Suicide Risk Assessment and Risk Formulation
Part I: A Focus on Suicide Ideation in Assessing Suicide Risk

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The main procedure used by clinicians to determine whether an individual may be at risk of suicidal behaviors is the suicide risk assessment (SRA). The purpose of the SRA is to identify risk and protective factors that then provide the data for the formulation of suicide risk. The suicide risk formulation (SRF) assigns a level of suicide risk that ideally leads to triage and treatment deemed appropriate for that level of risk. Some of the problems with the SRA are explored here, with an emphasis on addressing the over reliance on communicated suicide ideation, and recommendations are made for improvements. Part II of this article (Berman & Silverman, 2013, also appears in this issue of *STLB*) examines the process of an SRF and, similarly, makes recommendations to improve clinical practice toward the desired end of saving lives.

During the year prior to their death by suicide, approximately 32% of Americans make contact with a mental health care provider and 77% make contact with a primary care provider (Luoma, Martin, & Pearson, 2002). In the United Kingdom, 27% of those who die by suicide will have been in contact with mental health services in the year before their death (Appleby et al., 2012). As many as 1 in 10 suicidal deaths are by people seen in the emergency department within 2 months of dying by suicide (Knesper, American Association of Suicidology, & Suicide Prevention Resource Center, 2010; Skeem, Silver, Applebaum, & Tiemann, 2006).

Health care providers have significant opportunities to identify at-risk individuals and engage them in treatment designed to lessen the likelihood of suicidal self-directed violence, yet many lack the requisite training and skills to appropriately assess for suicide risk (Schmitz et al., 2012; Schulberg, Bruce, Lee, Williams, & Dietrich, 2004), even though the assessment of risk is a “core competency” that these professionals must possess (www.robertsimonmd.com; www.sprc.org). Tragically, the Joint Commission’s Sentinel Event Report denotes failures in assessment of suicide risk to be the leading root cause of hospital-based suicides, associated with 81% of the 600 suicides reported between 2004 and 2011 (www.jointcommission.org).

In this article we address the process of a suicide risk assessment (SRA) commonly employed by mental health practitioners, notably addressing the over reliance on

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1 The revised U.S. National Strategy for Suicide Prevention explicitly acknowledges this in Objective 9.1: Adopt, disseminate, and implement guidelines for the assessment of suicide risk among persons receiving care in all settings (www.actionallianceforsuicideprevention.org/NSSP).
communicated suicide ideation. In part II of this article (Berman & Silverman, 2013), we examine the process of suicide risk formulation (SRF) and make recommendations to improve clinical practice toward the desired end of saving lives. An SRA gathers data about observable and reported symptoms, behaviors, and historical factors presented by a patient that are associated with suicide risk and protection, ascertained by way of psychiatric interview; collateral information from family, friends, and medical records; and/or screening tools. An SRF is a process by which the clinician forms a judgment about a patient’s foreseeable risk of suicidal behavior based on data collected via an SRA (Haney et al., 2012). The SRA, therefore, is a precursor to an SRF, and the reliability and validity of the SRF is dependent on the robustness of the SRA.

SCREENING AND ASSESSMENT FOR SUICIDE RISK

There remains some confusion regarding the difference between a screening instrument as opposed to a screening assessment. A screening instrument or tool usually consists of a short list of questions that, if answered in the affirmative, indicate that a more thorough assessment should be conducted—ideally by a trained mental health professional.

The U.S. Preventive Services Task Force has found insufficient evidence that screening for suicide risk in the primary care setting reduces suicide attempts or deaths by suicide (Gaynes et al., 2004; O’Connor, Gaynes, Burda, Soh, & Whitlock, 2013). This may well be an indication that the questions asked in screenings are imprecise, vague, and nonspecific to the task at hand; that is, identifying those at risk of suicidal behaviors in the short- and near-term.

However, both the Joint Commission and the American Academy of Pediatrics have called for suicide screening for all patients in health care settings (The Joint Commission, 2010; Dolan, Fein, & The Committee on Pediatric Emergency Medicine, 2011). The Suicide Ideation Questionnaire (SIQ; Reynolds, 1998) and, more recently, a briefer variation on the SIQ, the Ask Suicide-Screening Questions (ASQ; Horowitz et al., 2012), are two examples of such rapid screening tools, the former developed with the intent to measure the severity of suicide ideation and the latter suggesting that it has predictive value regarding risk of suicide. This claim, however, has been questioned, essentially on the limited available data on the relationship between suicide ideation and death by suicide (Wintersteen, Berman, & Silverman, 2013).

