An Empirical Perspective on Acute vs. Chronic Suicide Risk

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The Pursuit of Typologies in Suicidology

- For over a century scientists studying suicide have endeavored to create typologies of suicidal individuals.
- Such typologies could inform prevention efforts as well as clinical assessments and treatments.
- We intuitively know that motivations for different suicidal people are not the same.
- Different people *think* about suicide differently—there are many considerations, goals, and influences…

The Notion of "Acute" vs. "Chronic" Suicidal Risk as Typologies

- Linehan (1993)
- Ellis & Newman (1996)
- Rudd, Joiner, & Rajab (2001)
- Wenzel, Brown, & Beck (2008)
- Fazaa & Page (2003)
- Jobes (1995; 2000; 2006)

Suicide Status Form-SSF II-R (Initial Session)

Patient: ____________ Clinician: ____________ Date: ________ Time: ________

Section A (*Patient*):

Rate and fill out each item according to how you feel right now.
Then rank in order of importance 1 to 5 (1=most important to 5=least important).

Rank	
___	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain:** 1 2 3 4 5 **:High pain** What I find most painful is: ________
___	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress:** 1 2 3 4 5 **:High stress** What I find most stressful is: ________
___	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low agitation:** 1 2 3 4 5 **:High agitation** I most need to take action when: ________
___	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness:** 1 2 3 4 5 **:High hopelessness** I am most hopeless about: ________
___	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate:** 1 2 3 4 5 **:High self-hate** What I hate most about myself is: ________
N/A	6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk: (will not kill self)** 1 2 3 4 5 **:Extremely high risk (will kill self)**

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all:** 1 2 3 4 5 **: completely**
2) How much is being suicidal related to thoughts and feelings about others? **Not at all:** 1 2 3 4 5 **: completely**

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much
I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: ________

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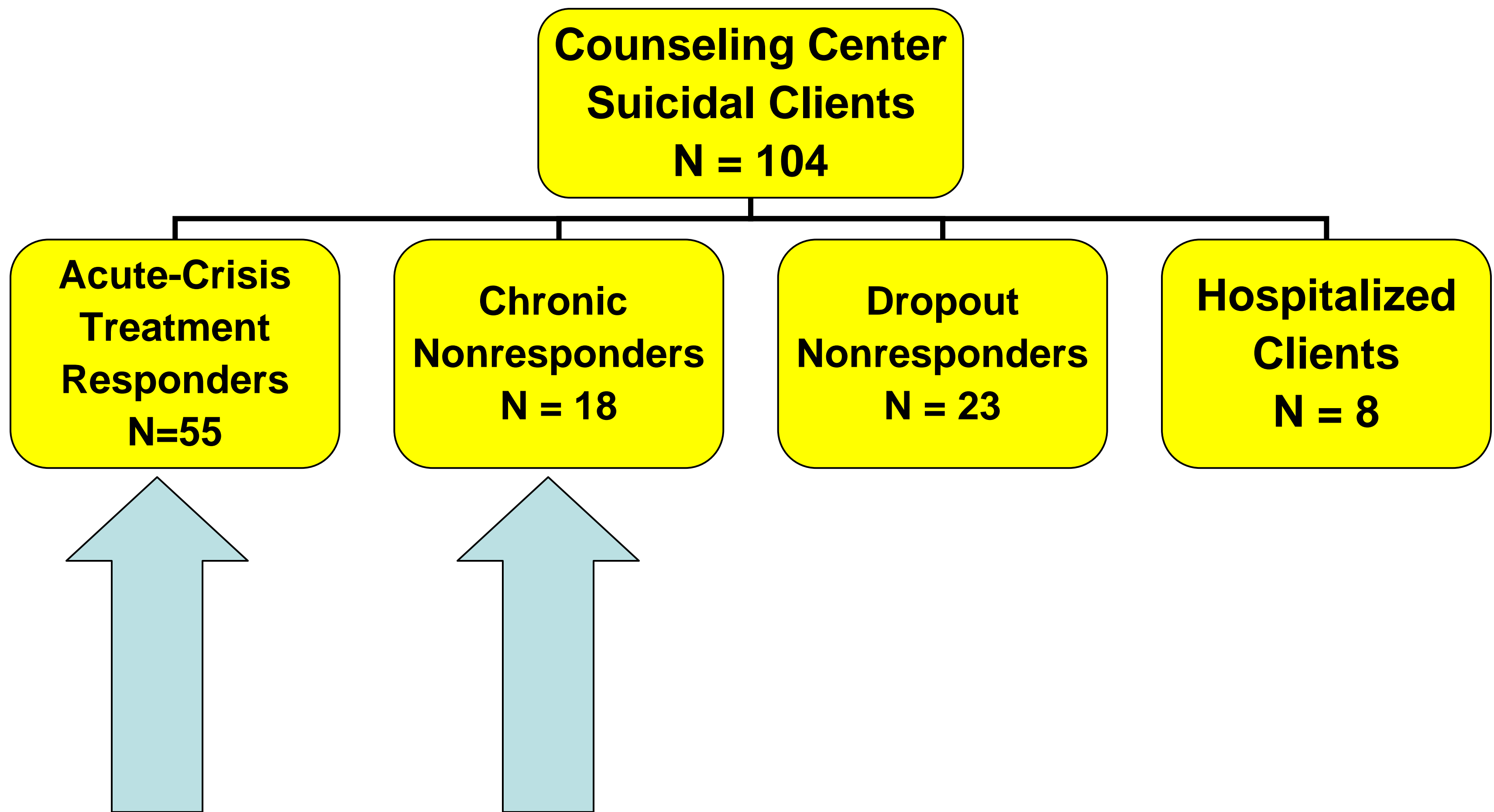
Theory Building:
Intrapsychic vs. Interpsychic Suicidality
(Jobes, 1995)

