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Suicide Assessment

Part 1: Uncovering Suicidal IntentA Sophisticated Art

By Shawn Christopher Shea, MD | December 3, 2009
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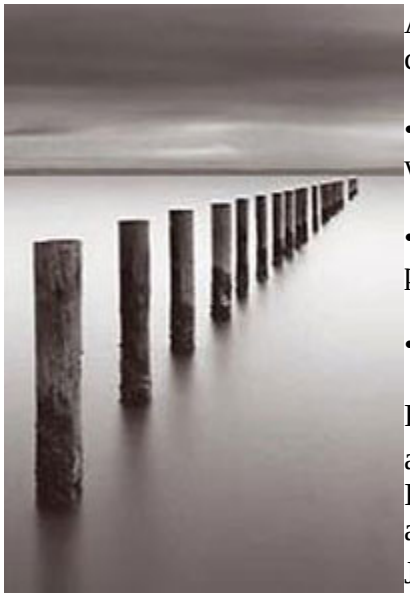

A sound suicide assessment approach or protocol is made up of 3 components:

• Gathering information related to risk factors, protective factors, and warning signs of suicide.

• Collecting information related to the patient's suicidal ideation, planning, behaviors, desire, and intent.

• Making a clinical formulation of risk based on these 2 databases.

Practical approaches to integrating these 3 aspects of a suicide assessment have been well delineated for adults and adolescents.[1-8] Innovative systematic approaches, such as the Collaborative Assessment and Management of Suicidality (CAMS) approach created by David Jobes,[9] have also been developed for integrating all 3 tasks while providing collaborative intervention, which may help lay the foundation for a more evidence-based protocol for suicide assessment. Recently, Joiner and colleagues[10] have delineated a promising approach based on the interpersonal theory of suicide, which gracefully integrates all 3 components necessary for a suicide assessment.

In the clinical and research literature, much attention has been given to the first and third tasks (gathering risk/protective factors/warning signs and clinical formulation). Significantly less attention has been given to the second task—the detailed set of interviewing skills needed to effectively elicit suicidal ideation, behaviors, and intent. But in many respects, it is the validity of the information from the second component that may yield the greatest hint of imminent suicide. Moreover, as any clinical supervisor will testify, there is little doubt that 2 clinicians, after eliciting suicidal ideation from the same patient, can walk away with surprisingly different information.

The importance of uncovering suicidal ideation

Some patients who are seriously suicidal may actually share their real intent, secondary to their own ambivalence and/or the effective interviewing skills of the clinician. Such information subsequently serves to sculpt safe triage, whether offered in an emergency department (ED), outpatient clinic, or on the telephone with a crisis counselor.

CHECK POINTS

- ✓ Patients who have the most serious suicidal intent may be the most likely to withhold it.
- ✓ The actual suicidal intent of the patient may be a combination of what the patient tells the interviewer is his or her intent, what plans and actions may reflect the patient's actual intent, and what intent the patient consciously or unconsciously withholds.
- ✓ Motivational theory suggests that in some instances, reflected intent—amount of ideation, extent of planning, and actions taken on planning—may be a more accurate indicator of actual intent than what a patient states is his intent.

This information may also be useful in a prospective sense if accurately documented; a thorough record of suicidal ideation and action provides subsequent clinicians with a baseline of the patient's suicidal activity at a specific point. This reference point can be used by future clinicians—such as crisis intervention clinicians or inpatient staff contemplating a pass for a patient—to determine whether the patient's current suicidal ideation is increasing or decreasing.

Not all dangerous patients relay suicidal ideation to clinicians.[11] One could argue that many dangerous patients—those who truly want to die and see no hope for relief from their suffering—would have little incentive to do so. Even if their ambivalence about attempting suicide leads them to voluntarily call a crisis line or go to an ED, they may be quite cautious about revealing the full truth, for a large part of them still wants to die. Such patients may be predisposed to share only some of their suicidal ideation or action taken on a particular plan, while hiding their real intent or even their method of choice (such as a gun tucked away at home).

Many reasons exist why patients, even with various ranges of intent, may be hesitant to openly share, including the following:

- The impulsive patient may lack extensive suicidal ideation before his or her attempt. (This is one reason it may be necessary to hospitalize a patient who denies suicidal ideation.)
- The patient has had marked suicidal ideation and is serious about completing the act but is purposely not relaying suicidal ideation or is withholding the method of choice because he does not want the attempt to be thwarted (another reason to hospitalize a patient who may be denying or minimizing suicidal ideation).
- The patient feels that suicide is a sign of weakness and is ashamed to acknowledge it.
- The patient feels that suicide is immoral or a sin.
- The patient feels that discussion of suicide is, literally, taboo.
- The patient is worried that the clinician will perceive him as crazy.
- The patient fears that he will be locked up if suicidal ideation is shared or, if during a crisis call, that the police will appear at his door.

- The patient fears that others will find out about his suicidal thoughts through a break in confidentiality.

- The patient does not believe that anyone can help.

- The patient has alexithymia and has trouble describing emotional pain or material.[12]

It is sometimes easy to believe that if we ask directly about suicide, the patient will answer directly—and truthfully. From the above considerations, it is apparent that this is not necessarily the case. The real suicidal intent of a patient can be more accurately conceptualized by the following "Equation of Suicidal Intent":

Real Suicidal Intent = Stated Intent + Reflected Intent + Withheld Intent

Thus, a patient's actual intent may equal his stated intent, reflected intent, and withheld intent; any one of these 3; or any combination of the 3. The more intensely a patient wants to proceed with suicide, the more likely he is to withhold his true intent. In addition, the more taboo a topic is (eg, incest and suicide) the more one would expect a patient to withhold information. In such instances, both conscious and unconscious processes may underlie the withholding of vital information.

From a psychodynamic perspective, a curious paradox can arise. If a patient believes that suicide is a sign of weakness or a sin, unconscious defense mechanisms (such as denial, repression, rationalization, or intellectualization) may create the conscious belief that the patient's intent is much less than it actually is. When asked directly about his suicidal intent, this patient may provide a gross underestimate of his potential lethality even though he is genuinely trying to answer the question honestly.

From a phenomenological perspective, it is not surprising that some seriously suicidal patients may relay their actual intent in stages. Whether evaluating such patients in an ED or on a crisis line, one would expect that the patient would share some information, see how the clinician responds, then share some more information, reevaluate "where this session is going," and so on.

Indeed, patients with serious suicidal intent who are trying to decide how much to reveal may share information about a mild overdose while consciously withholding their main method of choice (such as a gun, for they are well aware that once they share information about the gun it may be removed) until they arrive at a decision during the interview that they do not want to die. At this point, they may feel safe enough to share the full truth with the clinician.

Reflected intent: one of the master keys to unlocking real intent

Reflected intent is the quality and quantity of the patient's suicidal thoughts, desires, plans, and extent of action taken to complete the plans, which reflect how much the patient truly wants to commit suicide. The extent, thoroughness, and time spent by the patient on suicidal planning may be a better reflection of the seriousness of his intent and the proximity of his desire to act on that intent than is his actual stated intent.

Such reflections of intent may prove to be life-saving pieces of the suicide assessment puzzle. The work of Thomas Joiner[10,13] has provided insight into the importance of acquired capability for suicide (eg, intensive planning, multiple past attempts) as a reflection of the seriousness of intent and the potential for action.

A wealth of research and theory from an unexpected source—motivational theory—can help us better understand the importance of reflected intent. Prochaska and colleagues'[14,15] transtheoretical stages of change—precontemplation, contemplation, preparation, action, and maintenance—helped lay the foundation from which Miller and Rollnick's[16,17] influential work on motivational interviewing arose. When it comes to motivation to do something that is hard to do but good for oneself (eg, counseling), the extent of the patient's goal-directed thinking and his subsequent actions may be much better indicators of intent to proceed than his stated intent. In short, the old adage "actions speak louder than words" appears to be on the mark in predicting recovery behavior.

A patient in alcohol counseling may tell the counselor all sorts of things about his intent to change. Nevertheless, it is the amount of time he spends thinking about the need for change (reading the literature from Alcoholics Anonymous [AA]), arranging ways to make the change (finding out where the local AA meetings are), and the actions taken for change (finding someone to drive him to the meetings) that, according to Prochaska's theory, may better reflect the intent to change than the client's verbal report.

Motivational theories are usually related to initiating difficult-to-do actions for positive change. But they may be equally effective for initiating a difficult-to-do action that is negative, such as suicide. (Joiner [10,13] has pointed out that suicide can be quite a difficult act with which to proceed.) Once again, the amount of time spent thinking, planning, and practicing a suicide attempt may speak louder about imminent risk than the patient's immediate words about his intent.

Pitfalls of an incomplete elicitation of suicidal ideation

Premature crisis resolution. Arguably, the single most important task in a suicide assessment, whether in a face-to-face interview or on the phone, is to estimate the immediate risk of suicide and to triage safely with appropriate follow-up. Much of this determination of risk is contingent on an accurate estimate of the patient's suicidal intent. However, significant errors can be made, whether a clinician is in an ED or manning a crisis line.

Picture a patient who mentions suicidal thought and openly admits to a plan (eg, overdosing) yet is withholding much of his intent because of a strong desire to die. The clinician explores the ideation related to overdosing and then prematurely (before carefully eliciting other suicidal ideation and planning that may better reflect the patient's true intent and method of choice) begins crisis transformation. Being a skilled clinician, the crisis is effectively resolved. The client reports feeling much better. The clinician makes a recommendation for follow-up such as, "Sometime in the near future, I urge you to seek out a therapist."