The standard of care, generally defined as a duty to exercise that degree of skill and care ordinarily employed by a reasonable and prudent clinician in similar circumstances by members of the same profession, requires that the mental health professional recognizes the possibility that a patient has risk of suicidal behavior and to be foreseeable of that possibility. He or she is to be cognizant of risk factors and protective factors and to understand their dynamic contributions to the clinical presentation being evaluated.

Shea (2012) has divided the SRA into two separate but integrated components leading to an SRF:

1 Gathering of “static” risk factors (demographics, past history, family history, etc.), protective factors, and identification of warning signs
2 Exploring the extent of the patient’s suicidal process: presence or absence of suicidal ideation, motivations, intent, planning, and behaviors

We see the SRA as an independent process that informs an SRF. The outcome of the SRF then determines safety planning and management, triage decisions and treatment planning, and overall risk management. The SRA is a process, not an event. However, no method of SRA has been empirically tested for reliability and validity (Simon, 1998, 2002). Furthermore, no method of SRA has sufficient sensitivity and specificity to be effective (Simon, 2012).
Components of the SRA and Their Relationship to an SRF

Significant components of an SRA include inquiries about current and past: suicide ideation (SI), motivation, intent, and planning; suicide attempts and other acts of self-injury; mental disorders in family or relatives; exposure to suicidal behaviors in others; beliefs and attitudes about suicide; mental disorders (and outcomes of treatment); substance abuse; medical conditions; social history; perceived personal stressors; coping skills; and so forth.

A Focus on Suicide Ideation

Communicated SI is often seen as the gateway to the investigation of whether an individual might be “suicidal.” Hence, the normative approach to performing an SRA is to first inquire about the presence of SI. Tragically, too often the SRA consists of only asking the patient, “Are you thinking about suicide today?” with chart documentation merely reflecting, “No SI,” if no ideation is expressed or if its presence is denied. The clinical assumption is that the absence of SI is tantamount to the absence of any suicide risk; hence, the SRA too often stops at this point, and the chart documentation merely reflects “No SI.”

However:

1. Among those who die by suicide, SI is more likely to be denied than admitted to on clinical inquiry that is conducted reasonably proximate to the date of death. Neither does the absence or denial of SI indicate the absence of suicide risk or potential to engage in suicidal behaviors in the near term nor does the absence or denial of SI equate to no “imminent” or “acute” risk (Busch, Fawcett, & Jacobs, 2003).

2. Active SI, although important in leading to further assessment and risk formulation, is no more associated with death by suicide than is passive SI (Simon, 2008).

3. Although there is strong evidence of a relationship between suicide attempts and subsequent death by suicide, the association between currently expressed SI and subsequent death by suicide is less clear (Beck, Brown, Steer, Dahlsgaard, & Grisham, 1999). The reporting of current or recent SI has very little correlation with the development or expression of suicidal intent, the progression from SI to suicide attempts or to death by suicide in the near term (Fawcett et al., 1990; Kessler, Borges, & Walters, 1999; Isometsa et al., 1995; Borges et al., 2006; Borges, Angst, Nock, Ruscio, & Kessler, 2008).

4. The self-reporting of “seriously considering attempting suicide,” as asked, for example, in the Youth Risk Behavior Survey (Centers for Disease Control & Prevention, 2012), has very little correlation with the reporting of a history of suicide attempts within the last year, or whether a youth will die by suicide.

How is it that a cognitive construct, for example, seriously thinking about suicide, appears to be relatively divorced from the behavior of self-injury itself? How is it that so many individuals deny SI and then proceed to engage in self-injurious behaviors? We believe that the apparent disconnect is a result of how questions about SI are framed on both survey questionnaires and during a clinical interview, and the related clinical assumptions that lack empirical support.