AGENCY **O--O** COMMUNION

Intrapsychic Suicide	Interpsychic Suicide
Internal Pain Focus	**External Pain Focus**
Private Suicide	**Public Suicide**
Axis I	**Axis II**
(e.g., Vince Foster)	**(e.g., Marilyn Monroe)**

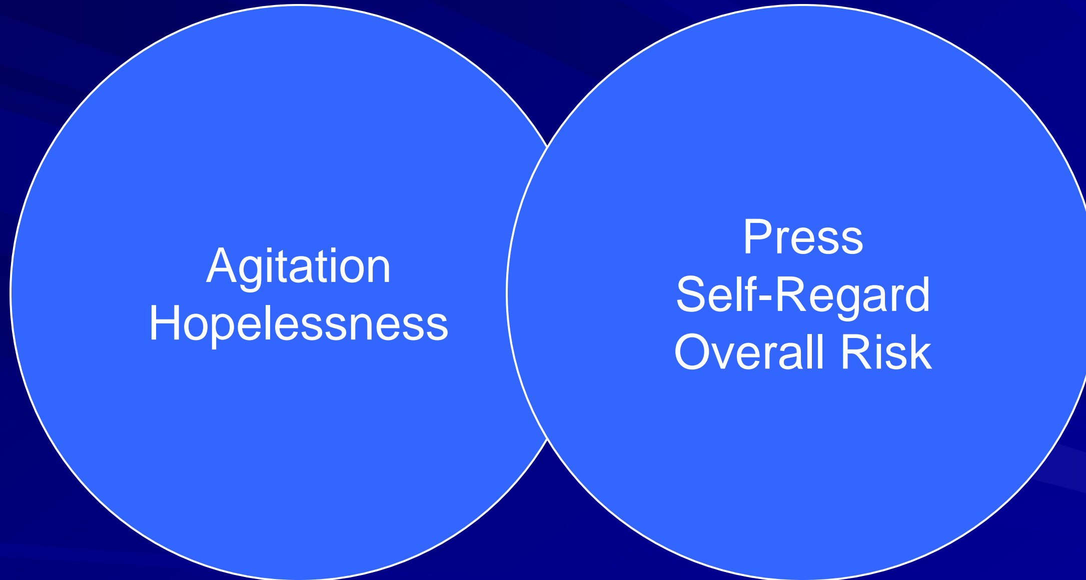
Acute = male, more lethal, suicide completer
Chronic = female, less lethal, suicide attempter

