

BECK

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Task Force Report of committee on
Nomenclature

DEVELOPMENT OF SUICIDAL INTENT SCALES

1. "seriousness of attempt"

2. " " of intent"

3. "hopelessness"

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Paper to be presented at
Workshop on Measurement of Suicidal Behaviors
Philadelphia, Pennsylvania
October 14-15, 1971

Over-refined?
Maybe this is the definitive
study for intent.

Introduction

Numerous writers have emphasized the need for a standardized classification and nomenclature for suicidal behaviors. The history of science indicates that in order to study a particular phenomenon, it is necessary to define its boundaries, describe its domain as precisely as possible, and specify its criterial attributes. The literature on suicidal behaviors reveals a good deal of semantic confusion, lack of clarity and definition, and inconsistent and often contradictory use of terms. Some authors have suggested that the term suicide has been applied to such a variety of activities, feelings, tendencies, and behaviors that it has lost its meaning as a concrete, specific concept (Tabachnick and Farberow, 1961).

Clinical and research experience with psychiatric classification demonstrate not only the need for a clear-cut system of classification and nomenclature but for rigorous definitions, criteria, and indices of behavioral phenomena. The reliability of the psychiatric nomenclature has been found to be too low for clinical, let alone research, purposes (Beck, Ward, Mendelson, Mock, and Erbaugh, 1961). Major factors accounting for low reliability are the ambiguity of terms and the lack of precise and comprehensive definitions (Ward, Beck, Mendelson, Mock, and Erbaugh, 1962). There is still a vast disparity in diagnostic labelling among clinicians, institutions, and nations using the same psychiatric nomenclature.

same thing!
invariable!

OK!

A review of the status of classification of suicidal behaviors reveals numerous competing taxonomies. Although many of these systems of classification have face validity and appear to embody insights into the nature of suicidal behaviors, there has been a paucity of systematic study of any of these systems (see Beck and Greenberg, 1971: The Nosology of Suicidal Phenomena: Past and Future Perspectives). In the absence of investigation of such elementary properties as interjudge reliability, it is difficult to choose among these taxonomies.

The nomenclature proposed by various writers have to a large degree reflected their particular disciplines or schools of thought. Thus, medical workers have tended to regard suicidal behaviors in terms of psychopathology. The interpersonal approach has been reflected in conceptualizing suicidal behaviors as a form of communication, as a kind of language, or as an attempt to manipulate the environment. Suicidal behaviors have also been classified from the point of view of disturbed life circumstances or crisis resolution. Sociological studies have used concepts, such as population density, role failure, social inflexibility, and culture trap.

Irrespective of the crucial determinants of suicidal behaviors, it is still necessary to have some uniform way of defining the phenomenon so that labels will have the same meaning whether applied by an intern in the emergency room or by a statistician of the Bureau of Vital Statistics.

The need for a uniform nomenclature and nosology has been recognized by the Center for Studies of Suicide Prevention of the National Institute of Mental Health. A Committee on Classification and Nomenclature, set up as part of the task force planning for "Suicide

Prevention in the Seventies" devoted several days of sustained discussion to this problem (February 1970). Since that time there has been continuing communication among members of the committee. As a result of the discussions, a preliminary classification of suicidal behaviors and definitions of terms has been developed. A brief resume of the thinking of the committee will provide the background and rationale for the present research proposal. ?/

In an attempt to find an umbrella term to encompass the relevant behaviors, a number of terms were considered and finally discarded. The overall term "Life-Threatening Behaviors" was proposed and then discarded because it did not convey the idea that the threat was to the individual himself (rather than to others); also, the term is somewhat awkward. "Suicidopathy" (Cohen, 1969) has the disadvantage of implying that all suicidal behaviors are pathological or else restricting the domain of the nomenclature to behaviors that are, indeed, pathological and thereby excluding "rational suicides," etc. The terms "Self-Assault" and "Self-Poisoning" (Kessel, 1965) solved some problems but presented new problems; a major objection was that the introduction of new terms would require a complete break of continuity with the traditional term, suicide, and would be unlikely to gain acceptance by workers in the field. The term "parasuicide" (Kreitman and Philip, 1969) included behaviors that imitated the suicidal act in order to gain certain objectives such as relief from an oppressive environment. However, this term has already stirred up a good deal of opposition among suicidologists.