Determining the Presence of Suicide Ideation

It is important to remember that simply asking about SI does not ensure that an accurate or complete response will be received. Among other factors, the level of
comprehension of what is being asked, as well as cultural or religious beliefs about death or suicide, may influence a patient's ability or willingness to speak about suicide during the assessment process. Moreover, if the patient is compromised in any way (e.g., currently under the influence of alcohol or other drugs, currently with active symptoms of mental illness such as psychosis, suffering from a recent or chronic traumatic brain injury, undergoing cognitive dysfunctions associated with certain medical conditions, etc.), the patient may well have difficulty in understanding the questions being asked.

There is great variability in how questions are asked about the presence of SI; what the clinician understands to be the range, type, and number of components encompassing the concept of SI; the context in which the question is being asked; and what the respondent believes to be the inclusiveness of the question being asked. For example, the respondent may wonder if the clinician is asking about SI occurring right now, recently (an ill-defined term), or under certain conditions; or if the clinician is asking about having thoughts of death, or thoughts about motivation, intent, and planning. Moreover, Beck et al. (1999) found that a retrospective report of SI at its worst point in a patient's life was a better predictor of eventual death by suicide than was current SI or hopelessness. Beck and colleagues highlighted the value of assessing the severity of past SI rather than relying solely on the presence or severity of SI on the day of the evaluation.

_How Common is SI in the General Population?_

Epidemiologic studies report that between 3.3% (Kessler, Berglund, Borges, Nock, & Wang, 2005) and 3.8% (www.samhsa.gov/data/NSDUH/2k10State/NSDUHIsae2010) of the adult U.S. population had SI in the past year. However, surveys such as these do not provide definitions for their terminology, so it is virtually impossible to know the true prevalence or incidence of SI. For example, Paykel, Myers, Lindenthal, and Tanner (1974) found that among 720 U.S. adults surveyed:

1. 7.8% felt life was not worth living;
2. 5.0% wished they were dead;
3. 2.3% had thoughts of taking their life; and
4. 1.5% seriously considered taking their life.

Similarly, Kessler et al. (1999) surveyed a large sample of U.S. adults and reported the lifetime prevalence of SI to be 13.5%. Nock et al. (2009) extended this effort cross-nationally, reporting on nearly 85,000 adults in 17 countries and found the lifetime prevalence of SI to be 9.2%. Furthermore, Nock et al. (2013) found that the lifetime prevalence of SI in a U.S. sample of adolescents was 12.1%.

As is evident from these data, estimates of the prevalence of SI in the general population vary considerably depending on how the question gets asked (and how the respondent understands the question) as well as the referent time frame. That said, these data suggest that in any year more than eight million Americans experience SI, while fewer than 40,000 Americans die by suicide. Hence, it is evident that SI has a very low predictive utility in relation to deaths by suicide.

_Do the Presence of Suicide Ideation Predict Anything?_

Kessler et al. (1999) also reported on transition probabilities to onset of plans among ideators, and attempts among ideators either with or without a plan. Of the respondents, aged 15 to 54 years, cumulative probabilities were 34% for the transition from suicide ideation to a plan, 72% from a plan to an attempt (hence 24.5% from ideation to planned attempt), and 26% from ideation to an unplanned attempt. About 90% of unplanned and 60% of planned attempts occurred within 1 year of the onset of SI.
Similarly, in an international sample, Nock et al. (2009) found that only 19% of those with SI made a planned attempt, while an additional 15.4% went from SI to an unplanned attempt. Both Kessler et al. and Nock et al. found that being younger and female were significantly associated with SI and attempt, yet these demographics are not risk factors most associated with those who die by suicide.

Nock et al. (2013) found that 33.4% of U.S. adolescents (aged 13–17 years) with SI developed a suicide plan, and 33.9% made an attempt. Overall, 20.3% of those with SI made a planned attempt, compared with 13.6% who made an unplanned attempt. The vast majority of adolescent transitions from SI to plan (63.1%) and from ideation to attempt (86.1%) occur within the first year of onset of SI.

As noted, only about one-fourth of U.S. adults with SI transition to a planned attempt or to an unplanned attempt. Hence, SI with plan was no more predictive of a suicide attempt than was SI without a plan. Importantly, the majority of individuals reporting SI do not go on to make a plan, and the majority of those with SI do not attempt suicide. However, the onset of SI is associated with increased suicide attempts within a year of onset of SI for both adults and adolescents.

