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Intake Interviewing With Suicidal Patients: A Systematic Approach

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Assessment and management of suicidal patients is one of the most challenging and stressful tasks associated with the practice of psychology. This article provides information on how to conduct suicide assessment interviews and initial patient management within the context of an intake interview. A brief review of professional training issues and suicide risk factors precede discussion of suicide assessment interviewing procedures. Strategies for evaluating depression, suicide ideation, suicide plan, self-control, and suicide intent are presented. General guidelines for initial management of and clinical decision making with suicidal patients are reviewed.

There is a movement within psychology to establish training standards for assessment and management of suicidal patients (Bongar, 1991; Jobes & Berman, 1993). The foundation of this movement includes concerns over potential malpractice, stress associated with working with suicidal patients, and ethical guidelines mandating competence (Bongar & Harmatz, 1989; Deutsch, 1984; Kleepsies, 1993). This article focuses on a particular aspect of working with suicidal clients. Specifically, it is a contemporary and systematic model for obtaining and organizing suicide-relevant information within the context of an intake interview. This article includes a brief examination of pertinent professional training issues, followed by a review of (a) suicide risk factors, (b) suicide assessment interviewing procedures, and (c) initial management of and decision making with suicidal patients.

Professional Training Issues

Teach Suicide Assessment Skills Early in Training

One never knows in advance whether a patient may be suicidal. Although suicide attempts occur infrequently in the general population, they occur more often within clinical populations (Buzan & Weissberg, 1992). Consequently, our policy is to assign practicum cases only to graduate students who have demonstrated competence in suicide assessment procedures (Sommers-Flanagan & Sommers-Flanagan, 1993). Working with suicidal patients without adequate training is not only anxiety provoking, it is risky, unprofessional, and unethical.

Philosophical Orientations Toward Suicide

Working with suicidal patients can elicit a wide range of strong feelings, attitudes, and opinions within practitioners. For example, Szasz (1986) has emphasized that suicide is a viable life choice; he views suicide prevention efforts as potentially interfering with patients' rights. He states:

> All this points toward the desirability of according suicide the status of a basic human right. . . .I do not mean that killing oneself is always good or praiseworthy; I mean only that the power of the state should not be legitimately invoked or deployed to prohibit or prevent persons from killing themselves. (1986, p. 811)

Alternatively, Shneidman (1984) is strongly against the "right" to suicide:

> Suicide is not a "right" anymore than is the "right to belch." If the individual feels forced to do it he [sic] will do it. (p. 322)

Having strong feelings and beliefs about suicide is not necessarily a problem. Both Szasz (1986) and Shneidman (1984) most likely manage their clinical caseloads at similarly competent levels despite their divergent opinions about suicide. However, it is crucial that psychologists in training examine their feelings, attitudes, and opinions about suicidal patients before beginning clinical work. Working with suicidal patients may in some cases evoke depressive or suicidal states within practitioners. Clinical objectivity and effectiveness is enhanced when practitioners have a high level of self-awareness about their underlying personal biases and vulnerabilities. Often, professional consultation and sometimes referral to another professional may be indicated.

Professional Consultation

Consultation serves a dual purpose for professionals working with suicidal patients. First, it provides much-needed professional support. For the sake of their emotional health, suicide assessors should not work in isolation. Dealing with suicidal patients is among the most stressful of all clinical activities, and

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input from other professionals should be welcomed (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988; Deutsch, 1984; Kleepsies, 1993). Second, consultation provides feedback about standards of practice. Consultation helps assure that usual and customary practice standards are met.

Documentation

Documentation is especially important when working with suicidal patients (Jobes & Berman, 1993; Soisson, VandeCreek, & Knapp, 1987). Suicide documentation forms such as the Suicide Status Form, Suicide Assessment Slip, and Suicide Status Log are recommended (see Jobes & Berman, 1993). Practitioners who conduct suicide assessments should document that they have (a) conducted a thorough suicide assessment, (b) obtained relevant historical information, (c) obtained previous treatment records, (d) directly evaluated suicidal thoughts and impulses of the patient, (e) consulted with one or more professionals, (f) discussed limits of confidentiality with the patient, (g) implemented appropriate suicide interventions, (h) provided appropriate resources to the patient (e.g., telephone numbers), and (i) contacted authorities (e.g., police, hospital personnel) and family members if a suicidal patient is at high risk.