The nomenclature evolved by the Committee is based on a descriptive rather than explanatory model, uses terms that would be

(1) acceptable to the diverse professional groups interested in suicidal behaviors, and lends itself to operational definitions. The classification system presented three major divisions: Completed Suicides, Suicidal Attempts, and Suicidal Ideation. It was felt that in place of expressing intent in terms of vague, qualitative concepts such as suicidal gesture, it would be useful to quantify intent either on a numerical scale or in terms of none, mild, moderate, and severe. This dimension would be applicable to all three divisions of the nomenclature. Medical lethality is clearly differentiated from intent and is also quantified. The qualifying term, method, is obviously of great value and is applicable to each division.

The preliminary schema of classification has already been presented by Dr. Alex Pokorny.

Construction of Suicidal Intent Schedules

Intent is defined as the seriousness or intensity of the wish of a patient to terminate his life. Intent is one component of overall suicidal risk (or suicidal potential), which includes a conglomerate of other factors, such as access to lethal methods, knowledge regarding the utilization of these methods, absence of protective individuals in the environment to intervene before or after the suicidal act. Suicidal risk also includes other indices which have been actuarially determined (such as age, social class, sex, etc.). Suicidal intent, on the other hand, is assessed simply by the behavior of the individuals as reported by others and by self-reports.

It should be recognized that the degree of intent reflected in an individual's overt behavior is a compromise between the wish to live and the wish to die. A balance between suicidal wishes and life-preservative wishes may lead to an "ambivalent suicide attempt."

On the other hand, a strong surge of the wish to die may obscure the self-preservation wishes. Thus, we conceptualize intent as consisting of two several major elements: first, ⁽¹⁾ the balance between the intensity of the wish to die vs. life-protective wishes; secondly, ⁽²⁾ the patient's subjective probability estimate that his suicidal plan or wish will result in death.

Suicidal intent generally cannot be determined by any single factor or even cluster of factors but must take into account a variety of rather disparate elements. Our post-attempt Intent Schedule (utilized following a suicidal attempt) includes items relevant, first to the a) circumstances surrounding the suicidal act. For example, evidence of premeditation such as the collection of pills; unusual secretive or mysterious behavior (later explicable in terms of making suicidal preparations); location of attempt (isolation, deception, concealment); timing of suicidal act so as to invite or forestall intervention; and attempt to get help following the suicidal act.

Clinical experience suggests that the individual who times the suicidal act in such a way that intervention is highly likely, who carries out his act in the presence of others who are likely to rescue him, or who notifies others after making an attempt acknowledges less serious intent (or more ambivalence) than the individual who carries out his suicidal attempt in such a way as to minimize the chance of intervention or rescue. This observation is supported:

study by Weiss, Nunez, and Schaie (1961).

Unlike other suicidal intent scales such as that proposed by McHugh and Goodell (1970) and by Cutter (1970), our Intent Schedule deliberately excludes indices relevant to the effectiveness of the suicidal act. The effectiveness of the suicidal act is reflected in the Lethality Scale which should be measured as a dimension independently of intent. Furthermore, certain characteristics of the planning and effectiveness of the suicidal attempt may reflect factors such as the individual's intelligence, familiarity with suicidal methods, and access to the particular fatal method(s). A previous nonfatal suicidal attempt may provide a certain amount of "know-how". Factors relevant to the effectiveness of the suicide attempt are excluded so that Intent will not be confounded with Medical Lethality.