Categorical Treatment Outcomes of a Five-Year Suicidal College Student Cohort (Jobes et al., 1997)



Discriminant Function Analysis (Jobes et al., 1997)

Acute Resolvers Chronic Non-Resolvers



$p < .036$

Johns Hopkins Counseling Center (n=152) Results

Mean Word Counts for Treatment Outcome Groups
(Overall mean word count = 75.54; range 0-226)

Status	M	SD
Resolved	62.40	40.14
Short-Term	60.74	43.59
Longer-Term	68.05	31.42
Non-Resolvers	**98.43***	60.26
Drop-Outs	61.29	41.09
Acute/Emergent	**103.45****	51.13
Attempters	75.79	42.53
Non-Attempters	75.12	49.06

"ACUTE"

"CHRONIC"

* $p < .01$ ** $p = .001$

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SSF Core Assessment

New Psychometric SSF Mayo Study (Conrad et al., 2009)

- A recent psychometric study of suicidal inpatients (n=140) at the Mayo Clinic has further established the validity and reliability of the SSF.

- Factor analysis of SSF responses produced a robust two factor solution
  - An chronic factor accounting for 53% of variance
  - A acute factor accounts for 19% of additional variance
  - 72% of total variance is a significant improvement from 1997 study (two factor solution accounted for 30% total variance)

Factor analysis from Conrad et al (2009) Mayo Clinic psychometric study of the Core SSF assessment (n=140)

(Spearman Promax Rotated Factor Pattern)

SSF Theoretical Variable		Factor 1	Factor 2	
Self-Hate	CHRONIC	.88*	-.09	
Hopelessness	CHRONIC	.85*	.05	
Pain	CHRONIC	.74*	.10	
Agitation		-.07	.92*	ACUTE
Stress		.12	.78*	ACUTE

Note: * Values greater than 0.4

- Factor 1: "Chronic" Suicidal Risk Profile accounted for 53% of variance
- Factor 2: "Acute" Suicidal Risk Profile accounted for an additional 19% of variance
- Therefore the robust two factor solution accounted for 72% of the total variance

Trying to predict reductions in suicidal ideation using first session SSF ratings