Because the clinician did not do a thorough assessment of reflected intent before beginning crisis transformation (he or she prematurely assumed that the method first supplied by the client—overdosing—was the method of choice), the clinician is unaware that the client has been thinking about shooting himself for weeks; has gotten the gun out on several occasions (loaded it once); and was in need of much more careful follow-up, including the fact that the patient's mother could have removed the gun. Unfortunately, three days after the "successful" crisis intervention, the patient's girlfriend leaves him, he begins drinking, and his suicidal intent returns with a vengeance and the sound of a gunshot.

Lost data for the receiving clinician. A clinician who helps a patient to open up about his suicidal ideation and who uses effective interviewing techniques **(described in Part 2 of this article online)** may have an unusually good opportunity to obtain an accurate picture of both stated and reflected intents during the initial crisis intervention. The patient may be affectively charged at the time and such

emotional turmoil may make the client's unconscious and conscious defenses less active so that it is easier for the truth to emerge.

It is of great value for a triage clinician, such as a school counselor, primary care physician, or crisis line counselor to gather as much information as possible at this time because during the trip to the ED a surprising number of patients undergo a "miraculous cure" during transport. In short, they clam up. It is important for professional gatekeepers to gather as much information as possible regarding reflected intent because the receiving mental health professional, whether in an ED later that night or in a community mental health center 2 days later, may be dependent on this relayed information when making a formulation of risk.

The power of a thorough elicitation of suicidal ideation, behavior, and intent to save a life

The issue of credibility. Especially in situations in which the patient is not known to the interviewer, such as may occur in EDs and during consultation and liaison assessments following a suicide attempt, a determination of the credibility of the patient's self-report is of vital importance. In such situations, one can compare the validity of what is being reported with what has been documented in the past. Although previous charts are not always available (electronic records may diminish this problem), when they are, information documented on reflected intent may be invaluable in assessing the reliability of the patient's current self-reporting.

A marked discrepancy between what the patient reports about past suicidal ideation and what is actually documented may be the best indicator of whether the patient is telling the truth. Such a contradiction may guide the clinician to seek collaborative sources of information and/or to discuss the discrepancies with the patient. It also emphasizes the need to reevaluate the patient's immediate safety.

Reaching for life. Regarding future safety, the act of eliciting a thorough database on suicidal ideation and actions may be of value not only in the content of the database obtained but in the therapeutic fashion in which this information is garnered. Clinicians who have been trained to use an engaging strategy for eliciting suicidal ideation, such as the **Chronological Assessment of Suicide Events–CASE Approach (see online article),**[1,18-20] may often create a positive interpersonal experience during the initial assessment. Such a patient may remember the sense of safety and comfort he felt talking with this clinician who neither overreacted nor underreacted to the patient's description of his suicidal thought. If, in the future, that patient becomes dangerously suicidal—and is debating whether to call for help or proceed with the attempt—the patient may decide to reach for the phone, not for a gun.

Closing comments

In **Part 2** of this series on suicide assessment, we will look at a flexible approach for uncovering suicidal ideation and intent that addresses the concerns described above. The CASE Approach is an interviewing strategy designed to increase the likelihood that the patient's stated intent is accurate, that the reflected intent is comprehensive and valid, and that the amount of withheld intent is minimized or absent.

But before we leave the topic of the importance of eliciting a thorough history of suicidal ideation and action, it cannot be overemphasized that collaborative sources, such as family members, therapists, and police, may play a defining role in gathering the pieces of the risk assessment puzzle. One study of completed suicides showed that 60% of the patients had communicated suicidal thoughts to a spouse and 50% to a relative.[21] Fortunately, the interviewing strategy described in the online article may prove to be equally useful in obtaining valid information from collaborative sources, who may have their own hesitation about sharing the patient's suicidal ideation.

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Suicide Assessment

Part 2: Uncovering Suicidal Intent Using the Chronological Assessment of Suicide Events (CASE Approach)

By Shawn Christopher Shea, MD | December 21, 2009
(Part 1 of this article online: "Uncovering Suicidal IntentA Sophisticated Art")
Dr Shea is director of the Training Institute for Suicide Assessment and Clinical Interviewing (www.suicideassessment.com) and adjunct professor in the department of psychiatry at the Dartmouth Medical School in Hanover, NH. He reports no conflicts of interest concerning the subject matter of this article.

The Equation of Suicidal Intent, which was introduced in **Part 1** of this 2-part series, postulates that the real suicidal intent of any given patient may be equal to any one of the following or a combination of the following[1]:

• Stated intent: what the patient directly tells the clinician about his or her suicidal intent

• Reflected intent: the amount of thinking, planning, or actions taken on suicidal ideation that may reflect the intensity of the actual suicidal intent

• Withheld intent: suicidal intent that is unconsciously or purposefully withheld from the clinician

Reflected intent was defined as the quality and quantity of the patient's suicidal thoughts, desires, plans, and extent of action taken on those plans, which may reflect how much the patient truly wants to commit suicide. The extent, thoroughness, and time spent by the patient on suicidal planning may, not in all, but in some patients be a better reflection of the seriousness of their intent and the proximity of their desire to proceed on that intent than the patient's actual stated intent. Such reflections of intent may prove to be lifesaving pieces of the suicide assessment puzzle.

The interviewing strategy known as the Chronological Assessment of Suicide Events (the CASE Approach) was designed to minimize the likelihood that at the time of risk formulation, such essential pieces of the puzzle would be missing. The goal was to create a practical interviewing strategy that could be reliably used to maximize the validity of the patient's stated and reflected intent while

minimizing withheld intent—no matter how tired or overwhelmed the clinician might be or how hectic the clinical environment may have become. The ultimate goal of the interviewing strategy is to help the clinician determine the patient's actual suicidal intent.

Key design elements and development

The CASE Approach is a flexible, practical, and easily learned interviewing strategy for eliciting suicidal ideation, planning, behavior, desire, and intent. It was developed to help the clinician explore both the patient's inner pain and the suicidal planning that often reflects this pain. It was specifically designed to help transform the hindrances that often block the open sharing of suicidal intent. Used effectively, it may lead a seriously dangerous patient—predisposed to withhold his suicidal intent—to share his intent. It may also help clinicians to determine more accurately the dangerousness of a patient by bringing to the surface hidden elements of the patient's reflected intent.

For clinicians, the practical problems related to uncovering a valid history of suicidal ideation, behaviors, desire, and intent are compounded by the hectic clinical settings of contemporary practice. The time constraints related to managed care pressures, the increased workloads necessitated by down-staffing, and an increasingly litigious society combine to place additional pressures on clinicians who may already be under considerable stress.

Moreover, complicated suicide assessments have a knack for occurring at the "wrong" times: in the middle of an extremely hectic clinic day or in the chaotic environment of a packed emergency department (ED) or crisis line center. And the stakes are high. An error can result in not only an unnecessary death—a terrible tragedy—but also in a lawsuit, much less important but very disturbing in its own right. In many suicide assessment scenarios, we find a harried clinician performing a difficult task, under extreme pressure, in an unforgiving environment. No wonder mistakes are made.

Some of the more common errors that occur during the elicitation of suicidal ideation are omissions, distortions, and assumptions—a potentially deadly triad. In my experience, as a past director of a psychiatric ED, a full-intake assessment center, and a call center, it appeared that errors in suicide assessment often did not stem from poor clinical decision making. More frequently, they seemed to result from a good clinical decision being made from a bad database. In my experience, the pieces of the puzzle most frequently distorted or missing at the time of the clinical formulation were those related to the extent of the patient's suicidal history, planning, and current intent.

The CASE Approach is not presented as the *right* way to elicit suicidal ideation or as a standard of care, but as a reasonable way that can help clinicians develop their own methodology. From an understanding of the CASE Approach, clinicians may directly adopt what they like, reject what they do not like, and add new ideas. It can be used and/or adapted with any suicide assessment protocol the clinician deems useful. The goal of the CASE Approach is to provide clinicians with a practical framework for exploring and better understanding how they approach eliciting suicidal ideation, behavior, desire, and intent so that they may develop an individualized approach with which they personally feel comfortable and competent.

Background

First developed at the Diagnostic and Evaluation Center of Western Psychiatric Institute and Clinic at the University of Pittsburgh in the 1980s, the CASE Approach was refined at the Department of Psychiatry in the Dartmouth Medical School and in front-line community mental health center work during the 1990s. Subsequent refinements in the 2000s have been implemented at the Training Institute for Suicide Assessment and Clinical Interviewing (TISA).

The CASE Approach has been extensively described in the literature.[2-6] Interviewing techniques from the CASE Approach have been positively received among mental health professionals and suicidologists, substance abuse counselors, primary care clinicians, clinicians in the correctional system, legal experts, military/VA mental health professionals, and psychiatric residency directors.[7-26] A free training monograph on how to teach the CASE Approach to psychiatric residents and other mental health professionals as well as an article emphasizing the importance of incorporating training in uncovering suicidal ideation in clinical interviewing courses for psychiatric residents and other mental health disciplines has appeared in the literature.[27,28]

Organizationally, the CASE Approach is a recommended practice by organizations as diverse as Magellan and the government of British Columbia.[29,30] It is routinely taught as one of the core clinical courses provided at the annual meeting of the American Association of Suicidology (AAS).[31] It is also one of the techniques described in the 1-day Assessing and Managing Suicide Risk (AMSR) course cosponsored by the Suicide Prevention and Resource Center and the AAS and in the 2-day Recognizing and Responding to Suicide Risk course sponsored by the AAS.[32,33]

The question of validity

The noted social scientist Thomas Kuhn once quipped, "The answers you get depend upon the questions you ask."[34] In no clinical task is this more self-evident than in the elicitation of suicidal ideation, which remains—excluding that subset of patients with characterological disorder who may garner comfort through talk of suicide—one of the most taboo topics in our culture.