The second source of information consists of communications from the patient prior to, during, or after the suicidal act. These include data such as a suicidal note, expression of desire to kill self, and interest in suicidal methods. Self-reports after the attempt are analyzed to infer the patient's state of mind prior to the attempt; for example, his subjective probability estimate that the suicide would result in death. These communications may be oral or written, direct or indirect, spontaneous or elicited only by questioning. The patient's provision for rescue may be ascertained either from observers or from his self-reports.

Pool of Items

Items directly relevant to Suicidal Intent have been collected from our own clinical investigations, from the literature on suicide, and from other investigators. Wherever possible, we have attempted

to obtain systematic evidence supporting the validity of certain items or clusters of items.

Separate forms of the Intent Schedule have been designed for Completed Suicides (C.S.), Attempted Suicides (A.S.), and Suicidal Ideation (S.I.), respectively. The Suicidal Ideation Scale is designed to assess the degree of intent at the time of interview and thus is relevant to the suicidal risk. This scale, of course, will serve the practical purpose of aiding the clinician in assessing the present suicidal potential of a patient. The Attempted Suicide Schedule is designed to measure intent prior to the suicidal act.

Medical Lethality Schedule

Medical lethality is defined as the danger to continued life as the result of a suicidal act. Lethality may be assessed (a) in terms of the physician's estimate of the probability that the patient will die. In severe cases the prognosis is based mostly on the "vital signs" (respiration, pulse, blood pressure). Neurological signs are useful in most types of self-poisoning. Indices include depth and duration of coma and residual damage; (b) in terms of the kind and degree of life-resuscitating methods employed (e.g., use of respirator, bronchoscopy, blood transfusions, cardiac massage, and other types of surgery). Other items include use of airway vasopressor agents, blood volume expansion, maintenance I.V. fluids, gastric lavage, forced diuresis, peritoneal dialysis, and hemodialysis. The form used at the Regional Poisoning Treatment Center at the University of Edinburgh will be adopted for our use.

Non poisoning?

Overview of Research Plan

Our research plan consists essentially of a longitudinal study of 600 suicidal patients. Since the C.S.S.P. Preliminary Schema for Classification of Suicidal Behaviors depends heavily on the concepts of suicide intent and medical lethality, scales have been developed to measure these constructs. These are labelled the Suicidal Intent Schedules and the Medical Lethality Scales. Through reliability and validation studies of the scales, we plan to develop operational definitions of the concepts of intent and lethality. Follow-up data will provide feedback regarding the validity of the scale as predictors of future suicidal behaviors.

Intake procedures may be summarized as follows: patients admitted to Philadelphia General Hospital and Hospital of the University of Pennsylvania, because of suicidal attempts or threats, are rated by a psychiatrist on our research team for the presence of depression or other psychopathology, and for the lethality of the attempt using the Medical Lethality Scale. The Suicidal Intent Schedule, Depression Inventory, and Optimism-Pessimism Scale are completed by a psychologist. A social worker obtains relevant information from the patient's family or friends, as well as follow-up data after his discharge; she investigates the extent of contact with the psychiatric clinic or other facilities and of further instances of suicidal behavior. The psychiatrist makes clinical ratings of psychopathology and lethality of suicidal attempt. Thus, the patients in the sample provide data both for studies of reliability and validity of the scales and for the

psychiatrist shouldn't need this!

longitudinal (validity) study.

A vulnerable (high yield) cohort is the main focus of our study. Reports in the literature indicate that patients admitted to a general hospital for nonfatal suicide attempts have a completed suicide rate of 4.8% in 3 years and 6.5%-6.9% in 4 years. Greer's review of the literature (1967) suggests a subsequent suicide rate of 1%-2% per year. Motto (1965) reports 8% suicide rate in a 5 to 8 year follow-up.

1% / yr

(8% in 8 yrs)

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PRELIMINARY REPORT OF RELIABILITY
OF
INTENT SCALE

The Suicidal Intent Scale is designed to record data regarding the intensity of the attempter's wish to die at the time of the attempt. One index of the patient's seriousness about ending his life is his expectancy that the attempt will be fatal. In order to assess this expectancy, the scale is completed on the basis of retrospective data obtained from the patient and relevant observers, such as family and police.

