide rates being highest immediately following the purchase of the firearm and declining risk occurring as time passes: 57 times higher during the first week following firearm purchase, declining to 30 times higher during the first month, and 7 times higher after 1 year (Wintemute et al., 1999). These latter statistics not only provide further support for the central role of preparatory behaviors, but also highlight the importance of asking about access to means on a recurrent basis with suicidal patients. Simply put, just because a suicidal patient does not have access to a firearm now does not mean he or she will not gain access to one in the future.

Because suicide attempts and death by suicide often occur within the context of an acute period of emotional distress, the removal or limitation of access to lethal means can reduce the probability for a suicide attempt in some cases or in other cases cause the suicidal individual to substitute to a less lethal method. Although means substitution might not seem at first to be an ideal outcome for patients, the fact that reattempt rates remain so low following a first suicide attempt suggests that constraining a suicidal patient's options to only those with low lethality could potentially be a life-saving strategy in both the short and the long term.

Having identified Mary as a multiple attempter and briefly assessing the first and worst-point suicide attempts, the BHC transitions to an assessment of the current suicidal episode:

**P:** So you told me a little while ago that you've been thinking about just ending it all. Have you thought about how, exactly, you might kill yourself?

**M:** Yeah. I'd just take a bunch of pills.

**P:** What kind of pills?

**M:** Oh, whatever's in my cabinet. I have sleep pills, pain pills, blood pressure pills; probably just taking all of those would do it.

**P:** When you think about overdosing on your meds, do these thoughts come and go or are they really severe, like you can't stop thinking about it?

**M:** Well it started off as just an idea, but now I think about it a lot, and it's really bad.

**P:** If you were to rate the severity of these thoughts from 0 to 10, with 0 being not severe at all and 10 being the most severe you've ever experienced, how would you rate those thoughts?
M: Probably a 6 or 7.
B: And have you thought about when or where you might do this?
M: At home. I usually think about it at night when I’m getting ready to go to bed. Sometimes I’ll just sit there and think about it, and the other day, I even went to the bathroom to see how many pills I had.
B: Did you count them or pour them out or anything like that?
M: No, I just kind of shook the bottles and felt how much they weighed.
B: Have you done anything to prepare for your death?
M: No, I don’t know that there’s much to get ready for.
B: Have you done anything else to practice or get ready for your suicide, like write a note or tell someone about it?
M: No, just that checking the other night.
B: So you have a large amount of meds at home that you could overdose on?
M: Yeah. I have lots of medical problems so I have all sorts of pills.
B: Have you considered any other ways for killing yourself other than taking your meds?
M: No, just the overdosing. That’s kind of my thing, I guess.
B: So you haven’t thought about shooting yourself or hanging yourself or cutting yourself or any other methods?
M: Oh no. That’s all too messy. I want it to be clean and peaceful.
B: Okay. I see.

In this segment, the BHC focuses his risk assessment on those factors that are most useful for estimating the risk level of the current suicidal episode: specificity of planning, intensity of suicide ideation, evidence of rehearsal or preparatory behaviors, and availability of means. The BHC also assesses for additional (especially more lethal) methods of suicide that Mary might be considering currently.

IDENTIFY PROTECTIVE FACTORS

Protective factors, in contrast to risk factors, serve to decrease risk for suicide. Identifying those factors in a patient’s life that serve as a “buffer” against suicide or otherwise mitigate risk is a useful strategy for developing management plans and interventions to target suicide risk. In general, protective factors include the patient’s personal strengths as well as those features of life that are generally going well. Examples of protective factors include the presence of reasons living (Linehan et al., 1983; Malone et al., 2000), which might convey a sense of optimism or hope for the future. Strong partnerships with family or frie (Turvey et al., 2002; Stratton & Boyer, 2001), and especially the presence of children in the home (Clark & Fawcett, 1994), have been associated with decreased risk of suicide and align with theoretical work that a sense of belongingness to a social group reduces the desire for suicide (Joiner, 2005).

