Examining Group Differences Between Suicidal Veterans Classified as Wish to Live, Ambivalent, or Wish to Die Using the Suicide Index Score

Brittany D. Morris
Western Kentucky University, brittany.morris759@topper.wku.edu

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EXAMINING GROUP DIFFERENCES BETWEEN SUICIDAL VETERANS
CLASSIFIED AS WISH TO LIVE, AMBIVALENT, OR WISH TO DIE USING THE
SUICIDE INDEX SCORE

A Thesis
Presented to
The Faculty of the Department of Psychology
Western Kentucky University
Bowling Green, Kentucky

In Partial Fulfillment
Of the Requirements for the Degree
Master of Arts

By
Brittany D. Morris

August 2014
EXAMINING GROUP DIFFERENCES BETWEEN SUICIDAL VETERANS CLASSIFIED AS WISH TO LIVE, AMBIVALENT, OR WISH TO DIE USING THE SUICIDE INDEX SCORE

Date Recommended: 07/15/2014

Stephen O'Connor, Director of Thesis

Rick Grieve

Amy Brausch

Dean, Graduate Studies and Research   Date
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I would like to first and foremost thank my grandmother and family for providing me with an abundance of love and support throughout my life.

Additionally, I would like to take this time to acknowledge my professors and colleagues that have been by my side during the most challenging part of my education; each of you have helped immensely any time I have ever needed anything and I am eternally grateful!
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A persistent difficulty in the field of psychology is identifying which individuals are at the greatest risk for suicide. Veterans of the US Military are at elevated risk for suicide as compared to the general population. One approach for designating tiers of risk is applying the “Suicide Index Score” to discriminate individuals based upon their reported wish to live (WTL) and wish to die (WTD; Kovacs & Beck, 1977). Brown, Steer, Henriques, and Beck (2005) demonstrated those who indicated a complete WTD and no WTL were at greatest risk to die. The current study expanded on previous research by using this approach with a highly elevated at-risk population of suicidal veterans.

Participants for this study included 93 suicidal veterans hospitalized at the Robley Rex Veteran Affairs Medical Center in Louisville, Kentucky. The WTL and WTD items from the Scale for Suicidal Ideation-Current were used to create two quasi-independent groups: WTL/Ambivalent and WTD. The following outcome measures were included as dependent variables: Acquired Capability for Suicide Scale, Interpersonal Needs Questionnaire, Outcome Questionnaire-45.2, Suicide Attempt and Self-Injury Count, Alcohol Use Disorders Identification Test, Drug Abuse Screening Test, and the Stages of
Change Questionnaire, as well as the Suicidal Ideation, Posttraumatic Stress Disorder and Insomnia items on the Common Data Elements.

T-tests were used to examine patient characteristics for continuous outcomes and chi-square analyses were used for nominal outcomes; however, no group differences were found. T-tests were then used to measure between-group differences on the dependent variables. Individuals classified in the WTD group reported significantly higher levels of thwarted belongingness $t(91) = 2.89$, $p = .00$, acquired capability $t(91) = 2.64$, $p = .01$, suicidal ideation, $t(91) = 3.51$, $p < .001$, and posttraumatic stress $t(91) = 2.53$, $p = .01$. Furthermore, a negative binomial regression was used for count outcomes and results revealed that those in the WTD group also reported significantly greater accounts of suicide attempts (incidence rate ratio [IRR] = 2.08; standard error [SE] = 0.63; 95% confidence interval [CI] 1.14-3.77; $p = .02$) and non-suicidal self-injury (IRR = 3.49; SE = 0.69; 95% CI 2.36-5.16; $p < .001$).
EXAMINING GROUP DIFFERENCES BETWEEN SUICIDAL VETERANS CLASSIFIED AS WISH TO LIVE, AMBIVALENT, OR WISH TO DIE USING THE SUICIDE INDEX SCORE

Suicide is a serious issue that has affected the lives of many individuals and families in the United States (U.S.). It is the 10th leading cause of death in the U.S. for all ages, accounting for 38,364 deaths annually (Heron, 2013). This number translates to 1 suicide every 13.7 minutes (McIntosh & Drapeau, 2012). A common strategy for suicide prevention has been to examine those who have made suicide attempts in the past. As of 2010, there was an estimated 959,100 annual nonfatal suicide attempts in the U.S. (using 25:1 ratio; Berman, 2011; McIntosh & Drapeau, 2012). However, previous research has demonstrated that approximately 50% of suicides occur during a first attempt (Isometsa & Lonnqvist, 1998). Therefore, prevention strategies must also focus on particular groups at elevated risk for suicide.

Suicide is the second leading cause of death in the U.S. military, with rates of 9 to 15 deaths per 100,000 service members from 2005 to 2011 (Ritchie, Keppler, & Rothberg, 2003). Rates of suicide have increased by 80% in the U.S. Army from 2004 to 2008 and have bypassed the rate of the U.S. general population (Lineberry & O'Connor, 2012). Findings from previous research suggest that suicide in the military may be related to an increased prevalence of mental health issues within this population rather than length and number of deployments (LeardMann et al., 2013). Due to the complexity of suicidal behavior, it is imperative to examine a broad array of known factors that can increase risk for suicidal thoughts and behaviors.
Risk Factors for Suicide and Related Behaviors in U.S. Military and Veterans

Previous research suggests there may be no significant association between suicide and military experiences (including combat experiences and deployment; LeardMann et al., 2013). Within this sample of 151,560 current and former U.S. military personnel, suicide risk was not directly related to military factors, but was independently associated with male sex, depression, bipolar disorder, and alcohol related disorders. Additionally, there has been a marked increase of diagnosed mental disorders in service members since 2005 (Mirza, Eick-Cost, & Otto, 2012).