Helping patients share this sensitive material in a valid manner becomes one of the cornerstones of the art of eliciting suicidal ideation. Excellent lists of potentially useful questions for uncovering suicidal ideation exist.[35] It is important to contemplate not only what material needs to be asked but also what the impact of the phrasing of such questions is on the validity of the data received.

The problem of maximizing validity was addressed in the development of the CASE Approach by returning to the core clinical interviewing literature where specific "validity techniques"—created to uncover sensitive and taboo material such as incest and substance abuse—had been described in detail. These techniques were designed by experts in various disciplines, including psychiatry, clinical psychology, and counseling.

Validity techniques are used throughout the CASE Approach and emphasize not only the impact of what we ask, but of how we ask it. Consequently, to understand the practical use of the CASE Approach it is first important to review those validity techniques used to sensitively raise the topic of suicide and also those used to explore the patient's suicidal planning and behaviors once the topic has been raised.

Two validity techniques for sensitively raising the topic of suicide

Before one can explore a patient's suicidal ideation, the topic must first be addressed. Sometimes patients do so spontaneously. In other instances, the interviewer must raise the topic in a fashion that is both engaging and likely to foster open sharing. Two validity techniques may prove to be of value here: normalization and shame attenuation.

Normalization (the process of normalizing the topic for the patient) is an unobtrusive method of raising the issue of suicide.[3] The clinician can relate that he or she has had patients who were undergoing pains and/or stresses similar to those of the current interviewee and share that they had experienced suicidal thoughts. The clinician might say, "You know, Mike, some of my patients, when they are feeling as

stressed out and depressed as you have been feeling, tell me that they sometimes get thoughts of killing themselves. I'm wondering if you've been having any thoughts like that recently?" or simply "Sometimes when people feel as much pain as you are feeling, they have thought of killing themselves, has that happened to you?"

A related but slightly different method is to use the validity technique called shame attenuation.[3] With normalization, the patient is always asked to look at what other people have felt. With shame attenuation, the patient's own pain is used as the gateway to the topic of suicide. The clinician might ask, "Considering all of the pain you've been feeling in the past couple of weeks, I'm wondering if you have had any thoughts of killing yourself?"

Both techniques are effective and engaging. Whichever one feels most comfortable to the interviewer and/or may be best suited for a specific patient can be used. Sometimes patients who may be feeling awkward about having suicidal ideation (secondary to stigmatization) may respond particularly well to the reassurance that other people have had such feelings. If the patient denies any suicidal ideation, ask a second time, softening the second inquiry by asking for even subtle suicidal ideation, "Have you had fleeting thoughts of suicide, even for a moment or two?" Sometimes the answer is surprising, and it may prompt hesitant patients to begin sharing the depth of their pain and the extent of their ideation.

Four cornerstone validity techniques used to explore the extent of suicidal ideation

The following four validity techniques although not developed with suicide assessment per se in mind, form the cornerstones of the CASE Approach:

- Behavioral incident
- Gentle assumption
- Symptom amplification
- Denial of the specific

These techniques were devised to increase the likelihood of eliciting a valid response to any question that might raise sensitive or taboo material for the patient.

The techniques were created to help clinicians explore traditionally sensitive histories, including sexual abuse, physical and psychological abuse, alcohol and drug use, and violence and antisocial behavior. Consequently, in addition to being useful in eliciting suicidal ideation, these validity techniques are "the bread and butter" of busy mental health professionals, substance abuse counselors, crisis line workers and counselors, and primary care clinicians whose patients often have sensitive issues they hesitate to discuss.

Behavioral incident

A patient may provide distorted information for any number of reasons, including anxiety, embarrassment, protecting family secrets, unconscious defense mechanisms, or conscious attempts at deception. These distortions are more likely to appear if the interviewer asks a patient for opinions rather than behavioral descriptions of events.

Behavioral incidents, originally described by Gerald Pascal,[36] are questions that ask for specific facts, behavioral details, or trains of thought (called fact-finding behavioral incidents), such as, "How many

pills did you take?" or that simply ask the patient what happened sequentially (called sequencing behavioral incidents), such as, "What did she say next?" or "What did your father do then?" By using a series of behavioral incidents, the interviewer can sometimes help a patient enhance validity by re-creating, step by step, the unfolding of a potentially taboo topic such as a suicide attempt.

As Pascal states, it is generally best for clinicians to make their own clinical judgments on the basis of the details of the story itself rather than relying on patients to proffer "objective opinions" on matters that have strong subjective implications. The following are prototypes of typical behavioral incidents:

- Did you put the razor blade up to your wrist? (fact-finding behavioral incident)
- How many bottles of pills did you actually store up? (fact-finding behavioral incident)
- When you say that "you taught your son a lesson" what did you actually do? (fact-finding behavioral incident)
- What did your father say right after he hit you? (sequencing behavioral incident)
- Tell me what happened next? (sequencing behavioral incident)

Clinical caveat: Behavioral incidents are outstanding at uncovering hidden information, but they are time-consuming. For instance, the time it would take to do a full initial intake only using behavioral incidents would be impractical. Obviously, the interviewer must pick and choose when to employ behavioral incidents, with a heavy emphasis on use when sensitive areas such as drug abuse, domestic violence, and suicide assessment are at issue.

Gentle assumption

Gentle assumption (originally delineated by Pomeroy and colleagues[37] for use in eliciting a valid sex history) is used when a clinician suspects that a patient may be hesitant to discuss a taboo behavior. With gentle assumption, the clinician assumes that the potentially embarrassing or incriminating behavior is occurring and frames his question accordingly, in a gentle tone of voice.

Questions about sexual history, such as, "What do you experience when you masturbate?" or "How frequently do you find yourself masturbating?" have been found to be much more likely to yield valid answers than, "Do you masturbate?" If the clinician is concerned that the patient may be potentially disconcerted by the assumptive nature of the question, it can be softened by adding the phrase "if at all" (eg, "How often do you find yourself masturbating, if at all?"). If engagement has gone well and an appropriate tone of voice is used, patients are seldom bothered by gentle assumptions. The following are prototypes of gentle assumption:

- What other street drugs have you ever tried?
- What other types of vandalism have you been involved in?
- What kinds of problems have you ever had at work?
- What other ways have you thought of killing yourself?

Clinical caveat: Gentle assumptions are powerful examples of leading questions. The clinician must use them with care. They should not be used with patients who may feel intimidated by the clinician or with

patients who are trying to provide what they think the clinician wants to hear. For instance, they are inappropriate with children when uncovering abuse histories because they could potentially lead to false memories of abuse.

Denial of the specific

After a patient has denied a generic question, it is surprising how many positives will be uncovered if the patient is asked a series of questions about specific entities. This technique appears to jar the memory, and it also appears to be harder to falsely deny a specific as opposed to a generic question.[3] Examples of denial of the specific, concerning drug use, would be: "Have you ever tried cocaine?" "Have you ever smoked crack?" "Have you ever used crystal meth?" and "Have you ever dropped acid?" The following are prototypes of denial of the specific:

- Have you thought of shooting yourself?
- Have you thought of overdosing?
- Have you thought of hanging yourself?

Clinical caveat: It is important to frame each denial of the specific as a separate question, pausing between each inquiry and waiting for the patient's denial or admission before asking the next question. The clinician should avoid combining the inquiries into a single question, such as, "Have you thought of shooting yourself, overdosing, or hanging yourself?" A series of items combined in this way is called a "cannon question." Such cannon questions frequently lead to invalid information because patients only hear parts of them or choose to respond to only one item in the string—often the last one.

Symptom amplification

This technique is based on the observation that patients often minimize the frequency or amount of their disturbing behaviors, such as the amount they drink or the frequency with which they gamble. Symptom amplification bypasses this minimizing mechanism: it sets the upper limits of the quantity in the question at such a high level that the clinician is still aware that there is a significant problem when the patient downplays the amount.[3] For a question to be viewed as symptom amplification, the clinician must suggest an actual number.

For instance, when a clinician asks "How much liquor can you hold in a single night. . . a pint? a fifth?" and the patient responds, "Oh no, not a fifth, I don't know, maybe a pint," the clinician is still alerted that there is a problem despite the patient's minimizations. The beauty of the technique lies in the fact that it avoids the creation of a confrontational atmosphere, even though the patient is patently minimizing behavior. It always involves the interviewer suggesting a specific number, set high.

It is worth repeating that symptom amplification is used in an effort to determine an actual quantity and it is only used if the clinician suspects that the patient is about to minimize. It would not be used with a client who wanted to "maximize," as with an adolescent who might want to give the impression that he is a "big-time drinker." The following are examples of symptom amplification.

- How many physical fights have you had in your whole life . . . 25, 40, 50?
- How many times have you tripped on acid in your whole life . . . 25, 40, 100 times or more?

• On the days when your thoughts of suicide are most intense, how much of your time do you spend thinking about killing yourself . . . 70% of your waking hours, 80%, 90%?

Clinical caveat: The clinician must be careful not to set the upper limit at such a high number that it seems absurd or creates the appearance that the interviewer doesn't know what he or she is talking about.

The macrostructure of the CASE Approach: avoiding errors of omission

The patient's history of suicidal ideation and actions can appear, at first glance, as a sprawling hodgepodge of details spanning the patient's life. The gathering of this vital information in a short period while attending to the delicate issues regarding patient engagement is a daunting task.

Besides invalid data, the other major problem for the front-line clinician is missing puzzle pieces, ie, errors of omission. A 2-part question faced the developers of the CASE Approach, "Why do interviewers frequently miss important data while eliciting suicidal ideation? Is there a way to decrease such errors of omission?"