By determining what factors function to keep the patient alive, the BHC can begin to more fully understand the suicidal crisis and build interventions and strategies that are more likely to be successfully implemented. Transition to protective factors within the context of the risk assessment also functions a “turning point” in the clinical encounter toward a discussion of “what is right in my life” and away from what has up to this point focused primarily on “what is wrong in my life.” Facilitating the process of talking about positive aspects of life can be a powerful intervention in and of itself and can potentially elevate a person’s mood as the BHC approaches the intervention stage of the encounter.

Protective factors can be assessed by asking the patient questions such as:

• Given all that we’ve talked about, what is it that keeps you alive right now?
• What reasons do you have for living?
• What has prevented you from acting on these thoughts?

It is important to note that, in general, protective factors have less empirical support than risk factors and BHCs should be cautioned again assuming that the presence of protective factors negates the presence of risk factors. Multiple attempters generally have fewer protective factors and resources to draw upon in times of crisis, which provides at least partial explanation for their increased vulnerability to crises. BHCs might therefore find this stage of the assessment particularly challenging when evaluating multiple attempters. In our experience, however, framing protective factors in terms of “what keeps you alive right now” is an approach that even the most despondent suicidal patient can almost always answer.

Having gained an understanding of Mary’s history of suicidal behaviors and the current suicidal episode, the BHC next transitions into the identification of protective factors:

B: You know, Mary, with all this going on in your life and given that you’ve been thinking so much about how to kill yourself, I’m wondering wha
it is that keeps you alive? I mean, what stops you from taking those pills?

M: Well I don’t want to kill myself. Well, I mean I do, but I guess that’s just not how I want it to end, you know? I’d rather live to be old and be happy.

B: So there’s a part of you that wants to live.

M: Yeah, I guess so.

B: So tell me what’s worth living for. What’s going well for you in life?

M: Well there’s my dog. I absolutely love him and who would take care of him if I were dead?

B: What’s his name?

M: Barney. He’s a corgi and he’s just the cutest little thing in the world. I love playing with him in the backyard. I should take him to the park or something but I’m too embarrassed to go because I just can’t walk because of my weight.

B: So Barney is a reason for you to live and so is playing in the backyard.

M: Yeah. And my husband would miss me, too. He’s had to put up with so much of my craziness for years, I’d hate for him to have to deal with this.

B: Sounds like he’s really important to you.

M: Yeah, he is.

B: Good. What else keeps you from killing yourself?

M: Well, I guess my religious beliefs, too. I haven’t gone to church in years, though.

In this segment of the risk assessment, the BHC begins identifying positive variables in Mary’s life that will serve as a foundation for risk management and intervention strategies. Encouraging Mary to discuss these issues further elicits positive emotions that directly counter the dysphoria of the suicidal state.

PUTTING IT ALL TOGETHER

The sequential and hierarchical approach outlined previously provides a useful framework for conducting suicide risk assessments in a manner that fits well within the context of primary care and provides adequate information to make well-informed, empirically based decisions about risk management and treatment. In our clinical experience, this approach is efficient enough to adequate time for the development and implementation of appropriate interventions. It is important to emphasize, however, that although this approach is useful and provides a natural flow and organization to the assessment, should not adhere so rigidly to this exact sequencing that the treatment is compromised. Flexibility in risk assessment is paramount and significantly enhances the BHC’s ability to elicit accurate information. As an example, if a patient would prefer to talk about the current episode before discussing past episodes, then the BHC should “go with the flow” and assess the current episode before assessing past episodes. The goal is to high-quality risk assessments is obtaining the information necessary for effective management and intervention; the order in which one obtains information is much less important.