Divided into three sections, the scale contains 19 items. Each item consists of three alternative statements graded in intensity from 0 to 2. After adequate information pertaining to each item is obtained during the course of the interview, the interviewer selects the alternative that applies best. The total score consists of the summed scores for each item.

The first section -- Circumstances Related to Suicidal Attempt -- (items 1 - 9), deals mainly with factual aspects of the attempt and the events surrounding it. The informant may be the patient and/or another relevant observer. Corroboration by other sources is desirable.

The second section -- Self Report -- (items 10 - 15) is used to record retrospectively the patient's thoughts and feelings at the time of the attempt.

The third section -- (items 16 - 20) is unscored, since the weighing of the alternatives is uncertain at this time. However, these items yield data on other aspects of suicide such as risk factors, the patient's current feeling about the attempt, conceptions of death, and the relation of alcohol to the attempt.

Following the scale is a section relevant to the reliability of ratings. The reliability of the informant, and the interviewer's confidence in his judgments and scoring, and the interviewer's estimate of the adequacy of the scale for this particular case are indicated.

The circumstantial data (first section) relate specifically to the overt behavior of the attempter prior to, during and after the suicidal attempt. Certain types of behaviors, such as writing a note, taking precautions against discovery, and accumulation of lethal quantities of pills are used as circumstantial evidence. However, this evidence must be tempered by the following considerations:

(a) the evidence may be ambiguous or fragmented or may come from unreliable sources; (b) it is possible for an individual to deliberately "fake" all of the circumstances suggestive of high suicidal intent; (c) individual may deny all such circumstances. Example (typical) alcoholic case.

The introspective data (second section) are potentially the most valuable data, but are completely dependent on the patient's willingness to cooperate in reviewing his state of mind just prior to making the suicidal attempt and also on his ability to recall his psychological state. It would be ideal, for instance, if the interviewer can elicit a genuine statement from the patient, such as "I had every intention of killing myself," or "I had mixed feelings about it. I did not know whether I had enough pills so I figured I'd leave it to chance."

Major factors limiting the validity of introspective data are: the patient may attempt to conceal relevant information from the examiner, may exaggerate or dramatize the description of his intent,

may have difficulty in recalling the data, or for other reasons may be unable to cooperate. Many suicidologists do not use such ideational data because of such questions about the patient's reliability. However, it should be borne in mind that psychiatric diagnosis in general is largely dependent on these kinds of data, and it requires a good deal of clinical skill to deal with the individual's defensiveness, denial, histrionic tendencies, acquiescence set, etc. in order to elicit information and to make a series of complex judgments regarding the mental status. Just as the diagnostician may suspect the presence of hallucinations by the way the patient evades the relevant questions or denies them in an exaggerated fashion, so the interviewer may suspect suicidal ideation according to the way the patient handles the questions. It may be necessary, for example, to use strategies such as leaving an evaded question unanswered and then returning to it at a later part of a patient's interview in a more circumscribed way. It should be noted too that a patient's reports, whether relevant to his description of his overt behavior or to his recall of state of mind just prior to the attempt, are subject to distortion. Agreement between the data of the first and second sections obviously provides a higher level of confidence than discrepancies between the two sections.

Rather than disqualify introspection reports because of their inconsistent validity, it would be well to specify conditions in which they are adequate or inadequate. It is noteworthy, incidentally, that medical diagnosis is fraught with similar perils. Systematic studies of inter-rater reliability and test-retest reliability of EKG's, EEG's, chest X-rays, and physical exams show a surprisingly low concordance

psychiatrist?

rate (about 60%). The validity (as determined by the pathologist) is at about the same level.