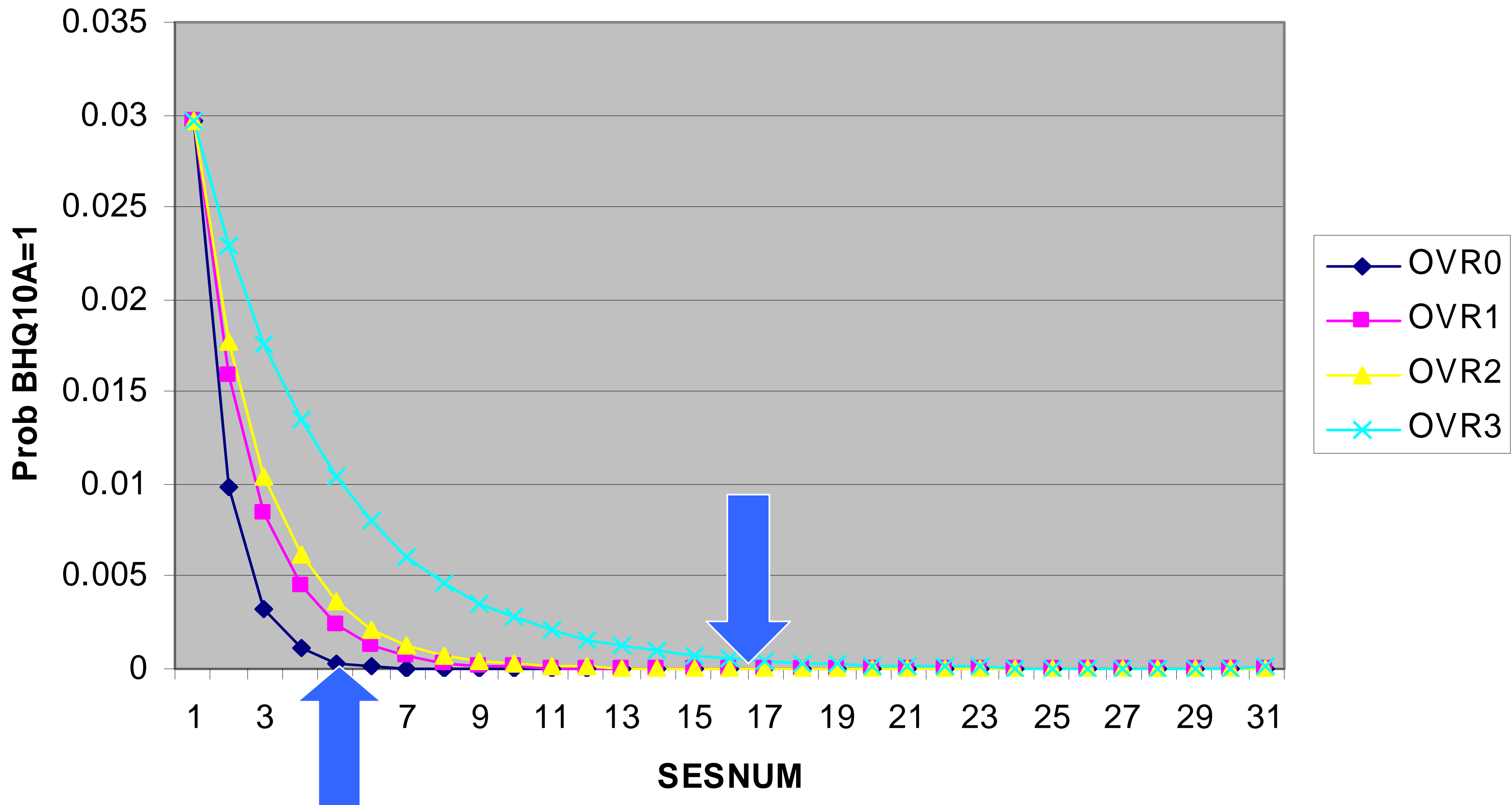
- BHM is administered prior to every session
- BHM item #10 (thoughts of ending life) was used as a proxy measure of on-going suicidal ideation

Sessions 1 2 3 4 5 6 7 8 9 10.........