Suicide Risk Factors

To facilitate professional competence, suicide assessment interviewers need to know risk factors associated with suicide. This is because, as an intake interview unfolds, patients frequently do not discuss their suicidal thoughts openly. This places the responsibility on the interviewer to gently probe for and detect suicide risk factors that may be present within a patient's life or behavior. Identifying suicide risk factors helps interviewers determine whether or not the intake interview should shift to a more structured focus on suicide assessment.

Despite the voluminous information available on suicide predictors (Buzan & Weissberg, 1992; Hubbard & McIntosh, 1992; Maltsberger, 1991; McIntosh, 1991; Fawcett et al., 1990; Johnson, Weissman, & Klerman, 1990; Murphy & Wetzel, 1990; Pokorny, 1983; Roy, 1989), practitioners must keep in mind that suicide is very difficult to predict; even the best suicide predictors account for only a minimal amount of variation in suicide behavior (Roy, 1989). The more significant predictors of suicidal behavior include (a) presence of a mental disorder (in particular, substance abuse, affective disorders, panic disorder, and schizophrenia are associated with suicide; Fawcett et al., 1990; Johnson et al., 1990; Murphy & Wetzel, 1990; Roy, 1989); (b) age over 45 (older adults are more likely to use lethal weapons and less likely to talk about their suicide plans; Miller, 1979; Patterson, Dohn, Bird, & Patterson, 1983); (c) sex (depending on age, men commit suicide 3 to 12 times more often than do women; Berman & Jobes, 1991; Evans & Farberow, 1988; Miller, 1979); (d) marital status (divorced, widowed, separated, and never-married people, especially men, are at higher risk for suicide; Buda & Tsuang, 1990; Tuckman & Youngman, 1968); (e) economic and employment factors (economic recessions and depressions and unemployment are linked to suicide; Dooley, Catalano, Rook, & Serxner, 1989); (f) chronic physical illness (DiBianco, 1979); (g) recent losses (loss of resources, ability, status and loved ones is associated with suicide; Hatton, Valente, & Rink, 1977); (h) hospital discharge and apparent improvement (patients improving from psychiatric disorders sometimes will suddenly commit suicide; Roy, 1989); (i) race or ethnic background (American Indians, certain Alaskan Indian tribes, and White men have higher suicide rates than other ethnic groups; Earls, Escobar, & Manson, 1990; Griffith & Bell, 1989); (j) previous attempt (patients who have attempted suicide previously are much more likely to commit suicide; Patterson et al., 1983).

As a risk factor associated with suicide, depression warrants special attention. Some experts believe depression before suicide is universal (Silverman, 1968). Evidence supporting the universality of depression as a condition of suicidality has been collected on populations as diverse as college students and terminally ill patients (Brown, Henteleff, Barakat, & Rowe, 1986; Westefeld & Furr, 1987). Furthermore, an estimated 10% to 15% of all clinically depressed individuals will commit suicide (Georgotas, 1985). Although not all depressed people are suicidal, depression is one of the best suicide predictors and is reliably evaluated in clinical interviews (Resnik, 1980). The strong association between depression and suicide suggests that practitioners be familiar with the criteria for depression in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV;* American Psychiatric Association, 1994) before conducting intake interviews.

Recent research suggests six variables may predict suicide within depressed populations (Fawcett et al., 1990). These include (a) severe psychic anxiety (intense thoughts and feelings of anxiety); (b) panic attacks (specific bouts of anxiety, physical symptoms of panic); (c) anhedonia (lack of pleasure associated with usually pleasurable activities); (d) alcohol abuse (increased alcohol consumption during a depressive episode); (e) concentration problems (high distractibility); (f) global insomnia (difficulty falling asleep, intermittent awakening, and early morning awakening). Additionally, self-reported hopelessness, helplessness, and excessive guilt are important predictors of suicide (Beck, Brown, & Steer, 1989). To keep track of the numerous risk factors associated with suicide, it is recommended that practitioners use a checklist during intake interviews (see Appendix).

Conducting Suicide Assessment Interviews

Suicide assessment interviews are procedurally similar to general intake interviews (see Othmer & Othmer, 1994; Shea, 1988; and Sommers-Flanagan & Sommers-Flanagan, 1993, for detailed intake or diagnostic interviewing procedures). Obviously, an extensive suicide assessment is not automatically a portion of every intake interview. However, in cases where clients exhibit demographic features, traits, and behaviors associated with several risk factors, formal suicide assessment should be integrated into the general intake procedure. In particular, when evaluating suicidal patients, interviewers should focus on depression, suicide ideation, suicide plans, level of self-control, and suicide intent.