The answers lie in a field of study known as facilics. Facilics is the study of how clinicians effectively structure interviews and has given rise to the supervision method known as "facilic supervision." This is a supervision system designed to train clinicians to uncover a comprehensive database while ensuring that the patient feels that he has been talking with a caring clinician rather than "being interviewed" by some guy with a clipboard.

From a technical standpoint, facilics is the study of how clinicians structure interviews, explore databases, make transitions, and use time. Over the past 20 years, facilic supervision has become a popular tool.[3,28,38,39] It is used to train psychiatric residents and clinicians across disciplines to efficiently and sensitively perform an initial interview—including a *DSM-IV-TR* differential and a bio-psycho-social-spiritual overview.[40]

According to facilic principles, clinicians tend to make more errors of omission as the amount and range of required data increase. Errors of omission decrease if the clinician can split a large amount of data into smaller, well-defined regions. With such well-defined and limited data regions, the interviewer can more easily recognize when a patient has wandered from the subject. The clinician is also more apt to easily track whether the desired inquiry has been completed and does not feel as overwhelmed by the interview process.

If the desired data within each region is logically chosen, the databases make innate sense to the interviewer and require little memorization. Such a simplified interview format is easily learned and hard to forget, and it provides a reliable interview strategy available on a consistent basis no matter how stressed the clinician may feel.

These principles are applied to the elicitation of suicidal ideation by organizing the sprawling set of clinically relevant questions into 4 smaller and more manageable regions. The regions represent 4 contiguous time frames from the distant past to the present, hence the name "chronological." In each region the clinician investigates the suicidal ideation and actions present during that specific time frame. Generally, each region is explored thoroughly before moving to the next; the clinician consciously chooses not to move with a patient's tangential wandering unless there is a very good reason to do so. In the description below, the term "suicide events" can include any of the following: death wishes, suicidal feelings and thoughts, planning, behaviors, desire, and intent.

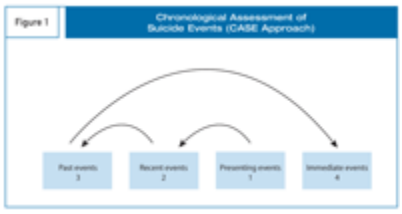
In the CASE Approach (**Figure 1**) the clinician sequentially explores the following 4 chronological regions in this order:

1. Presenting suicide events (past 48 hours)

2. Recent suicide events (over the preceding 2 months)

3. Past suicide events (from 2 months ago back in time)

4. Immediate suicide events (suicidal feelings, ideation, and intent that arise during the interview itself)



The sequencing of the regions shown in **Figure 1** was specifically designed to maximize both engagement and the validity of the obtained data. For most patients, once the topic of suicide has been raised, it seems natural to talk about the presenting ideation or attempt, if one exists, first. Following this exploration, it is easy for the interviewer to make a natural progression into recent ideation followed by past suicide events.

When performed sensitively by the interviewer, explorations of the 3 time frames before the interview generally improve both engagement and trust as the patient realizes that it is okay to talk about suicidal ideation. Once trust has been maximized, it is hoped that this positive alliance will increase the likelihood of the patient sharing valid information. It is then an opportune time to explore suicidal ideation and intentions that are being experienced by the patient during the interview itself, a critically important area of a suicide assessment. Here, the most subtle nuances of facial expression or hesitancy of speech may indicate that a suicide attempt is imminent.

The microstructure of the CASE Approach: exploring specific time frames

When exploring each of the 4 time frames, the CASE Approach addresses 2 complementary aspects of interviewing strategy: (1) Which data are important to gather in this time frame? (2) Which specific validity techniques may be the most valuable for uncovering the desired data and what sequence may enhance their effectiveness?

In this article, a brief but illustrative overview of the exploration of each time frame is presented. This overview emphasizes the required database for each region. In two of the regions—presenting suicide events and recent suicide events—the second aspect, concerning the actual choice of validity techniques and their sequencing, will be delineated in full, including a reconstructed dialogue of the techniques put into action.

For the interested reader, an article that details the recommended interviewing techniques and sequencing for all 4 time frames of the CASE Approach can be found at the TISA Web site (http://www.suicideassessment.com). A word-for-word annotated transcript of the entire CASE Approach used in a patient with a complicated presentation is also available.[2]

Step 1: The exploration of presenting suicide events

Whether the patient spontaneously raises the topic of suicide or the topic is sensitively uncovered with techniques such as normalization or shame attenuation, if the suicidal events are active during the previous 2 days' time, they are viewed as "presenting events," in the sense that the patient has been

"currently" experiencing them. If a patient presents with such current suicidal behavior or with pressing suicidal ideation, it becomes critical to understand their severity. Depending on the severity of the ideation or attempt, the patient may require hospitalization or further crisis intervention. Moreover, the clinician's formulation of the patient's immediate risk will determine the urgency of recommended follow-up, whether this triage is made from an ED or from a crisis hotline.

But what specific information would give the clinician the most accurate picture of the seriousness of presenting suicidal thought or behavior? The answer seems to lie in entering the patient's world at the time of the suicidal ideation, to find out exactly how close the patient came to attempting or completing suicide. If there was indeed an attempt, then answers to the following questions can provide valuable information:

- How did the patient try to commit suicide? (What method was used?)

- How serious was the action taken with this method? (If the patient overdosed, what pills and how many were taken? If the patient cut himself, where was the cut, and did it require stitches?)

- How serious were the patient's intentions? (Did the patient tell anyone about the attempt afterwards? Did the patient hint to anyone beforehand? Did the patient make the attempt in an isolated area or in a place where he or she was likely to be found? Did the patient write a will, check on insurance, write suicide notes, or say good-bye to significant others in the days preceding the event? How many pills were left in the bottle?)

- How does the patient feel about the fact that the attempt was not completed? (A very good question here is "What are some of your thoughts about the fact that you are still alive now?")

- Was the attempt well planned or an impulsive act?

- Did alcohol or drugs play a role in the attempt?

- Were interpersonal factors a major role in the attempt? These factors might include feelings of failure or speculation that the world would be better off without the patient, as well as anger toward others (a suicide attempt undertaken to make others feel pain or guilt).

- Did a specific stressor or set of stressors prompt the attempt?

- At the time of the attempt, how hopeless did the patient feel?

- Why did the attempt fail? (How was the patient found, and how did the patient finally get help?)

Answers to such questions can provide invaluable information regarding how serious the patient's attempt was, reflecting the patient's true intent to die, no matter what the patient's stated intent may be. Statistical risk factors will not reveal whether a given patient intended death or not. Aside from patients who may accidentally kill themselves when not intending to die (ie, perhaps acute intoxication has so clouded the patient's consciousness that he or she becomes unaware of how many pills have been ingested), in most instances people kill themselves because they have decided to do so. Suicide is not only an act of the heart but an act of the mind—a cognitive decision.

If no actual attempt has been made in the past 48 hours, then it is the reflected intent—the extent of suicidal desire, ideation, planning, and procurement of means—that will help the clinician determine the triage (inpatient versus outpatient) and rapidity of follow-up if outpatient care is recommended. This

information is coupled with what has been uncovered regarding risk factors, protective factors, and warning signs in other areas of the interview in determining safe disposition and follow-up whether seeing the patient in a clinic or ED, or listening to the patient on a crisis line.

For these reasons, it is useful to find answers to the questions described above if an attempt has occurred, or if one has not, a detailed uncovering of suicidal ideation and reflected intent is helpful. At first glance, especially for a clinician in training, this list of questions may appear intimidating to remember. Fortunately, one of the validity techniques discussed earlier—the behavioral incident—can provide the clinician with a simpler and more logical approach than memorization. The reader will recall that behavioral incidents are used when the clinician asks for a specific piece of data (eg, "Did you put the gun up to your head?") or asks the patient to continue a description of what happened sequentially (eg, "Tell me what you did next").

In the CASE Approach, during the exploration of the presenting events, the interviewer asks the patient to describe the suicide attempt or ideation itself from beginning to end. During this description the clinician gently, but persistently, uses a series of behavioral incidents guiding the patient to create a "verbal videotape" of the attempt, step by step. Readers familiar with cognitive behavioral therapy (CBT) and dialectical behavioral therapy will recognize this strategy as one of the cornerstone assessment tools—behavioral analysis.

If the patient begins to skip over an important piece of the account, the clinician gently stops the patient. The clinician "rewinds the videotape" by asking the patient to return to where the gap began. The clinician then uses a string of behavioral incidents from that point forward to fill in the gap, until the clinician feels confident that he has an accurate picture of what happened.

This serial use of behavioral incidents not only increases the clinician's understanding of the extent of the patient's intent and actions, it also decreases any unwarranted assumptions by the clinician that may distort the database. Creating such a verbal videotape, the clinician will frequently cover all of the material described above in a naturally unfolding conversational mode, without much need for memorization of what questions to ask when.

The serial use of behavioral incidents can be particularly powerful at uncovering the extent of action taken by the patient regarding a specific suicide plan, an area in which patients frequently minimize. For example, the series may look something like this in a patient who actually took some actions with a gun: "Do you have a gun in the house?" "Have you ever gotten the gun out with the intention of thinking about using it to kill yourself?" "When did you do this?" "Where were you sitting when you had the gun out?" "Did you load the gun?" "What did you do next?" "Did you put the gun up to your body or head?" "Did you take the safety off or load the chamber?" "How long did you hold the gun there?" "What thoughts were going through your mind then?" "What did you do then?" "What stopped you from pulling the trigger?"

In this fashion, the clinician can feel more confident at obtaining a valid picture of how close the patient actually came to committing suicide. The resulting scenario may prove to be radically different—and more suggestive of imminent danger—from what would have been assumed if the interviewer had merely asked, "Did you come close to actually using the gun?" to which an embarrassed or cagey patient may quickly reply, "Oh no, not really." Once again, an example of reflected intent being potentially more accurate than the patient's stated intent.