The scale was designed to be general so as to deal effectively with the typical suicide attempt. Special judgments and evaluations must be made by the clinician when dealing with special or unique features of the atypical case (the schizophrenic attempting suicide in compliance with an auditory hallucination, the hysteric attempting for histrionic display, etc.). In cases in which the self-report or even the circumstances of the attempt are intricately enmeshed in the psychopathology of the patient, special care must be taken by the interviewer to evaluate the facts and make his interpretation for that individual case. The scale is obviously not appropriate for all cases (just as X-ray diagnosis often is equivocal for individuals with atypical body builds). In such cases, the interviewer indicates in the reliability section that the scale is not adequate for that particular case and state the reasons.

Preliminary Evaluation of Suicidal Intent Scale (Post Attempt)

In making a final evaluation of the predictive validity of our scale we will, of course, analyze how much of the variance may be accounted for by other factors that have been found to be related to fatal and nonfatal suicide attempts. These include the following kinds of information: demographic variables, intelligence, education, composition of household, real-life situation, previous suicidal attempts, previous episodes of psychiatric disturbance, previous use of drugs and/or alcohol, etc.

Inter-rater Reliability

Forty-five consecutive patients were interviewed as soon after a suicide attempt as possible. Each patient was seen by a pair of interviewers, who alternated in interviewing successive patients. An experienced interviewer was paired with an inexperienced interviewer. In one case the experienced interviewer would do the interviewing while the inexperienced interviewer observed. In the next case the inexperienced interviewer was responsible for the interview while the experienced interviewer was the observer. Following the interview, each interviewer independently completed the Suicide Intent Scale. The total intent scores for each case was computed and the coefficient in 45 cases was $r = .95$. Although the correlation coefficient was undoubtedly inflated by contamination, practical considerations precluded completely independent interviews.

Assessment of Internal Consistency

An odd-even computation was performed and yielded a correlation coefficient $r = .70$. After correction for attenuation (Spearman-Brown), the correlation coefficient was $.82$. Although the internal consistency is not as high as many inventories, the following factors should be kept in mind:

Yeah! (1) The final decision as to the value of each of the items will be determined at the end of our longitudinal study, at which time certain items may be dropped. *Duration?*

(2) Some items that are rarely endorsed are often "pathognomonic signs" of serious suicidal intent. For example, it has been well established that most fatal suicide attempts occur at home. However, a very high proportion of nonfatal suicidal attempts also occur at home. We have some evidence from comparing fatal and non-fatal cases, however, that the unusual case who leaves home, locks himself in his hotel room and puts up a "do not disturb" sign is more likely to have a fatal outcome.

The item test correlation coefficients on 70 cases are presented in Table 1.

Construct Validity

We have not as yet attempted to determine the concurrent validity of the Suicidal Intent Scale because of the huge disparity in the criteria used by different clinicians in assessing suicidal intent.

However, if we can get a group of clinicians to agree among themselves on criteria, we can then evaluate the concurrent validity of the scale.

Meanwhile, we are haunted by the problem of evaluating the construct validity of the test. Professor Meehl and his colleague, Professor Cronbach, introduced this tricky concept into the field of psychometrics 17 years ago. Their valuable concept raises what appears to be insoluble problems at times: for example, have we invented some personality trait which does not exist out there in the real world? Even if such a trait or behavior does exist in some form or another, does our scale actually measure it?

Cronbach and Meehl (1955) demonstrated convincingly that when there is no generally accepted criterion for a hypothesized state, a complicated, logical, and empirical analysis is required. The validation procedure involves several steps; first the investigator inquires: What predictions can be derived from his theory regarding the variation of scores from person to person or from occasion to occasion? Secondly, he conducts investigations to confirm or disconfirm these predictions.

We have made the following predictions to assess the construct validity of our scale:

(1) Using the circumstantial data of the scale, we predict that the scores of fatal suicide attempts are higher than non-fatal attempts. In a study comparing the scores of 31 fatal attempters (derived from case records at the Medical Examiner's Office) with the scores of 49 nonfatal attempters, we found that the mean score on the Circumstantial part of the scale was 10.2 for the fatal cases and 6.2 for the nonfatal cases ($t = 5.45, p > .0005$). A far more extensive study of this nature will be conducted.