Evaluating for Depression

The key emotional issue for suicidal patients is depression or personal distress. Suicidal patients wish to terminate their

personal discomfort and consider suicide a viable method of eliminating discomfort (Shneidman, 1984).

Because depression is implicated in most suicides, it is essential to evaluate patients' level of depression. When evaluating patients' depression, interviewers should begin with open-ended queries about patient emotional state or mood and move to closed questions and subjective ratings of mood states. For example:

> How would you describe your mood?
>
> What feelings would you say you experience most often during the course of the day?
>
> Have you felt particularly guilty (or sad or hopeless)?
>
> Rate your depression today on a scale of 1 to 10; 1 means you are so depressed you would just as soon die, and 10 means you feel the best anyone could ever feel.

Depressed patients often have been depressed before and may have attempted suicide previously. Consequently, the patient's current mood should be compared with his or her previous mood. Behavior patterns associated with most positive and most negative mood states should be determined.

> Today you rated your mood a "3." Has there been a time when you would have given yourself a lower rating?
>
> What's the worst you've ever felt and how would you have rated that mood?
>
> When you are at your worst mood of all, how do you act then? What might I see if I could watch you like a mouse in the corner when you are at your worst?
>
> What might I see if I watched you when you are feeling happy and up?

If, through questioning, previous suicide attempts are identified, the nature and quality of these attempts should be explored. The following questions can be used to obtain information pertaining to a patient's previous suicide attempt:

> What kind of method did you use when you made an attempt previously?
>
> What happened after you took the pills (or slashed your wrist, etc.)?
>
> Did someone find you and take you to the hospital?
>
> After you were revived, when you came to after having tried to kill yourself, what were your reactions?
>
> How did you feel about the fact that you were still alive?

Other key beliefs and affective states associated with suicidal behavior include feelings of helplessness, hopelessness, worthlessness, and guilt. For example, research has shown that believing the future is hopeless may more accurately indicate suicide risk than overall level of depression (Beck, Brown, & Steer, 1989). Although some patients will comment directly on these issues, others will be less direct, and still others will completely avoid talking about their hope for the future or their beliefs about themselves. Consequently, suicide assessment interviewers should be prepared to directly ask patients about these important beliefs and affective states. Sample questions include the following:

> What do you believe will happen to you in the future?
>
> Do you believe a time will come when you will feel better?
>
> How do you suppose you'll be feeling a week (month, year) from now?
>
> Have you considered psychotherapy or medications?
>
> Do you think either psychotherapy or medications might help you feel better?
>
> Sometimes people who are feeling down also feel guilty . . . is there anything you're feeling guilty about now?
>
> Is there anything you think you deserve to be punished for?
>
> How have you been feeling about yourself?
>
> What do you believe are some of your more positive traits?

If significant thoughts or feelings of hopelessness, helplessness, worthlessness, or guilt are present, the duration, frequency, and intensity of those thoughts and feelings should be determined. Is the mood disturbance of relatively recent onset, or is it of a long-standing nature? Do the thoughts and feelings come and go, or are they persistent and pervasive? Wollersheim (1985) has suggested asking patients "Is it *blue* or *black*?" to evaluate mood intensity. Patients who indicate their mood is black are communicating about the depth of their depression and, perhaps, about their lack of hope for change. Generally, suicide risk is higher in patients struggling with intense depressive symptoms for an extended period without relief or hope for the future.

Depression is a multifaceted disorder with signs and symptoms occurring in many different areas. As emphasized in *DSM-IV,* interviewers should inquire about symptoms within social, cognitive, somatic, behavioral, and emotional areas of functioning (see *DSM-IV* for diagnostic criteria for depression).

Careful observation of patient behavior during intake interviews is critically important. Psychomotor retardation may be apparent in slowed speech and response latency. There may be little verbal input from the patient, or in extreme cases, muteness. The patient may exhibit slowed body movements or conversely may appear agitated and anxious, speaking rapidly, pulling on hair or clothing, rubbing hands together, or even pacing. Agitation may also be evident in the patient's report of feeling restless and feeling as if there is something he or she must do. Resnik (1980) has noted that suicide risk is increased when depressed people become anxious, agitated, or angry, all of which may indicate energy and motivation toward committing suicide.