Also note, in the above sequence, the use of questions such as, "When did you do this?" and "Where were you sitting when you had the gun out?" These types of questions, also borrowed from CBT, are known as "anchor questions" for they anchor the patient into a specific memory as opposed to a

collection of nebulous feelings. Such a refined focus will often bring forth more valid information as the episode becomes both more real and more vivid to the patient.

The exploration of presenting suicide events can be summarized as follows. The clinician begins with a question, such as, "It sounds like last night was a very difficult time. It will help me to understand exactly what you experienced if you can sort of walk me through what happened step by step. Once you decided to kill yourself, what did you do next?"

As the patient begins to describe the unfolding suicide attempt, the clinician uses 1 or 2 anchor questions to maximize validity. The interviewer then proceeds to use a series of behavioral incidents, making it easy to picture the unfolding events—the "verbal videotape." The strategy and the metaphor of making a verbal video tape has been quite popular with residents and graduate students, as well as front-line staff, for the clinical task seems clear and is easily remembered even at 3 am in a busy ED. The best way to further our understanding of exploring the region of presenting events using the CASE Approach is to see the strategy in action.

Clinical illustration of Step 1: exploring the region of presenting suicide events (past 48 hours)

Frank Thompson is a good soul. He is also a tired soul. He commented to the charge nurse, "I've had a good life, I don't know, maybe it's just time to pass on." Frank has been a farmer in the rolling hills of western Pennsylvania for over 5 decades. His dad was a farmer. His grandfathers were both farmers. He was married to a wonderful woman, Sally, for 50 years. She died of brain cancer 2 years ago. Frank is plagued by diabetes and moderately severe heart and lung disease from having sucked on far too many cigarettes for far too many years. He occasionally uses oxygen to help with his labored breathing. Frank has had 7 hospitalizations since Sally died. Since her death, he has developed a mild drinking problem. On top of it all, there is a chance that he is going to lose his farm to foreclosure.

Frank has 5 children and 21 grandchildren and a pack of great grandkids to boot. His children are supportive, but only 1 lives nearby—Nick. It is Nick who has brought his dad in to the ED. Nick received a call from his dad earlier in the morning that he wasn't doing well. Nick got off work early and was caught off-guard by the depressive look of his father. Later during the night, while the two of them were sitting on the front porch, his dad shared a secret that prompted Nick to get in the car and bring him down to the ED immediately. Apparently, his dad had taken a handful of aspirin and some antibiotics 2 days ago.

We are picking up this interview about 20 minutes deep, where the clinician is about to enter the region of presenting events using the CASE Approach:

Patient: It's been a long haul over the past 2 years. Sometimes too long a haul, if you know what I mean. I'm way too old for all this crap.

Clinician: And it's got to be hard to do it alone.

Patient: You bet! With Sally gone it's all so very different.

Clinician: I'm sure the pain of her loss is beyond words. With that amount of pain on board, Mr Thompson, have you had any thoughts of killing yourself? (shame attenuation used to gently raise the topic of suicide)

Patient: I suppose my son may have already said something to you. . . . I took some pills . . . I know it was dumb, but nothing came of it anyway.

Clinician: When was that? (behavioral incident)

Patient: Couple of nights ago. But like I said, nothing came of it. I'm not sure I need any help. I'm not going to do anything stupid, you don't have to worry about that. (Note that the clinician is not going to take the clients "stated intent" as necessarily an accurate picture of his real intent. Instead, the clinician is going to uncover Mr Thompson's reflected intent by weaving a verbal videotape using behavioral incidents.)

Clinician: You know what, Mr Thompson . . . that may be true, but I just want to get a better feeling for what you've been going through so we can make a wise decision together. Where were you when you took the pills? (behavioral incident serving as an anchor point)

Patient: In the kitchen. I was sitting in a little kitchen nook where Sally and I used to eat lunch. I always loved that little place.

Clinician: (gently smiling) Yea, I bet it brings back warm memories of Sally.

Patient: (smiling back) Yea, it does.

Clinician: What kind of pills did you take? (behavioral incident)

Patient: Some aspirin, some penicillin.

Clinician: How much did you take of each one? (behavioral incident)

Patient: About a handful of each. (Note that there can be quite a difference in what a patient means by a "handful." It is a perfect time to clarify with a behavioral incident.)

Clinician: When you say a handful, how many of each do you mean? (behavioral incident)

Patient: About 10 of each.

Clinician: Any other pills?

Patient: (pause) I also took about 5 digoxin I'm on, more than I'm supposed to, I know that. (This is a fact that the son was unaware of and had not reported to the clinician.)

Clinician: Did you have any pills left? (behavioral incident)

Patient: Not a lot, I don't keep many pills in the house and my prescriptions have basically run out.

Clinician: Did you look for any other pills? (behavioral incident)

Patient: (pause) Not really pills (pause) I did go through the drawer wondering if there was any rat poison around, but I realized that was stupid too. (pause) Trust me, suicide is not the answer, God did not put us on this earth to kill ourselves. (Unexpected information is coming to the surface. Clearly, the son has not been told everything. The searching for the rat poison reflects more suicidal intent than might be expected from phrases like, "God did not put us on this earth to kill ourselves.")

Clinician: I'm glad you feel that way. And maybe we can help some too. At least I hope so.

Patient: Maybe.

Clinician: You know, right after you took the pills, what was the next thing you did. (sequencing behavioral incident)

Patient: Went to bed, just to sort of to see what would happen? I was just so tired of it all.

Clinician: How did you feel about the fact that you woke up okay?

Patient: I don't know. Sort of didn't care. It's just the way it is.

Clinician: Had you been drinking at all, even a little bit? (behavioral incident)

Patient: Nope. I'm trying to lay off the stuff. It just gets me more depressed. Don't get me wrong, I'm still drinking, but not over the past couple of days. (Notice that the clinician does not pursue a complete drug and alcohol history here; this will be carefully delineated as a risk factor in a different section of the interview or may have already been done.)

Clinician: I know from your son that you called him the next day. Had you tried any other ways of killing yourself before you called him?

Patient: Nope. I just thought I needed a rest of some sort, and I wanted to talk it all over with Nick.

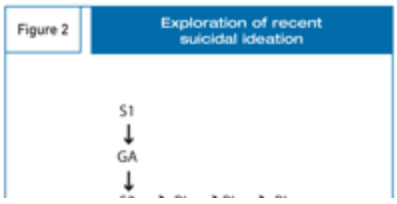
Clinician: Good. How about over the past couple of months, have you had any other thoughts of overdosing? (behavioral incident, the clinician is gracefully moving into the region of recent suicide events with a bridging question)

Step 2: The exploration of recent suicide events

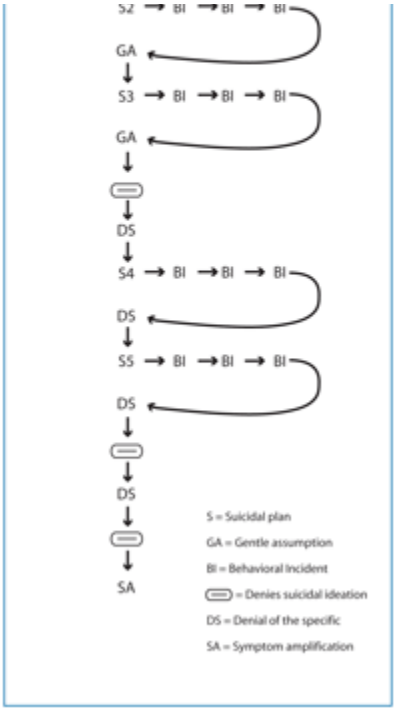
The region of recent events may very well represent—from the perspective of motivational theory—the single richest arena for uncovering reflected intent. It is here that with an ambivalent patient or with a patient who strongly wants to die and is hesitant to share his real intent for fear of what will happen (possible hospitalization, involuntary commitment, or removal of a method of choice) that a skilled interviewer may uncover ideation and planning that provide a more accurate indication of the patient's real intent, which is being consciously withheld.

It is also the arena when, with a patient whose unconscious defense mechanisms may be minimizing their conscious awareness of the intensity of their real suicidal intent, a more accurate picture of the patient's intent may emerge. Specifically, the patient's actions taken toward procuring a method of suicide and/or the amount of time spent preoccupied with suicide may betray the severity of the patient's real intent better than his or her stated intent would suggest. In my opinion, the ability to explore effectively the region of recent suicide events represents one of the most critical of all clinical interviewing skills for mental health professionals to master. It is also the region of the CASE Approach where all 4 of the cornerstone validity techniques are put to strategic use. Consequently, it warrants some careful delineation.

Sometimes when the clinician raises the topic of suicide with techniques such as normalization or shame attenuation, the patient's reported events do not lie within the previous 2 days' time (in essence there are no presenting events), in which case the clinician immediately begins exploring the region of recent events. On the other hand, if the patient



had reported a true presenting event, the clinician would have needed to make a bridging statement to transition into the recent suicide events after having explored the presenting event in detail (**Figure 2**). Often this is initiated by smoothly eliciting any thoughts in the past 2 months related to the same plan that the patient discussed in the presenting events. Once recent thoughts or actions regarding the same method have been explored, a gentle assumption is used to look for a second suicide method. My favorite gentle assumption is the simplest one, "What other ways have you thought of killing yourself?"



If the same plan was also contemplated or a second method is uncovered, sequential behavioral incidents are used to create another verbal videotape reflecting the extent of action taken with this new method. The interviewer continues this use of gentle assumptions, with follow-up verbal videotapes as indicated with each newly uncovered plan, until the patient denies any other methods when asked, "What other ways have you thought of killing yourself?"