(2) We predicted that nonmanipulativeness of the suicide attempt (Item #9) would show a significant positive correlation with the overall intent score and also with the Depression Inventory score. This was found to be the case.

(3) Our theoretical formulation regarding the relationship of hopelessness, depression, and suicide behavior is as follows: We regard hopelessness as an important precursor to serious or fatal suicidal attempts. Depressed patients characteristically show hopelessness based on cognitive distortions (Beck, 1962). Non-depressed patients, however, who are objectively trapped by an insoluble problem, may have a relatively undistorted negative view of the future. Framing this in statistical terms we, therefore, predict the correlation between hopelessness and suicidal intent to be higher than the correlation between depression and suicidal intent. Hopelessness, thus, would be a more important precursor to a serious suicide decision than would be depression, per se. In a study of 73 patients, the correlation between the Depression Inventory and Intent was .26; between Intent and Pessimism was .47; and between Pessimism and Depression, it was .69. This interesting finding, of course, will require further investigation.

Summary

A 20 item schedule for assessing the intensity of Suicidal Intent has been constructed. It will be tested in a five year longitudinal study of 500 suicide attempters. At the completion of the study, item analysis and analyses of the total scale and other variables will

(we're reporting on 578 (we have another 425))

be made. At that time we hope to be able to develop an adequate instrument which will be available for practical use by professionals and para-professionals involved in the detection and assessment of suicidal risk and may also serve as a guide to the families of high-risk cases.

Table 1

Item-Test Correlations of Suicidal Intent Scale

Item	r
1. Isolation	.30
2. Timing	.47
3. Precautions	.42
4. Act to Gain Help	.38
5. Final Acts	.36
6. Degree of Planning	.46
7. Note	.37
8. Communication of Intent	.24
9. Purpose of Attempt	.42
10. Expectation Regarding Fatality	.77
11. Concept of Lethality	.54
12. Seriousness	.73
13. Ambivalence to Living	.71
14. Concept of Reversibility	.65
15. Degree of Premeditation	.63

*16. Reaction to Attempt	.25
*17. Visualization of Death	.18
*18. Number of Previous Attempts	.25

Notes

I. $r = .25$, $p < .05$
 $r = .32$, $p < .01$

II. $n = 73$

III. * Item score not included in Total Test Score

all 01/54 ♂/♀!

{ Help sought before present att
 after
 (Termination behavior)

suic note left
 Communication of intent

{ serious } present att - inj
 - intent

Prior suic atts

Intent Scale

CIRCUMSTANCES RELATED TO SUICIDAL ATTEMPT

1. Isolation
 0. Somebody present
 1. Somebody nearby or in contact (as by phone)
 2. No one nearby or in contact
2. Timing
 - () Does not apply
 0. Timed so that intervention is probable
 1. Timed so that intervention is not likely
 2. Timed so that intervention is highly unlikely
3. Precautions Against Discovery and/or Intervention
 0. No precautions
 1. Passive precautions as: avoiding others but doing nothing to prevent their intervention (alone in room with unlocked door)
 2. Active precautions (as locked door)
4. Acting to Gain Help During/After Attempt
 - () Does not apply
 0. Notified potential helper regarding attempt
 1. Contacted but did not specifically notify potential helper regarding attempt
 2. Did not contact or notify potential helper

Too specific?

eg. Tried to but unable to?
5. Final Acts in Anticipation of Death
 0. None
 1. Patient thought about making or made some arrangements in anticipation of death
 2. Definite plans made (changes in will, giving gifts, taking out insurance)
6. Degree of Planning for Suicide Attempt
 0. No preparation
 1. Minimal or moderate preparation
 2. Extensive preparation
7. Suicide Note
 0. Absence of note
 1. Note written, but torn up or note thought about
 2. Presence of note
8. Overt Communication of Intent Before Act
 0. None
 1. Equivocal communication
 2. Unequivocal communication
9. Purpose of Attempt
 0. Mainly to change or manipulate environment
 1. Components of "0" and "2"
 2. Mainly to remove self from environment