The case of Mary illustrates a number of critical points that were discussed. First, routine suicide screening identified a high-risk patient who was previously unknown to be high risk. Some BHCs might argue that case vignettes demonstrate why routine screening should not be conducted. Primary care: It “derailed” the BHC from the chief reason for the consult (diabetes), resulting in little if any useful feedback to the PCP regarding the management of this disease. This argument fails to consider other prioritizations of health care needs, however. Simply put, if Mary kills herself, she cannot effectively manage her diabetes. Because suicide screening was in place, a previous unrecognized multiple attempter in an acute period of distress was identified and assessed—an important first step to improving her health and well-being. Related to this, this argument assumes that suicide risk is completely independent of all other health issues, which is in sharp contrast to a considerable body of evidence demonstrating that suicidality is associated with increased rates of complaints and functional impairment. This leads us to the vignette’s second key point: the timing of the BHCs questioning about suicide risk.

Although the full transcript of this encounter is not provided, it should be noted that the BHC checked the suicide screening item before the appointment began, but he did not immediately ask about suicide. Instead, the BI started the appointment as usual by focusing on the requested consultation issues. Consistent with the hierarchical sequencing of the risk assessment, the BHC begins “on common ground” with the patient and gradually escalates the intensity of the encounter toward the issue of suicide risk. He follows Mary lead in the encounter until he finds a natural transition point (i.e., Mary’s sharp-critical self-statements) to shift to the more intense issue of emotional distress. When Mary confirms the presence of emotional distress, the BHC normalizes this experience and shifts to the more intense issue of suicide ideation. In the matter of minutes, the BHC has effectively and smoothly focused the clinic encounter on suicide risk, obtaining buy-in from Mary at each step.
The third key point, and the natural balance to the previous point, is that the BHC did not wait until the final moments of the appointment to ask about suicide risk, but rather raised the issue as soon as possible to allow adequate time for discussion. Delaying suicide risk screening until the end of a clinical encounter is an all-too-common clinical practice that only leads to one of two situations: (1) inadequate time devoted to risk assessment and management or (2) extension of the appointment beyond the schedule's structure, resulting in the BHC falling behind. Screening only works if there is adequate time to conduct an appropriate risk assessment and effectively manage that risk. The most effective BHCs therefore raise suicide risk as soon as possible to maximize the time that can be spent on the issue.

Fourth, the BHC remains calm and completes the assessment even when the patient is reporting very high-risk behaviors. Although it is not possible to convey a sense of "calmness" on the part of the BHC through this written vignette, his continuation of the risk assessment despite Mary's report of high-risk behaviors demonstrates his commitment to fully understanding Mary's situation before making a clinical decision. In the face of this self-report, especially the disclosure of a reasonable suicide plan with access to means and recent rehearsal behavior (i.e., shaking the pill bottles), we would understand why the BHC might choose to discontinue the interview and immediately recommend hospitalization. However, he instead chooses to collect all of the relevant information before making any decisions.

Related to this, the BHC refuses to argue with Mary about suicide and manages his emotional reactions to Mary's disclosures. Because the clinician's primary goal is to prevent death by suicide, it can be very tempting to attempt to "talk the patient out of it." However, this typically only serves to move the patient into a position of justifying or arguing in support of suicide. The BHC's neutral stance and approach during the assessment demonstrates to Mary that suicide is an issue that can be talked about openly and can be understood. The effect this has on Mary is best seen in her disclosure that she has never talked about suicide with anyone before.

When assessing Mary's past history of suicidal behaviors, the BHC identifies and briefly assesses the first, worst-point, and current suicidal episode, providing him with a general sense of the suicidal trajectory over time in a time-efficient manner. Without a doubt, a full assessment of each of Mary's seven suicide attempts would provide useful clinical information. However, to do so would take much greater time than is feasible within the constraints of the primary care setting. By picking these three points in time, in combination with Mary's statements about other attempt episodes, the BHC gains the following clinical information: (1) Mary is a multiple attempter; (2) Mary generally attempts suicide via medication overdose ranging in low to moderate lethality; (3) the medical severity and lethality of Mary's attempts seem to be increasing over time; (4) she tends to attempt at home before bed using readily available means; and (5) suicide attempts seem to occur primarily during depressive episodes. These clues provide important information for the BHC to develop management and intervention strategies specific to Mary.