Once the use of a gentle assumption yields a blanket denial of other methods, if, and only if, the clinician feels that the patient may be withholding other methods of suicide, the clinician uses a short series of denials of the specific. The interviewer must use his or her clinical judgment to decide whether or not the use of denials of the specific is indicated. None would be warranted if the patient had low risk factors, had high protective factors, and had reported minimal or no suicidal ideation to that point in the interview. On the other hand, if the clinician's intuition was suggesting that this particular patient may be withholding critical suicidal ideation or planning, then denials of the specific could be employed. This technique can be surprisingly effective at uncovering previously withheld suicidal material. The interviewer doesn't drive this technique into the ground with an exhaustive series of methods but simply asks for any unmentioned methods that are common to the patient's culture and of which the clinician is suspicious that this specific patient might be withholding.

By way of example, if the patient has talked about overdosing, guns, and driving a car off the road, the clinician might employ the following short list of denials of the specific, pausing after each for an answer: "Have you thought about cutting or stabbing yourself?" "Have you thought about hanging yourself?" "Have you thought about jumping off a bridge or other high place?" "Have you thought about carbon monoxide?" As before, if a new method is revealed, the clinician uncovers the extent of action taken by asking a series of behavioral incidents. It is here—with the selective and well-timed use of denials of the specific—that a highly dangerous patient, who has been purposefully withholding his method of choice, may suddenly share it, perhaps prompted by a wedge of healthy ambivalence.

After establishing the list of methods considered by the patient and the extent of action taken on each method, the interviewer hones in on the frequency, duration, and intensity of the suicidal ideation with a symptom amplification. He might ask, for example, "Over the past 2 months, during the days when you were most thinking about killing yourself, how much time did you spend thinking about it . . . 70% of your waking hours, 80%? 90%?"

The strategy for exploring the suicidal history of the past 2 months is easy to learn and simple to remember. It also flows imperceptibly for the patient, frequently increasing engagement as the patient is pleasantly surprised at how easy it is to talk to the clinician about issues that had frequently been

shouldered as a topic of shame. It also becomes apparent from the questioning that the interviewer is quite comfortable talking about suicide and has clearly discussed it with many others. This represents yet another shame-reducing metacommunication.

With each bit of information, the clinician is invited deeper and deeper into the patient's unique world. A clearer and clearer picture emerges of how serious the patient's suicidal planning has become; this may better reflect the real intent than the patient's stated intent. Moreover, a sound database has been collected for future clinicians that can alert them to the types of methods the patient frequently contemplates and it can also serve as a method of assessing the patient's current credibility as a historian as discussed in **Part 1** of this series.

There is no better way to illustrate the power of this strategy than to see it directly at work with Mr Thompson. The skilled interviewing has already uncovered information that suggests that Mr Thompson's real intent may be higher than his stated intent would suggest. Moreover, his list of risk factors is high and his support system other than his nearest son have been markedly weakened by the loss of his wife. The fact that he is wrestling with the notion that it is "wrong" to kill oneself may be creating both ambivalence (good) and a skewed self-admission as to the depth of his suicidal desire and intent (bad), because unconscious defense mechanisms could be protecting him from viewing himself as a bad person by minimizing the severity of his real intent.

Notice that the clinician is quite explicit with the time frame, stating the exact duration as opposed to using a vague term such as "recently." This specificity is important because it helps the patient remain focused on the desired time frame while decreasing time-wasting sidetracks.

Patient: Nope. I just thought I needed a rest of some sort, and I wanted to talk it all over with Nick.

Clinician: Good. How about over the past couple of months, have you had any other thoughts of overdosing? (behavioral incident, the clinician is gracefully moving into the region of recent suicide events with a classic bridging question)

Patient: A few times but I never got no pills out or something.

Clinician: What other ways have you thought about killing yourself? (gentle assumption)

Patient: Oh not much. . . . I suppose I thought about hangin' myself, but that is not a good way to die. You know, it doesn't always work, at least that's what I been told.

Clinician: Have you ever gotten a rope out or something else to use to hang yourself? (behavioral incident)

Patient: No sir, I haven't.

Clinician: What other ways have you thought about killing yourself? (gentle assumption)

Patient: Well, I have gone out to the barn to see if we still had some of that pesticide I used a couple of years ago.

Clinician: And? (variant of a sequencing behavioral incident)

Patient: Oh we did. And . . . and I was thinking about taking some and then burning the barn down with me inside it.

Clinician: Hmmm.

Patient: Yea (pause) sort of Hollywoodish (smiles) but it's no good, way too apt to not work out right.

Clinician: How often did you go out to the barn thinking about that? (behavioral incident)

Patient: Maybe 4 or 5 times, I don't really remember exactly.

Clinician: What other ways have you thought of killing yourself? (behavioral incident)

Patient: That's about it. Nothing else really.

The CASE Approach is doing exactly what it is supposed to be doing . . . getting those puzzle pieces out on the table that might better reflect the severity of Mr Thompson's suicidal intent in the recent past. The resulting information is a bit surprising. The use of the gentle assumptions has resulted in a method (pesticides and burning down the barn) that quite frankly the clinician would not have thought to ask about. Gentle assumptions allow patients to provide such individualized plans that may never have come to the clinician's awareness had gentle assumptions not been used. The number of times Mr Thompson went to the barn is also disturbing. Despite his ability to still retain a sense of humor, the depth of his angst is becoming more and more apparent.

Note that Mr Thompson has now flat-out denied any other methods when presented with a gentle assumption. "What other ways have you thought about killing yourself?" The clinician is about to use a short string of denials of the specific. His persistence is prompted by the presence of high risk factors, the clear depth of Mr Thompson's anguish, and by the fact that during the exploration of presenting events, and thus far in the exploration of recent events, details are being uncovered that Mr Thompson had not shared earlier. In addition, there was one other fact that seems odd to the clinician:

Clinician: What about carbon monoxide, you know, with a car or tractor? (denial of the specific)

Patient: My old barn is so drafty, you couldn't do that if you tried (smiles weakly)

Clinician: Have you thought of jumping off a building or bridge? (denial of the specific)

Patient: Nope.

Clinician: You know, Mr Thompson, most farmers I know like to hunt or at least have a gun around to protect their animals, and sometimes when they are in a lot of pain like you've been having they think of shooting themselves, I'm wondering if that has crossed your mind? (denial of the specific introduced with a normalization)

Patient: (long pause, looks away ever so slightly) I suppose.

Clinician: Did you ever picture a place where you might shoot yourself? (behavioral incident)

Patient: There is a place down by Willow Creek that was the favorite place that Sally and I used to go. (pause) It's just lovely, even in the winter it's lovely. (sigh) And I've often thought that if I had to go, that's where I would do it.

Clinician: Did you ever go there with a gun, thinking you might kill yourself? (behavioral incident)

Patient: Yea, (pause) yea, I've done that.

Clinician: Did you load the gun? (behavioral incident)

Patient: Yea.

Clinician: What did you do next? (sequencing behavioral incident)

Patient: Put it in my mouth. I read somewhere that's how you should do it. (pause) Someone told me once they knew a guy who did that but didn't point it upwards so the darn thing shot right out the back of his neck (slight chuckle) hard to believe (shakes his head).

Clinician: Sounds like you were pretty close though.

Patient: Yea. Yea. I guess I was.

Clinician: Was the safety off? (behavioral incident)

Patient: Yea. (looks down)

Clinician: (said very gently) You really miss her don't you?

Patient: (patient bursts into tears) Oh God, I miss her. She made my world. She was my world.

Clinician: What made you put the gun down, Mr Thompson? (behavioral incident)

Patient: I don't really know. Maybe I thought I should be around for all my grandkids, but I just don't know anymore.

Clinician: Mr Thompson, roughly when was this? (behavioral incident)

Patient: About 2 weeks ago.

Clinician: Right around then, when things were really tough, how much time were you spending thinking about killing yourself, 70% of your waking hours, 80%, 90%? (symptom amplification)

Patient: (Lifts head up and looks the clinician right in the eye) The truth is—I couldn't get it out of my mind.

This interviewer is earning his pay. He may also be saving Mr Thompson's life. Mr Thompson's intent to kill himself is much higher than his originally stated intent implied. In addition, it was only through the skilled use of a denial of the specific that the patient's true method of choice emerged. With this added information reflecting the potential seriousness of Mr Thompson's suicidal intent, hospitalization appears to be more appropriate, and there is now an opportunity to have the gun removed from the farmhouse as well.

The CASE Approach is built to uncover pieces of the puzzle that enhance the likelihood that our clinical formulation of risk will be more accurate. Some of the pieces of the puzzle will alert the clinician to the possible dangerousness of the patient (as seen with Mr Thompson) and others may point to the patient's

safety. It is not the domain of this article to discuss the way these pieces are used for clinical formulation—the third task of a suicide assessment. We are interested in the power of the interviewing techniques to uncover the pieces in the first place.

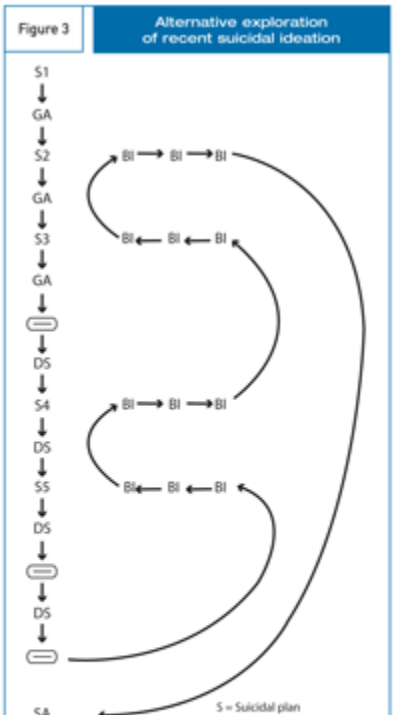
Also note that the interview strategy has uncovered clear-cut grounds for an involuntary commitment. The behavioral specificity of the CASE Approach is ideal for uncovering grounds for commitment. In this instance, the newly uncovered information serves to alert us to the intensity of the patient's intent, which even if it has settled a bit could easily be rekindled to a dangerous level in a day or two, merely by the power of his grief or perhaps by news of a foreclosure with a subsequent return to drinking.