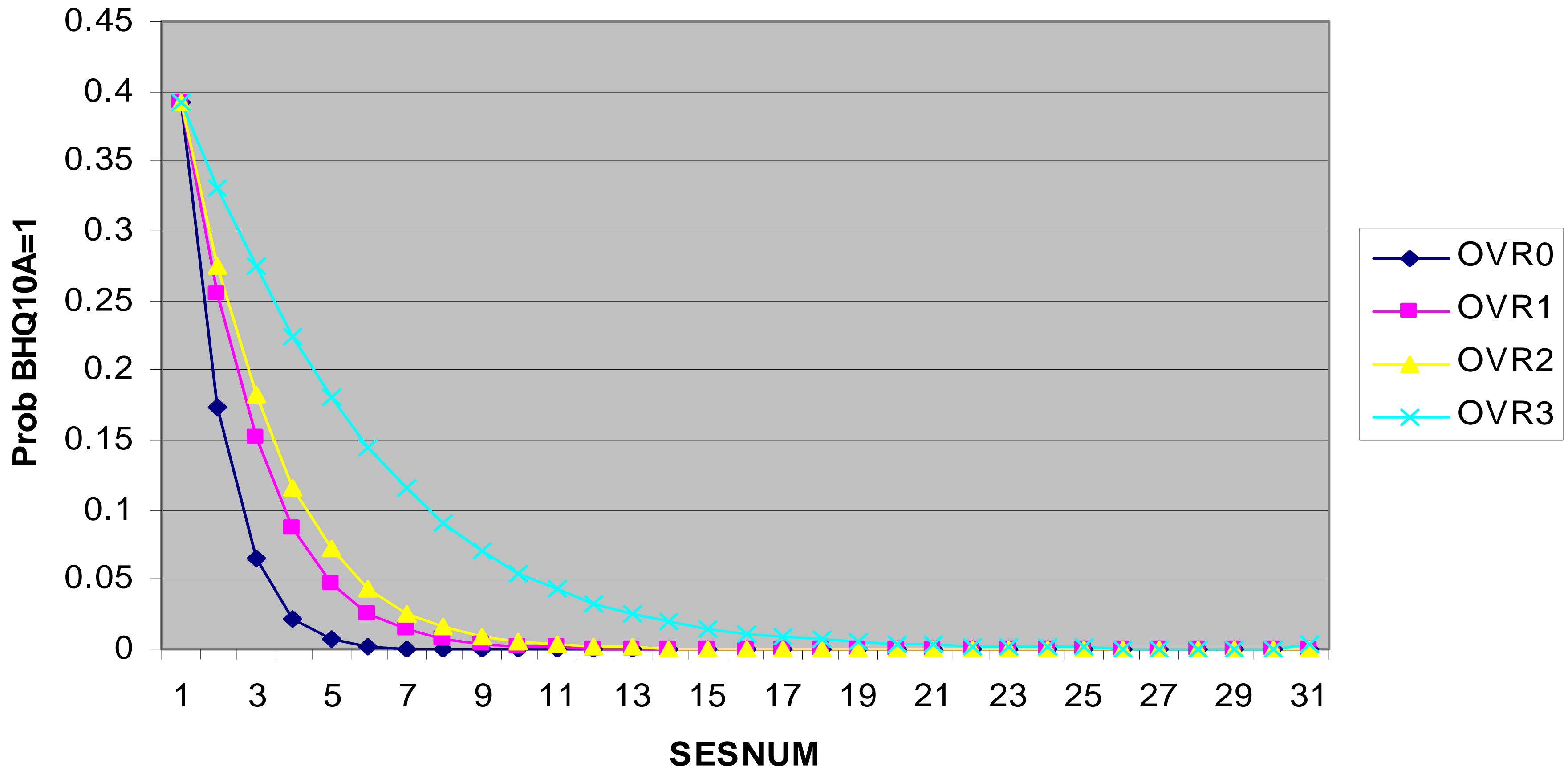
Initial SSF Ratings:

- Pain
- Stress
- Agitation
- Hopelessness
- Self Hate
- Overall Risk

The SSF Overall Risk of Suicide rating differentially predicts reductions in suicidal thoughts