Exploring Suicide Ideation

As an intake interview proceeds, it sometimes becomes clear that patients are harboring suicidal thoughts. In such cases, interviewers need to inquire directly and calmly about patients'

suicidal thoughts and feelings. Wollersheim (1974) has suggested the following standard question: "You certainly seem to feel extremely depressed. Feeling this miserable, have you found yourself thinking of suicide?" (p. 223). A common fear of many interviewers is that asking directly about suicide will put ideas in the person's head. There is absolutely no clinical evidence to suggest this occurs (Pipes & Davenport, 1990). Rather, most patients are probably relieved to have the opportunity to talk about suicidal thoughts. In addition, the invitation to share self-destructive thoughts reassures patients that the clinician is comfortable with the subject, in control of the situation, and capable of dealing with the problem (Wollersheim, 1974).

Most suicidal patients will readily admit self-destructive thoughts when asked. However, some deny suicidal thoughts. If denial occurs, interviewers must choose whether or not to continue asking the patient about suicide ideation. Wollersheim (1974) has suggested making it easier for patients to admit suicidal thoughts:

> Well, I asked this question since almost all people at one time or another during their lives have thought about suicide. There is nothing abnormal about the thought. In fact it is very normal when one feels so down in the dumps. The thought itself is not harmful. However, if we find ourselves thinking about suicide rather intently or frequently, it is a cue that all is not well, and we should start making some efforts to make life more satisfactory. (1974, p. 223)

If patients admit to suicide ideation, the frequency, duration, and intensity of suicidal thoughts should be explored.

Assessing Suicide Plans

As a suicide assessment proceeds, the patient should always be asked if he or she has threatened or attempted suicide in the past or if close friends or family members have committed suicide. Nearly three-fourths of those who ultimately commit suicide have previously attempted suicide (Resnik, 1980). Generally, the greater the lethality of the last attempt, the higher the present risk.

Once rapport is established, many patients will become willing to give details of their suicidal plans. It is useful for interviewers to begin with a paraphrase and a question, such as the following:

> You have talked about how you sometimes think it would be better for everyone if you were dead. Have you planned how you would kill yourself if you decide to follow through on your thoughts?

Many patients will respond to the preceding question with reassurance that indeed they are not really contemplating a suicidal act. They may cite religion, fear, children, and so forth, and note they simply think of it sometimes but would never follow through on their suicidal thoughts. In some cases, after hearing a patient's reasons for living, further assessment of suicidal plans may not be necessary. However, if patients identify a potential suicide plan, further exploration is necessary.

When exploring and evaluating suicidal plans, the following four areas should be assessed (Miller, 1985): (a) specificity of the plan, (b) lethality of the method, (c) availability of the proposed method, (d) proximity of social or helping resources. Notice the previous four areas of inquiry can be easily recalled using the acronym S-L-A-P.

Specificity. This refers to suicide plan details. The more specific the plan, the higher the risk. Some patients clearly outline a particular method of suicide. Others avoid the question. Still others will state something like, "Oh I think about how things might be easier if I were dead, but I don't really have a plan." At this point it is up to clinical judgment to determine how hard to push the patient for plan specification. Again, we recommend following Wollersheim's (1985) advice in most cases—make the deviant response more acceptable:

> Many people who think about suicide have had passing thoughts about how they might do it. What thoughts have you had about how you would commit suicide if you decided to do so?

This statement by the interviewer is worded to accomplish two objectives. First, the statement reassures the patient that "many people" have thoughts about suicidal plans. Second, the question assumes the patient has had such thoughts and inquires about them.

Lethality. This refers to how quickly enactment of a plan could produce death. The greater the lethality, the higher the suicide risk. Lethality varies, depending on how a particular method is used. If a patient is at high risk for suicide, questioning should go beyond inquiry about a general method (e.g., firearms, toxic overdose, razor blade, etc.) and focus on how a method will be used. For example, do patients plan to use firearms (and shoot themselves in the stomach, temple, or mouth)? Does the plan involve ingesting aspirin or cyanide? Does the plan involve "slashing" wrists with a razor blade or the throat with a knife?