From the perspective of interviewing technique, notice that once the use of a gun was uncovered, the clinician deftly used a series of behavioral incidents to create a verbal videotape of what actually happened. Fact-finding behavioral incidents such as, "Did you load the gun?" and sequencing behavioral incidents such as, "What did you do next?" provided concrete information regarding the seriousness of Mr Thompson's intent.

Also note that the string of behavioral incidents led the patient to remember and describe his inner world at the time of the gun incident. This is a common phenomenon—a rather beneficial side effect of the behavioral incident technique. The technique is designed to improve the validity of hard behavioral data, but as patients begin to re-imagine their experiences, they are often drawn into their internal cognitions and emotions at the time as well. This often provides a window into the soul of the patient. Within the soul, we may find strong reasons to live or, as with Mr Thompson, a shattered soul where there seems to be only good reasons to die as reflected by his telling comment, "She was my world." It is exactly this type of important puzzle piece, which may not spontaneously emerge in an interview, that interview strategies such as the CASE Approach are designed to gently coax to the surface.

In short, while responding to a series of behavioral incidents, patients sometimes share the delicate arabesque that occurs as they weigh their reasons for dying against their reasons for living. As Jobes and Mann41 and others have pointed out, an understanding of a patient's reasons for living is an important aspect of suicide assessment that has traditionally not been given the attention in the literature that it warrants.

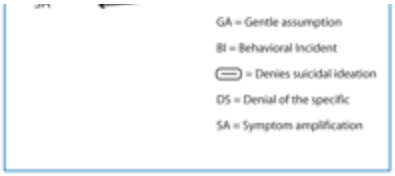
There are other ways to approach the task of exploring the region of recent events. In another method (**Figure 3**), the clinician first generates the entire list of suicide methods contemplated by the patient and then explores each one in detail.



Both strategies are easy to remember. The clinician can try both strategies or develop entirely new ones. There is no correct strategy. The goal is not to have a cookbook method of exploring recent suicidal ideation but to be comfortable with a well-practiced strategy so that one can creatively modify it to the specific needs of the clinical situation at hand.

I want to re-emphasize that the extensiveness of the questioning during the region of recent events is entirely dependent on the interviewer's ever-evolving read on the dangerousness of the patient. For example, if a client has low risk factors, has high protective factors, denies any thoughts of suicide during the exploration of presenting events, and reports only one fleeting thought of shooting himself (no gun at home) during the early exploration of the recent events, a clinician most likely

would not use denials of the specific nor symptom amplification. It would not make sense to do so and might even appear odd to the patient. The CASE Approach is flexibly sculpted to the specific needs of the patient as determined by the perceptions of the clinician.



Step 3: The exploration of past suicide events

Clinicians sometimes, during the initial interview, spend too much time on this area. Patients with complicated psychiatric histories (eg, some people with a borderline personality disorder) may have lengthy past histories of suicidal material. One could spend an hour just reviewing this material, but it would be an hour poorly spent.

Under the time constraints of busy practices and managed care, initial assessments by mental health professionals usually must be completed in an hour or less. Time is at a premium. What past suicidal history is important to gather? In the CASE Approach the interviewer seeks only information that could potentially change the clinical triage and decision about the follow-up of the patient. Thus, the following questions are worth investigating:

- What is the most serious past suicide attempt? (Is the current ideation focused on the same method? "Practice" can be deadly in this arena. Does the patient view the current stressors and options in the same light as during the most dangerous past attempt?)

- Are the current triggers and the patient's current psychopathological state similar now as to when the most serious attempts were made? (The patient may be prone to suicide following the break-up of relationships or during episodes of acute intoxication, intense anxiety, or psychosis.)

- What is the approximate number of past gestures and attempts? (Large numbers here can alert the clinician to issues of manipulation, making one less concerned, or may alert the clinician that the patient has truly exhausted all hope, making one more concerned. In either case, it is important to know.)

- When was the most recent attempt outside of the 2 months explored in Step 2? (There could have been a significant attempt within the past 6 months that may signal the need for more immediate concern.)

Step 4: The exploration of immediate suicide events

In this region, the interviewer focuses on, "What is this patient's immediate suicidal intent?'' As with previous regions, it remains important to remember that reflected intent (which might be revealed by nonverbal communications) may be a better indicator of real intent than what the patient states in his or her intent. The clinician explores any suicidal ideation, desire, and intent that the patient may be experiencing during the interview itself and also inquires whether the patient thinks he or she is likely to have further thoughts of suicide after leaving the office, ED, or inpatient unit, or gets off the phone following a crisis call. The region of immediate events also includes any appropriate safety planning. The focus of the exploration of immediate events is thus on the present and future (easily remembered as the region of Now/Next).

Exploring immediate desire (the intensity of the client's pain and desire to die) and the client's intent (the degree with which the client has decided to actually proceed with suicide) is clarified by discerning the relationship between the two, for they are not identical despite being intimately related. A patient could have intense pain with a strong desire to die yet have no intent as reflected by, "I could never do

that to my children." Conversely, over time, a patient's pain could become so intense that it overrides his or her defenses that had prevented intent, resulting in a patient who impulsively acts.

A sound starting place is the question, "Right now, are you having any thoughts about wanting to kill yourself?" From this inquiry, a variety of questions can be used to further explore the patient's desire to die, such as:

1. "How would you describe how bad the pain is for you in your divorce right now, ranging from 'It's sort of tough, but I can handle it okay' to 'If it doesn't let up, I don't know if I can go on'?"

2. "In the upcoming week, how will you handle your pain if it worsens?"

Questions such as the following can help delineate intent:

1. "I realize that you can't know for sure, but what is your best guess as to how likely it is that you will try to kill yourself during the next week from highly unlikely to very likely?"

2. "What keeps you from killing yourself?"

It is important to explore the patient's current level of hopelessness and to assess whether the patient is making productive plans for the future or is amenable to preparing concrete plans for dealing with current problems and stresses. Questions such as, "How does the future look to you?" "Do you feel hopeful about the future?" and "What things would make you feel more or less hopeful about the future?" are useful entrance points for this exploration. If not addressed in an earlier time frame, an exploration of reasons for living can be nicely introduced here with, "What things in your life make you want to go on living?"

The task of developing a safety plan is frequently facilitated by asking questions, such as, "What would you do later tonight or tomorrow if you began to have suicidal thoughts again?" From the patient's answer, one can sometimes better surmise how serious the patient is about ensuring his safety. Such a question also provides a chance for the joint brainstorming of plans to handle the reemergence of suicidal ideation. Sound safety planning often includes a series of steps that the patient will take to transform and/or control suicidal ideation if it should arise. Such planning could begin with something as simple as taking a warm shower or listening to soothing music and end with calling a crisis line or contacting a cab to return to the hospital if out on a pass.

Such questioning leads the clinician to the complex issue of whether or not "safety contracting" as opposed to "safety planning" may be of use with any specific patient. In my opinion, each patient is unique in this regard.

Safety contracting has become somewhat of a controversial topic. To understand its use in a practical sense, it is important to remember that in addition to the fact that it may metacommunicate caring and concern on the part of the interviewer, there are 2 main reasons or applications for safety contracting: (1) as a method of deterrence and (2) as a sensitive means of suicide assessment. These applications are radically different and their pros and cons are equally radically different. The intensity of the debate, in my opinion, is generated because most of what is "debated" has to deal primarily with its application as a deterrent, which has many limitations.

For instance, safety contracting may frequently be counterproductive in patients dealing with borderline or passive-aggressive pathology. With such patients, it is sometimes best to avoid the whole issue of safety contracting, because it may embroil the dyad in ineffective debates with statements such as, "I

don't know what to tell you. I guess I'm safe, but on the other hand, I can't make any guarantees. Do you know anybody who can?"

If one uses safety contracting as a deterrent, it is critical to use it cautiously. It guarantees nothing and may yield a false sense of security. Moreover it should never be done before a sound suicide assessment has been completed. Generally speaking, I believe that safety contracting as a deterrent is viewed by most suicidologists as inferior to sound safety planning, although, to date, there is no research to prove the effectiveness of safety planning as a deterrent.

The power of the patient's superego and the power of the therapeutic alliance may play significant roles in whether safety contracting, employed as a deterrent, may have use with a specific patient. I am convinced that in some patients, it may play a role in deterrence as with a patient in a long-standing therapeutic alliance, with minimal characterological pathology and a powerful superego. I have had several seasoned therapists approach me after workshops commenting that they have had patients clearly state that the safety contract functioned as a deterrent with one patient saying on a Monday after a particularly bad weekend, "The only reason I am alive today is our contract, for I couldn't do that to you. I couldn't break my word to you."

But deterrence is not the only, and, in my opinion, is not the main reason to use safety contracting. The process of contracting for safety may be more frequently useful as an exquisitely sensitive assessment tool. In this capacity, it is selectively used in a small number of patients, who have no characterological pathology, in which the interviewer is leaning toward nonhospitalization after completing a suicide assessment but is bothered either by his or her intuition that the patient is more dangerous than they have stated or analytically feels something does "not add up here." In such cases, rather than use safety planning, which has no interpersonal pressure to it, the clinician may opt to use safety contracting, in which the patient is "put on the spot" to make an agreement. Such an "interpersonal push" may prompt nonverbal leakage of hidden ambivalence or dangerous suicidal intent.