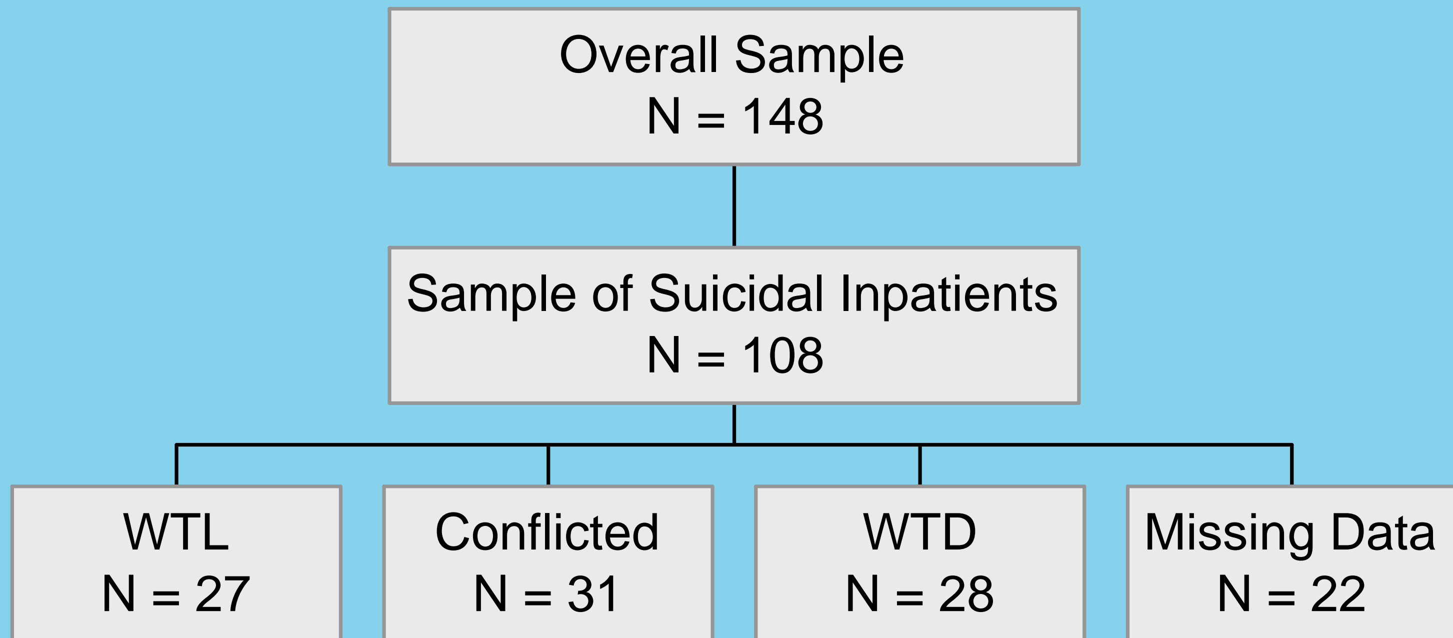
The effect is moderated by SSF ratings of Hopelessness and Self-Hate



The under-appreciated importance of suicidal *ambivalence*…

- Suicidal ambivalence is cognitive/emotional state of being torn between living and dying.
- Beck & Kovacs (1977) "internal struggle hypothesis"
  - 50% of the 1977 sample displayed some degree of suicidal ambivalence.
  - Three subgroups: Ambivalent; No wish to Live; and No Wish to Die.
  - *Ambivalence was predictive of suicidal intent*.