Availability. This refers to how quickly a patient could implement a plan. In other words, is the means available for immediate plan implementation? If overdosing with a particular medication is planned, medication availability should be evaluated. Most people keep more than enough lethal substances within their homes to complete a suicide. If driving a car off a cliff is the plan, and neither car nor cliff is available, immediate risk may be low. Because of the easy access to firearms in many places, it is good to inquire about the availability of ammunition as well as a gun.

Proximity. This refers to proximity of helping resources (i.e., are individuals who could intervene and rescue if an attempt is made close or at a distance?). Obviously, this requires questioning about family, roommates, friends, and neighbors. Any of these people could be resources or liabilities. Generally, the further a patient is from potential helping resources, the greater the risk.

Assessing Patient Self-Control

Individuals who fear losing control, or who have a history of losing control, are often at high risk for suicide. In assessing risk, Wollersheim (1974) has recommended evaluating self-control. For example, "Sometimes, have you been afraid that, in spite of yourself, in one of your really down periods, you might go ahead and commit suicide?" (1974, p. 224). If patients feel little internal control over their suicidal impulses, external control (i.e., hospitalization) may be necessary.

Patient self-control should be thoroughly explored. If the patient previously has had suicidal thoughts, questions about what

helped maintain control are useful. Information about what helped patients maintain control before may assist interviewers' efforts at managing the patient's suicidal behavior in the present.

C: Yes, I often fear losing control late at night.
I: Sounds like night is the roughest time.
C: I hate midnight.
I: So late at night, especially around midnight, you are sometimes afraid you will lose control and kill yourself. So far, something has kept you from doing it.
C: Yea. I think of the way my kids would feel when they couldn't get me to wake up in the morning. I just start bawling my head off at the thought. It always keeps me from really doing it. (Sommers-Flanagan & Sommers-Flanagan, 1993, p. 256)

Although a brief verbal exchange should never be used to make a determination of safety versus hospitalization, in this situation the patient's love for her children helped prevent her from losing control.

In addition to directly questioning about patient self-control, interviewers need to gather information from the patient's behavioral history. Tendencies toward destructive substance use, verbal outbursts, physical altercations, and so forth, may indicate impulse-control problems. Also, patients with a history of excessive overcontrol may be at extreme risk for suicide because once they begin to think about suicide, they become preoccupied or compulsive about acting on their thoughts.

Assessing Intent

A final area of suicide assessment during an intake interview involves evaluating suicidal intent. Suicidal intent may be established through self-report, peer or family report, or behavioral observation. Essentially, intent involves determining whether a patient is talking and acting in ways that suggest he or she intends to commit suicide.

Some patients are persistent and creative in their efforts to kill themselves. We have worked with patients who swallowed needles, razor blades, and any dangerous substance they could locate (e.g., Drano). Some have run onto busy freeways or thrown themselves into dangerous rivers. Others hang themselves with pillowcases or slash their wrists with the top of a soda bottle. Such patients may or may not have planned their suicide. Instead, they use any available means to end their lives because they are desperately seeking self-destruction.

It can be helpful to have patients rate their suicidal intent on a scale of 1 to 10 (1 being *no intent* and 10 being *total intent*). Intent can be rated as *absent, low, moderate,* or *high.* The greater the intent, the greater risk of suicide.

Initial Management and Decision Making With Suicidal Patients

When evaluating suicidal patients, crisis intervention strategies may be used to further the assessment process and to reduce suicide risk. For example, establishing a suicide contract may be illuminating about the extent of suicidality. Similarly, administering a questionnaire, such as the Reasons For Living Inventory (Linehan, 1985), can help patients orient themselves toward reasons for living rather than for dying. However, this article is devoted to specific assessment interviewing procedures, and readers are directed elsewhere for intervention strategies (Maltsberger & Buie, 1989; Shneidman, 1984; Sommers-Flanagan & Sommers-Flanagan, 1993).

Decision Making

There is no simple formula to guide clinical decisions regarding suicidal patients. The checklists in the Appendix may assist assessment and decision-making procedures.

Decision making with suicidal patients is, in part, a quantitative process. Suicidality can be measured along a continuum from *nonexistent* to *extreme:* (a) *nonexistent* = no suicidal ideation or plans; (b) *mild* = suicidal ideation but no specific or concrete plans—few risk factors are present; (c) *moderate* = suicide ideation and a general plan exist, but self-control is intact, there are several "reasons to live," and the patient does not "intend to" commit suicide—some risk factors are present; (d) *severe* = suicide ideation is frequent and intense; suicide plan is specific, lethal, available, and there are few nearby helping resources; self-control is questionable, but intent appears absent; there may be many risk factors present; (e) *extreme* = same as *severe,* but patient expresses a clear intent to commit suicide when the opportunity presents itself—usually many risk factors are present.