Fawcett et al. (1987, 1990) followed over 950 patients for 10 years and registered 32 deaths by suicide (3.4%). Hopelessness and SI were significantly associated with those who died by suicide more than a year after the intake evaluation. Another study found that SI expressed in the hospital was only weakly associated with suicide occurring within a year of discharge (Large, Sharma, Cannon, Ryan, & Nielsen, 2011). Hence, the acknowledgment of SI was a more significant chronic than acute risk factor.

**Does the Denial of Suicide Ideation Predict Anything?**

Although it is presumed that suicidal behavior must be preceded by SI, and may well be, persons at risk of suicide do not necessarily communicate their SI when asked. Moreover, for a proportion of patients, suicidal behavior occurs within minutes of SI reaching consciousness (Simon, 2002); for others, the behavior may occur relatively on impulse (DeMoore, Plew, Bray, & Snars, 1994). Hence, not having or not consciously being aware of SI may lead to an honest response to an examiner’s question about the presence of SI, but not be predictive of suicidal behavior at another moment in time, even in the relatively near term.

Several studies have found that the majority of patients who die by suicide deny having suicidal thoughts when last asked prior to their death and/or communicate their risk only in more behavioral (versus verbal) messaging (Appleby, Shaw, & Amos, 1999; Barraclough, Bunch, Nelson, & Sainsbury, 1974; Busch et al., 2003; Chavan, Singh, Kaur, & Kochar, 2008; DeLong & Robins, 1961; Denneson et al., 2010; Hall, Platt, & Hall, 1999; Hjelmeland, 1996; Isometsa et al., 1995; McKelvey, Davies, Pfaff, Acres, & Edwards, 1998; Smith et al., 2013).

Isometsa et al. (1995) found that of more than 600 individuals who had visited a health care professional within 28 days of their death by suicide, only 22% had disclosed suicide intent at that visit. Of these, only 30% who saw an inpatient mental health professional and only 39% who saw an outpatient mental health professional disclosed their intent to die by suicide at their last visit. Busch et al. (2003) reported 78% of depressed patients denied SI at their last clinical encounter prior to dying. Similarly, Denneson et al. (2010) found that 72% of suicide decedents who were assessed for SI at their last VA medical center contact denied such thoughts. Smith et al. (2013) reported that, among veterans with a history of depression who died by suicide, 85% denied SI when assessed (at any point in time) and 73% denied SI when assessed within 7 days of their death by suicide.
The primary care physician is typically the first and often the last medical provider visited by those who die by suicide (DoDSER, 2009; Pirkis & Burgess, 1998). Schulberg et al. (2004) reported that an average of 45% of those who died by suicide saw a primary care physician within 1 month of their deaths, and that only 19% to 54% of suicidal patients explicitly informed the physician of SI or plans.

Data from the National Violent Death Reporting System (NVDRS) found that only 28.3% of almost 9,950 individuals who died by suicide in 16 U.S. states disclosed their intent to die by suicide (Karsch, Logan, McDaniel, Parks, & Patel, 2012). Studies of self-disclosure among both adolescents and adults have found that those who made severe suicide attempts had the lowest self-disclosure scores when compared to those with either just SI or less severe suicide attempts (Apter, Horesh, Gothelf, Graffi, & Lepkifker, 2001; Horesch, Zalsman, & Apter, 2004).

There is no question but that there is a “push/pull” between the patient and the clinician that occurs in probably all clinical settings. For the clinician, the presence or absence of SI serves as the trump card in the decision to admit a patient, discharge a patient, keep a patient in the hospital, or refer a patient to specialized mental health treatment. Indeed, the presence or absence of SI typically is the data that leverages managed care decisions about triage, discharge, and so forth.

For the patient, denying SI may occur for a number of reasons, including: (1) stigma that is associated with acknowledging symptoms of a mental disorder; (2) belief that suicide is a sin or a sign of weakness; (3) belief that nobody can help (hopelessness); (4) fear of being ridiculed, maligned, and/or judged negatively by the clinician or others; (5) fear of a loss of autonomy and control over one’s life and choices; (6) fear that the clinician might overreact and hospitalize the individual involuntarily; and/or (7) an intent to die and a wish not to be thwarted by a clinician’s decision to hospitalize or a decision not to be released from hospitalization (see Shea, 1999).