Mayo Clinic Participants



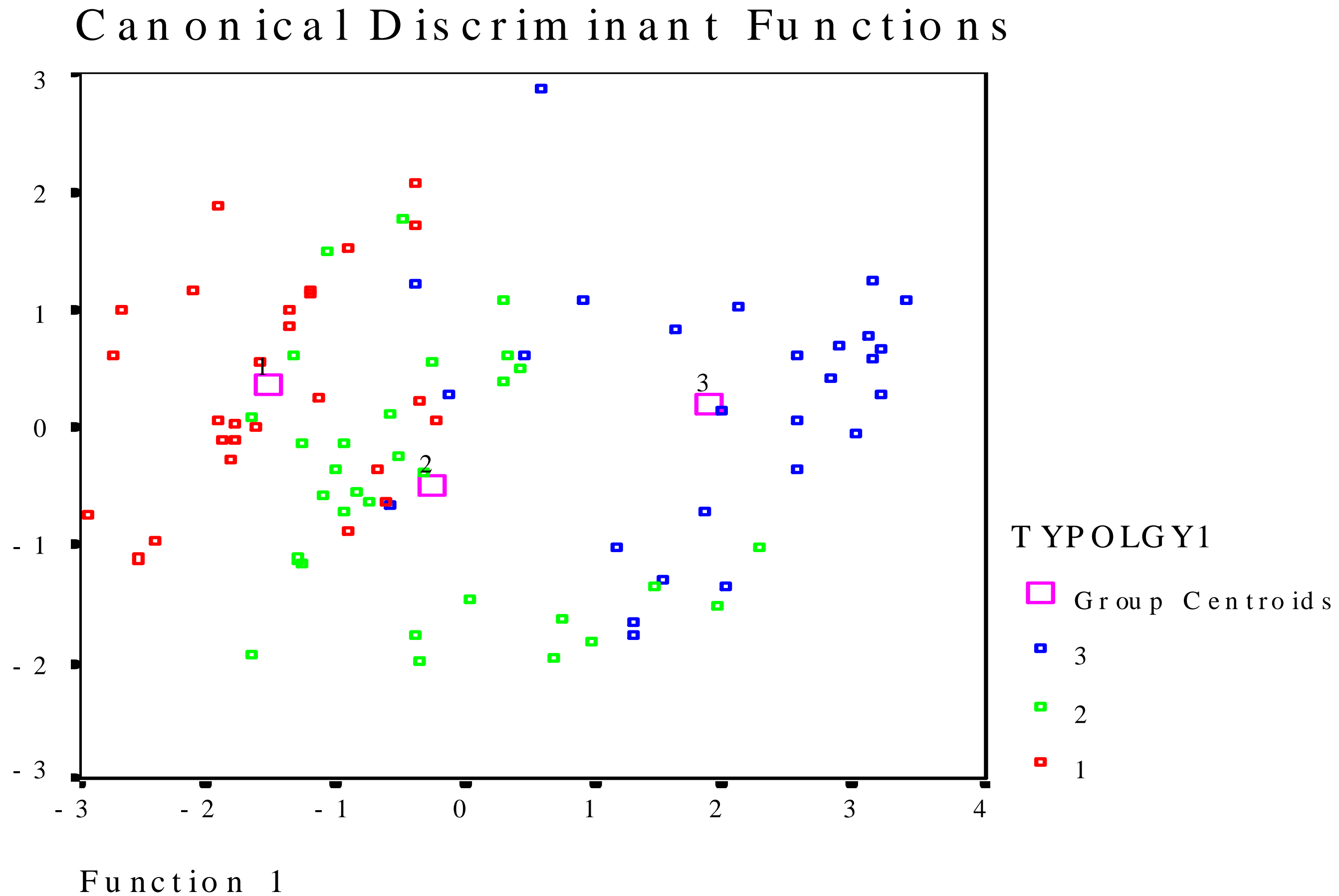
Scores from Four Assessment Tools were used Predict Group (WTL vs. Conflicted vs. WTD)

- Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974)
- Reasons for Living Inventory (Linehan, Goodstein, Nielsen, & Chiles, 1983)
- Suicide Status Form (Jobes, 2006)
  - Overall Risk of Suicide Rating
- Outcome Questionnaire (Lambert et al., 1996)
  - Symptom Distress, Interpersonal Functioning, and Social Role

Discriminant Analysis Results:
Tests of Equality of Group Means

	Wilks' Lambda	F	df1	df2	Sig.
SSF/ORS	.450	50.63	2	83	.000
RFL Inv	.771	12.34	2	83	.000
BHS	.476	45.64	2	83	.000
OQ45	.602	27.45	2	83	.000

All Groups Scatterplot



Summary of Group Classification Results

- Using scores from the four assessments we were able to correctly classify the three typologies 77% of the time.
  - Low WTL = 82%
  - Conflicted = 74%
  - High WTL = 74%

- Cohen Kappa = .65, which falls in the moderate range of reliability (.6-.8)

- Bottom-line: We are able to use assessment tools to predict three distinct typologies of suicidal states (cross-sectionally) with an inpatient suicidal sample.