Sixth, the BHC asks clarifying questions to get specific information about Mary's thoughts, plans, and intentions. Mary's responses are often vague and ambiguous, so the BHC follows up with clarifying questions to improve the precision of the information. For example, when the BHC first asks for past self-injurious behaviors of any type, Mary initially says "a few times." When the BHC follows up with a very specific question about the number of suicide attempts (using very specific language "trying to kill yourself or hoping you would die"), she discloses she has attempted suicide seven times in her life—a very different number from a "few times." The BHC's effectiveness in improving his precision is in part to the fact that he used clear, easy-to-understand language that minimizes misunderstanding. When asking about suicide attempts, he used the words "try to kill yourself" or "hoping you would die," not "hurt yourself" or "hurt yourself"—other such imprecise terminology. In addition to improving the precision of the assessment, the BHC's ability to use these terms further reinforces the sense that suicide can be discussed openly and honestly.

Finally, during the assessment of protective factors, the BHC not only asks Mary to provide a list for the purposes of documentation, but rather engages her in a conversation about these issues. The BHC uses the assessment of protective factors as an intervention in and of itself to elevate mood and increase cognitive flexibility. When Mary lists her dog as a reason for living, the BHC takes a moment to ask for the dog's name, which individualizes this process and increases Mary's emotional attachment to positive memories (i.e., playing with her dog in the backyard). Mary quickly falls into the habit of negating these positive experiences through self-criticism, but the BHC chooses not to confront these tendencies because this could spark an adversarial stance. Instead, the BHC simply highlights the positive aspect of ownership, thus reinforcing and strengthening this memory trace—an important skill for Mary to develop, as will be discussed in subsequent chapters.

**CORE COMPETENCIES FOR THE BEHAVIORAL HEALTH CONSULTANT**

1. Know those risk and protective factors that have demonstrated the most robust empirical association with suicidal behaviors.
2. Routinely screen all referred patients for suicide risk.
3. Integrate a risk assessment for suicide risk early in the appointment...
4. Elicit suicide ideation, behavior, plans, and intent using a sequential and hierarchical approach to questioning that decreases patient reluctance to discuss suicide and increase accurate self-disclosure.

5. Remain calm and complete the entire suicide risk assessment before formulating risk management decisions.

CHAPTER 5

Strategies for Managing Suicide Risk in Primary Care

As discussed in previous chapters, suicide risk is best conceptualized existing on two dimensions: baseline (or chronic) risk, which is an individual’s “set point” level of risk when not acutely distressed or dysphoric and acute risk, which is the short-term dimension of risk that occurs when the suicidal individual is symptomatic and in crisis. Because baseline risk is higher for multiple attempters, acute suicidal episodes become more easily triggered and last for longer periods due to increased vulnerability to suicidal crises. We therefore recommend behavioral health consultants (BHCs) differentiate among four categories of suicide risk outlined in Table 5.1. Using the four categories will assist the BHC in recognizing and considering suicidal from both dimensions of risk and will further aid in the communication patient risk levels between BHCs and primary care staff. Critically, use of the two-dimensional categorization scheme assists clinic staff in recognizing how suicide risk fluctuates over time—from baseline to acute exacerbation back to baseline—and aids providers in responding appropriately to chronic suicidal patients.

Accurate categorization entails two simple questions, the first of which addresses baseline risk and the second of which addresses acute risk:

1. Is the patient a multiple attempter? If yes, they are categorized as chronic high risk. If no, they are categorized as nonchronic risk.

2. Is the patient symptomatic and in crisis? If yes, they are categorized with the “acute exacerbation” qualifier. If no, they are categorized as baseline.

Categorizing patients in this manner is a simple yet critical step in the assessment of overall suicide risk.