If, in fact, the presence or absence of SI serves as the ticket of admission or discharge from the ED or inpatient unit, then it is incumbent upon the clinician to go beyond a denial of SI to be reassured as to the presence or absence of risk. Quite simply put, a “No” response to a clinical query regarding the presence of SI does not suffice to constitute an SRA (Simon, 2002).

Is There a Difference Between Active and Passive Suicide Ideation and, If There is, Does the Difference Make a Difference?

Suicidal thoughts come in many forms, often cloaked in a cultural context. Patients do not always volunteer them; hence, they must be inquired about; and when reported, some phrasings may disguise other meanings. Thoughts range from the nonspecific (“Life sucks”) to the specific ("I wish I were dead"), and from passive (“I’d like to go to sleep and not wake up”) to active (“I’m thinking of killing myself”).

When SI extends to suicide planning and/or preparation, the level of risk is presumed to be greater; that is, the more detailed and specific the plan, the greater the risk (American Psychiatric Association, 2003; Joiner, Rudd, & Rajab, 1997). However, this guideline has developed an unintended corollary: the less active the SI, the less the risk of suicide. Hence, when passive SI is expressed, clinicians see less risk than when active SI is expressed. The reality is that there is simply no empirical support for this supposition.

Baca-Garcia, Perez-Rodriquez, Oquendo, Keyes, and Hasin (2011), using data from two nationally representative surveys, compared the desire for death (passive SI) and active SI as clinical markers for suicide risk. Resnick (2002) hypothesized that a patient determined to die regards the mental health professional as an adversary.
suicide attempts. They found that the risk of lifetime suicide attempt was similar among those with lifetime desire for death with no (active) SI and those with lifetime SI with no desire for death. Respondents with both lifetime desire for death and SI had the highest risk of lifetime suicide attempts. They concluded that querying individuals about their desire for death has the same value as assessing active SI to examine risk of suicide attempt.

ASSESSING SUICIDE IDEATION IN THE PRIMARY CARE SETTING AND EMERGENCY ROOM

Suicide ideation is present in 2% to 7% of all primary care patients (Olfson, Shaffer, Marcus, & Greenberg, 2003; Olfson, Weissman, Leon, Sheehan, & Farber, 1996), yet the rate of inquiry of SI in primary care is abysmally low (36%–42%), even when patients present with depression or requests for antidepressant medication (Feldman et al., 2007; Vannoy et al., 2010). Vannoy and Robins (2011) conducted a secondary analysis of 1,776 adult patient primary care encounters, 128 involving patients scoring >14 on the nine-item depression scale of the Patient Health Questionnaire (PHQ-9 Spitzer, Kroenke, & Williams, 1999). Suicide ideation was endorsed by 59%. However, suicide-related discussions occurred in only 11% of these encounters. Of interest, they found that physician inquiries about suicide were more often made with patients who had the lowest levels of SI (<2 on the PHQ-9), and the inquiries themselves were often biased to elicit a denial of ideation (e.g., negatively polarized). Hooper et al. (2012) explored factors associated with primary care physicians' self-reported intentions to conduct an SRA with standardized virtual patients presenting with moderately severe major depression and found that only 36% of 404 physicians stated they would do an SRA with these patients.

Primary care physicians often resort to the PHQ-9 (item 9) to screen for SI. This single PHQ question (“Have you had thoughts that you would be better off dead or of hurting yourself in some way for at least several days in the last 2 weeks?”) is a compound question concurrently asking about both active thoughts of self-harm and passive thoughts about whether life is worth living. Thompson, Henkel, and Coyne (2004) point out that endorsement of the first clause, “better off dead,” might well reflect unaddressed pain or the burden and functional impairment associated with chronic physical illnesses, while endorsement of the second clause, “hurting yourself in some way,” could reflect a confession of nonadherence or unhealthy lifestyle rather than SI. A positive response to such compound questions requires further probing by the clinician. However, such compound questions can easily confuse a respondent (Thompson et al., 2004).