When used in this highly selective fashion, as the interviewer asks whether the patient can promise to contact the clinician or appropriate staff before acting on any suicidal ideation, the interviewer searches the patient's face, body, and tone of voice for any signs of hesitancy, deceit, or ambivalence. Here is the proverbial moment of truth. Nonverbal leakage of suicidal desire or intent at this juncture can be, potentially, the only indicator of the patient's true immediate risk.

Using the interpersonal process of safety contracting as an assessment tool, the clinician may completely change his mind about releasing a patient on the basis of a hesitancy to contract, an avoidance of eye contact, or other signs of deceit or ambivalence displayed while reluctantly agreeing to a safety contract. I vividly remember one patient, who adamantly did not want to be admitted to the hospital, whom I was about to discharge from my ED, but about whom I felt intuitively something was askew despite a careful suicide assessment. I decided to employ safety contracting as an assessment tool. When I asked whether he could promise to call us before ever acting on any suicidal ideation, he hesitated and briefly glanced down. When I pointed out that it looked hard for him to make the contract, he welled up and said, "I just want to die." I commented, "You know, I think we should bring you into the hospital," at which point he looked at me and said, with a pained foreboding "You probably should." It was a chilling moment. He then agreed to be admitted.

The interviewer who notices such nonverbal clues of ambivalence can simply ask, "It looks as though this contract is hard for you to agree to. What's going on in your mind?" The answers can be benign or alarming (as above) and the resulting piece of the puzzle—that could only be provided by the process of safety contracting—may lead to a change in disposition. This use of safety contracting as an assessment tool, based on nonverbal leakage of suicidal intent, unlike safety contracting as a deterrent (which

probably has limited use in an ED) may be particularly useful in an ED. Thus safety contracting is complicated, and CASE-trained clinicians neither generically condemn nor condone its use but attempt to make a wise decision on the basis of the specific needs of the client and the clinical task at hand.

For a practical review of how to effectively use safety contracting, the reader is referred to "Safety Contracting: Pros, Cons, and Documentation Issues" where one will also find references to numerous articles on the subject.[42] Remember that safety contracting is no guarantee of safety whatsoever.

Finally, it cannot be emphasized enough that continuing concerns about the safety of the patient or the validity of the patient's self-report may require contacting collaborative sources.

A few notes on what the CASE Approach is not

It is important to remember that the CASE Approach is a flexible interview strategy devoted solely to the elicitation of suicidal events. It is not a complete interview and is always employed within the body of some other clinical interview, such as an initial assessment, ED assessment, or crisis call.

Neither is the CASE Approach a suicide assessment protocol. A suicide assessment protocol is composed of all 3 of the following tasks: (1) gathering information related to the risk and protective factors and the warning signs for suicide; (2) gathering information related to the patient's suicidal ideation, planning, behaviors, desire, and intent; and (3) the clinical decision making that is subsequently applied to these 2 databases to create a formulation of risk. These are 3 very different tasks and skill sets.

The CASE Approach is merely designed as an aid to the second component of a suicide assessment approach—gathering information related to the patient's suicidal ideation, planning, behaviors, desire, and intent. The CASE Approach complements, not replaces, the 2 other critical components of a sound suicide assessment.

Thus, the CASE Approach is *not* a method of uncovering the risk/protective factors for suicide; such vital information will be gathered in other areas of the overall interview. For example, the role of ongoing alcohol use will be explored in the history of substance abuse. The presence and intensity of the patient's anxiety/agitation will be explored in the exploration of the patient's symptoms and his mental status. The presence of psychosis will be explored in the examination for psychotic disorders, and the availability of support systems (and other related critical risk factors such as Joiner's concepts of not feeling that one belongs to a valued group or feeling that one is a burden to others) will be flexibly and sensitively explored in other areas of the interview, such as the social history or perhaps when the patient is sharing the pain of his presenting crisis or triggering stresses.

The data garnered from the CASE Approach on suicidal ideation, behavior, and intent is added to the previously or subsequently garnered information regarding risk and protective factors in other sections of the interview and/or from collaborative sources to be used in the third component of a suicide assessment protocol—clinical formulation of risk—using whatever style of clinical formulation the clinician feels comfortable using. The CASE Approach says absolutely nothing about how to formulate risk, it is merely an interviewing strategy that attempts to provide the best possible puzzle pieces from which a clinician can make a sound formulation of risk.

Moreover, the CASE Approach is flexibly adapted to the unique needs and personality traits of the individual patient, as well as the unique demands of the clinical situation—ED assessment versus

ongoing psychotherapy versus inpatient setting. For instance, it was not designed nor is it recommended for use with children, although future child researchers may find that elements of the CASE Approach may prove to be useful.

Finally, the Case Approach is not a cookbook style of interviewing, applied in the same way with every client. The CASE Approach is altered markedly with a patient who might want to manipulate himself into a hospital or who might have borderline personality traits and for whom "suicide talk" may be used to seek comfort or concern from caregivers; it may also be markedly altered with actively psychotic patients. Practical details on how the CASE Approach is effectively adapted to patients with specific pathological states, such as psychosis or borderline personality, as well as a detailed exploration of the other 2 critical aspects of suicide assessment—risk/protective factors and clinical formulation of risk—are described elsewhere for the interested reader.[2]

Training applications, research directions, and implications for suicide prevention programs

The CASE Approach is designed to allow the clinician to enter the patient's world of suicidal preoccupation sensitively and deeply. During the elicitation of suicidal ideation and intent with the CASE Approach, something else may have been accomplished that is very important: the interviewer has helped the patient share painful information that, in many instances, the patient has borne alone for too long. Perhaps the thoughtfulness and thoroughness of the questioning, as illustrated with the CASE Approach, will have conveyed that a fellow human cares. To the patient, such caring may represent the first realization of hope.

By using this strategy routinely, clinicians can become adept at it, learning how to flexibly alter it to fit the unique needs of specific clinical settings and with diverse types of patients. In most suicide assessments, the CASE Approach can be completed within several minutes. Even with more complicated patients, as might be seen in a particularly complex ED presentations, it rarely requires more than 5 to 10 minutes. In a patient who has low risk factors, has high protective factors, and answers negatively to questions in the regions of presenting suicide events, recent suicide events, and past suicide events, the CASE Approach can be completed in 3 questions. With such a patient, the clinician wouldn't even enter the region of immediate events.

Because the strategies of the CASE Approach are based on easily identifiable interviewing techniques, the skills of the interviewer employing the strategy can be easily observed, monitored over time, and objectively tested for quality assurance purposes. It is hoped that such behaviorally specific characteristics will also allow quantitative and qualitative research to be done on both the ability of the CASE Approach to be taught (and retained) as well as research regarding its ultimate effectiveness in procuring a comprehensive and reliable database on suicidal ideation and intent. Such research could provide the foundation for an evidence-based model for effectively eliciting suicidal ideation, similar in fashion to the way that cardiopulmonary resuscitation was developed. As with CPR, such an evidence-based interviewing strategy could be used as the basis for certifying clinicians to competence across the country.

In the meantime, as we wait for the appropriate research to be undertaken, the CASE Approach allows experienced clinicians to study how they are currently eliciting suicidal ideation and also suggests new ways of doing so. Returning to the Equation of Suicidal Intent, the CASE Approach provides a platform for exploring suicidal ideation and behaviors that may maximize the likelihood that (1) a patient will share what would have been withheld intent, (2) a patient will more openly share his reflected intent, and (3) the patient's stated intent will be as accurate as possible.

It is hoped that with the versatility and the ease with which the CASE Approach can be taught and competency tested, that it will prove valuable in 2 pressing new populations:

- Military personnel serving or returning from Afghanistan and Iraq (including suicide potential in their highly stressed family members) as well as veterans and soldiers stationed stateside

- Students in college, middle school, and high school

It is hoped that the CASE Approach will play a major role in the training of psychiatric residents and other mental health graduate students in social work, counseling, and psychology, for whom the instillation of sound suicide assessment skills is one of the most pressing of educational tasks.[27,28] More details on how to employ the CASE Approach and information on available workshops and experiential training on its effective use, no matter what the discipline or the clinical setting, are available at the TISA Web site.[43]

A practical example highlights the promise of the CASE Approach in yet another training arena, medical and nursing student education. It is well documented that at least 50% of patients who kill themselves have seen a primary care clinician within a month of their deaths.[44] A typical primary care clinician sees patients who warrant a suicide assessment on a daily basis. To prepare medical and nursing students for this future task—as part of the numerous competency skills that they are currently required to demonstrate before graduation—every student could be asked to learn and effectively demonstrate the use of an interview strategy for eliciting suicidal ideation, such as the CASE Approach.

It is likely that such medical and nursing students would be significantly more competent in eliciting suicidal ideation than the typical medical and nursing graduate of today. Perhaps even more important, because the students would both understand the importance of asking for suicidal ideation and simultaneously be more comfortable with a way of doing it, they might be considerably more aggressive in seeking it out in their future primary care settings. The result could be a tangible decrease in the death rate related to suicide.

The epigraph to this article was the quotation from the always insightful and wry Oscar Wilde, who commented, “My reality is constantly blurred by the mists of words.” Language can indeed be misleading, and during a suicide assessment, miscommunication is not only problematic . . . it is sometimes lethal. The CASE Approach is an attempt to cut through some of the mists created by language to the truth regarding a patient’s intent to die by suicide. If we are lucky, when the mists recede, it is hope that remains.

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