Patients who present with mild-to-moderate suicide potential usually can be managed on an outpatient basis. Obviously, the more frequent and intense the ideation and the more clear the plan (assess using S-L-A-P), the closer the patient should be monitored.

Extremely suicidal patients warrant swift and directive intervention. Such patients should not be left alone while intervention options are considered. They should be informed, in a supportive but directive manner, of actions needed to ensure their safety. Such actions may involve contacting the police or a county mental health professional. Personally transporting a severely suicidal patient to a hospital (or anywhere) ought to be avoided. Suicidal patients may jump from moving vehicles or throw themselves into freeway traffic in order to avoid hospitalization.

Patterson et al. (1983) developed an acronym to assist decision making with suicidal patients. Their acronym is S-A-D P-E-R-S-O-N-S, referring to (a) sex, (b) age, (c) depression, (d) previous attempt, (e) ethanol (alcohol) abuse, (f) rational thinking loss, (g) social supports lacking, (h) organized plan, (i) no spouse, and (j) sickness.

Patterson et al. (1983) have recommended that patients receive one point for each risk factor identified in a clinical interview. There are 10 possible points on the SAD PERSONS scale. Patterson et al. suggest close follow-up with patients who score from 3 to 4, strong consideration of hospitalization for patients who score from 5 to 6, and hospitalization or commitment of patients with scores from 7 to 10. Details of this approach may be obtained from Patterson's original article.

Standardized Suicide Assessment Devices

There are many standardized suicide assessment questionnaires available commercially and in the literature. Suicide as-

sessors may use these questionnaires in conjunction with an intake interview in order to obtain further information about a patient's suicidality. The utility of many of these questionnaires has been discussed elsewhere (Eyman & Eyman, 1990; Maris, Berman, Maltsberger, & Yufit, 1992). Review of suicide scales and questionnaires is beyond the scope of this article.

Conclusion

This article primarily focuses on one facet of working with suicidal patients, namely, suicide assessment within the context of an intake interview situation. The model presented in this article and the associated checklist are designed to facilitate competent and systematic assessment of suicide potential during an intake interview. This model may also assist practitioners in the difficult management and decision-making processes associated with suicidal patients.

Evaluating and working with suicidal patients is a challenging and anxiety provoking process, a multidimensional activity that requires practitioners to juggle ethical, legal, clinical, and personal issues in the context of a potentially life-threatening situation. Many critical issues, such as ongoing management of suicidal patients, specific instruments for assessing suicidality, legal and ethical dilemmas, and crisis intervention, were not addressed in this article. Nonetheless, the interviewing strategies and format described above may assist practitioners in their efforts to function competently when initially interviewing suicidal patients.

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Appendix

Checklist of Key Suicide Assessment Risk Factors and Interviewing Topics

Identify risk factors associated with suicide that fit your client.
- _____Vulnerable group due to age/sex characteristics.
- _____Previous attempt.
- _____Alcohol/drug abuse.
- _____Presence of psychiatric disorder.
- _____Unemployment.
- _____Unmarried/alone.
- _____Physical health problems.
- _____Significant personal loss (of ability, objects, or persons).

_____Evaluate for depression.

_____Evaluate for risk factors associated with suicidal behavior among depressed patients.
- _____Panic attacks.
- _____General psychic anxiety.
- _____Lack of interest/pleasure in usually pleasurable activities.
- _____Alcohol abuse increase during affective episode.
- _____Diminished concentration.
- _____Global insomnia.

_____Evaluate for hopelessness, helplessness, or excessive guilt.

_____Evaluate characteristics of suicide ideation.
- _____Frequency.
- _____Intensity.
- _____Duration.

_____Evaluate suicide plans.
- _____Specificity.
- _____Lethality.
- _____Availability.
- _____Proximity.

_____Evaluate patient level of self-control.
- _____Self-report of self-control.
- _____History of impulsive behavior.
- _____History of overcontrolled behavior.

_____Assess level of suicidal intent.
- _____Absent.
- _____Low.
- _____Moderate.
- _____High (rate high if this is consistent with patient self-report or if patient engaged in a previous lethal attempt).

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