Intent Scale

SELF REPORT

10. Expectations Regarding Fatality of Act

- 0. Patient thought that death was unlikely or didn't think about it
- 1. Patient thought that death was possible but not probable
- 2. Patient thought that death was probable or certain

11. Conceptions of Method's Lethality

- 0. Patient did less to himself than he thought would be lethal or patient didn't think about it
- 1. Patient wasn't sure or thought what he did might be lethal
- 2. Act exceeded or equalled what patient thought was lethal

12. Seriousness of Attempt

- 0. Patient did not consider act to be a serious attempt to end his life
- 1. Patient was uncertain whether act was a serious attempt to end his life
- 2. Patient considered act to be a serious attempt to end his life

13. Ambivalence toward Living

- 0. Patient did not want to die
- 1. Patient did not care whether he lived or died
- 2. Patient wanted to die

no ambivalence indicated!

14. Conception of Reversibility

- 0. Patient thought that death would be unlikely if he received medical attention
- 1. Patient was uncertain whether death could be averted by medical attention
- 2. Patient was certain of death even if he received medical attention

15. Degree of Premeditation

- 0. None; impulsive
- 1. Suicide contemplated for 3 hours or less prior to attempt
- 2. Suicide contemplated for more than 3 hours prior to attempt

NOT SCORED

16. Reaction to Attempt

- a. Sorry made attempt
- b. Accepts both attempt and fact he's still alive
- c. Regrets he's still alive

17. Visualization of Death

- a. Viewed as life-after-death or reunion with decedents
- b. Viewed as never-ending sleep or darkness
- c. Not visualized or thought about

Intent Scale

NOT SCORED (cont.)

18. Number of Previous Attempts

- a. None
- b. One or two
- c. Three or more

19. Consumption of Alcohol at Time of Attempt

() Does not apply

- a. Enough alcohol was ingested so patient was confused and didn't know what he was doing at time of attempt
- b. Alcohol was drunk to get up enough nerve to make attempt
- c. Alcohol was taken to potentiate drugs ingested or other method used

20. Use of Drugs at Time of Attempt

() Does not apply

- a. Patient under the effect of a drug so he didn't know what he was doing at time of attempt or not aware of full implications of attempt
- b. Drug used to free patient of inhibition so attempt could be made
- c. Drug used to potentiate and supplement method used

RELIABILITY RATINGS

- (1) The reliability of the patient _____ % good fair poor uncertain

Low reliability is due to (indicate the % of contribution to overall patient reliability rating):

- (a) confusion of patient as a medical consequence of suicide attempt _____ %
- (b) lack of truthfulness _____ %
- (c) disorientation at time of suicide attempt, due to influence of alcohol or drugs _____ %
- (d) disorientation at time of suicide attempt, due to emotional state of patient _____ %
- (e) inability of patient to retrospect back to time of the attempt _____ %
- (f) inability of patient to answer significant questions _____ %

- (2) The % of the Scale that the patient did not explicitly answer _____ %
The confidence of the interviewer in his inferences regarding these unanswered questions _____ %

- (3) The extent to which unconscious processes on the part of the patient have distorted his responses to questions on the Intent Scale:

Significant distortion Moderate distortion Little or no distortion

As a result of this distortion, the patient's score is:

Misleadingly high Misleadingly low Essentially unchanged

The interviewer's confidence in his inference of unconscious processes:
_____ % high moderate low

- (4) The extent to which special circumstances relating to the suicide attempt or to the patient's personality make the Scale less applicable or inclusive in this case

Scale is:

Considerably less applicable _____
Moderately less applicable _____
No special factors make Scale less applicable _____

The special factor is _____

- (5) The interviewer's overall confidence in the reliability of the Intent Scale as a measure of suicidality in this case, in view of the factors considered in (1), (2), (3), and (4):

_____ % confidence; High Moderate Low reliability