Even when the compound PHQ-9 screening question is separated into a two-stage screening, such that positive responses are then followed up to differentiate the active from the passive component, the predictive value of these components with regard to future suicidal behavior over the next 6 months is minimal (Schulberg et al., 2005). As noted above, even when patients with greater vulnerability to being suicidal present in primary care offices, and are positively screened, for example, as depressed, rates of inquiry of SI remain low. One reason for this may be that the PHQ-9 suicide item does not appear to be a very good suicide screen (Razykov, Ziegelstein, Whooley, & Thomas, 2012).

Similarly, Claassen and Larkin (2005) found that SI was common in emergency department (ED) patients presenting for medical problems, with 11.6% reporting SI, and 2% reporting definite suicide plans. However, there is wide variance between and within EDs in conducting suicide risk screening and assessments (National Action

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3Four of the 31 patients with suicide plans attempted suicide within 45 days of ED presentation.
Alliance for Suicide Prevention Clinical Care & Intervention Task Force, 2011); most patients who present to the ED are not assessed for suicide risk, primarily because of time constraints, inadequate training, and a lack of screening instruments (Larkin et al., 2009).

Ronquillo, Minassian, Vike, and Wilson (2012) reviewed the research on assessing adult suicide risk in EDs and concluded that existing quantitative assessments of suicide risk “are not sensitive enough to predict” which patients will die by suicide. Interestingly, these authors believe it is possible to recognize people who are at low risk of suicide when they generally lack a prior history of SI, do not feel hopeless or depressed, can think rationally, have not made a suicide plan, are not using alcohol or drugs excessively, and have a social support system—all elicited by conducting a thorough SRA that goes beyond a denial of SI.

CONCLUSIONS

Conducting an SRA by only inquiring about SI is minimally productive and not predictive. The exact relationship between SI and subsequent suicidal acts remains elusive, and asking only one question about SI (in person; on a screening instrument; in a survey) is an inadequate probe to elicit the presence of suicidal thoughts, preoccupations, intent, or plans (Thompson et al., 2004). If eliciting the presence of SI is, in fact, the gateway to exploring suicide risk, then we must recognize that multiple probes must be used—in as a culturally sensitive, nonjudgmental, and supportive manner as possible, being fully aware of clearly defining one’s terms and of the context in which the questions are asked.

Clinicians must recognize that the denial of SI is insufficient to constitute a complete SRA, and chart documentation of “No SI” is unacceptable shorthand for conducting a complete SRA. How the question gets asked has a great deal to do with what response is given and the degree of honesty of that response (Shea, 2012; Thompson et al., 2004).

The context in which a question is asked will often affect the veracity of the answer given. Many patients report that they are more honest on self-administered, self-report scales than in a clinical interview, and, indeed, differences in response rates to questions about SI have been found (Yigletu, Tucker, Harris, & Hatlevig, 2004). Similarly, patients have been found to more openly confide information to a computerized interview than to an interview with a psychiatrist (Petrie & Abell, 1994). Summarizing findings from multiple studies, Lin et al. (2007) stated that patients prefer computer-mediated interviews for the assessment of sensitive topics such as suicide because they feel less embarrassed, more relaxed, and more honest. Many, perhaps most, adolescents will not answer truthfully when parents are in the room. Being asked such questions by a stranger in an unfriendly or chaotic setting (e.g., the ED) can influence the response given.

In addition to the need to develop and disseminate a standardized definition of SI and a set of questions to elicit a clinically useful response, research on the predictive value of SI is needed, specifically with regard to its association with short-term risk of suicidal behavior and the elements of SI (intent, planning, frequency, intensity, duration, controllability, passive versus active, etc.) that are most associated with near-term suicidal behavior.

Suicide risk may exist and may even be imminent with or without communicated SI. SI has a less than strong association with death by suicide; it is a better predictor of suicide attempt, but is neither necessary nor sufficient for the assessment of that risk. SI comes in a variety of forms, and little to no research has been conducted to assure clinicians that one or another form, such as passive versus active SI, with or without intent, is more or less associated with near-term or long-term risk of death by suicide.
A reasonably conducted SRA will sufficiently catalogue observable and reported risk factors that inform the yet-to-be formulated judgment about a patient’s level of suicide risk. In our companion article (Berman & Silverman, 2013), we address similar issues attendant to the process of an SRF and make recommendations for the clinician and field of suicide.

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