Additional research, however, has found somewhat inconsistent supporting evidence that particular military subgroups are at greater risk for suicide. Bullman & Kang, 1994; Jakupcak et al., 2009; Kang & Bullman, 2009 demonstrated that, among individuals enlisted during Vietnam, Operation Enduring Freedom (OEF), and Operation Iraqi Freedom (OIF) were at increased risk, potentially due to the increased rates of Posttraumatic Stress Disorder (PTSD) and/or other comorbid disorders which often lead to suicidal behaviors (Jakupcak et al., 2009). Furthermore, research on 34,534 Vietnam War casualties suggests that veterans who endured wounds or were hospitalized due to combat wounds were also at an increased likelihood for suicidal behaviors (Bullman & Kang, 1994; 1996).

Although specific risk factors for veterans with suicidal ideation have been recognized, improving identification of risk factors for suicide attempts and suicide remains important. Veterans who have endured PTSD, depression, and alcohol-related issues often suffer from suicidal thoughts and behaviors; however, focusing on diagnoses to predict suicide attempt produces large false positive rates. Autopsy reports reveal that
90% of all individuals who have completed suicide had one or more mental disorders (McIntosh & Drapeau, 2012); however, the vast majority of patients with disorders do not attempt or die by suicide. Since diagnoses should not be used to predict suicidal behavior, Pitman and Caine (2012) suggest it is potentially useful to focus on a more narrow, high-risk population of individuals with suicidal ideation in inpatient hospital settings. Previous research suggests that there is a significant occurrence of suicide after being discharged from psychiatric facilities (Goldacre, Seagroatt, & Hawton, 1993). It is crucial to find and validate methods to identify individuals at the highest risk of a suicide attempt and completion so that mental health practitioners can facilitate proper help and treatment during this time. Risk factors can be beneficial to examine, but may limit the identification of additional dynamics associated with suicide.

**Beyond Risk Factors: Theoretical Models**

Due to the complexity of suicidal behaviors and risk factors, it is especially important to investigate theoretical models of suicidality. Although there are many speculations for why particular individuals turn to suicide, there is a lack of empirical support and theoretical development for many of these. Currently, the Interpersonal Psychological Theory of Suicide (IPTS; Van Orden et al., 2010) and the Cognitive Behavioral Theory (Wenzel & Beck, 2008) are two that have undergone the most extensive research.

The IPTS assesses and incorporates the many risk factors that are involved in suicidal ideation and suicide attempts. Van Orden et al. (2010) propose that there are three constructs that are central to suicidal behavior: thwarted belongingness, perceived burdensomeness, and acquired capability to complete these suicidal desires. They
hypothesize that the most dangerous form of suicidal ideation is when there is a simultaneous combination of these desires and capability to initiate and follow through with the ideations. It is essential to understand these concepts to facilitate in identifying and treating suicidal individuals.

Thwarted belongingness occurs when the psychological need to belong is not met and there is an absence of reciprocity in caring relationships. Individuals who experience a sense of thwarted belongingness feel disconnected and believe they do not have satisfying social interactions. It is believed that, once individuals feel this sense of detachment a desire for death or passive suicidal ideation develops. Previous research supports that this need to belong is composed of two facets: a need for frequent and pleasant interactions with the same people, as well as a need for these interactions to occur in a long-term and stable condition (Van Orden et al., 2010).

Family conflict, unemployment, and physical illness are three risk factors with extensive support for their associations with suicide. The underlying commonality between these three is a sense of perceived burdensomeness. Furthermore, according to the theory, perceived burdensomeness is also comprised of two dimensions: a perception that one is so flawed that he or she is a liability to others and self-hatred regarding those beliefs. These individuals carry the conviction that others will be better off if they are dead (Van Orden et al., 2010). Sentiments may include statements similar to the following: “I make things harder for my family and friends” or, “I am worthless.”

According to the IPTS, these two interpersonal constructs of desire are not sufficient for lethal suicidal behavior to result; individuals must also acquire the capability to initiate a lethal suicide plan. Van Orden and colleagues (2010) believe that
individuals must lose a sense of fear related to suicidal behaviors before attempting suicide because the majority of humans are biologically predisposed to fear death. Additionally, individuals acquire capability for suicide by increasing their pain tolerance through habituation of physically painful or self-harm behaviors. No matter the lethality of the method, it is presumed that the common factor is that the individual maintains the cognitive appraisal that the pain involved in the process is tolerable.

The concept of acquired capability is particularly important when examining a veteran population. Van Orden et al. (2010) suggest that habituation to pain and fear can be created through exposure. A study on military personnel found that branch of the military was associated with the method used for suicide (i.e., hanging/knots for Navy, shooting/guns for Army, falling/heights for Air Force; Van Orden et al., 2010). Combat exposure has also been shown as a direct pathway to acquired capability in that higher levels of exposure were associated with higher levels of capability (Bryan, Cukrowicz, West, & Morrow, 2010). These veterans have been exposed to the fear of one’s own possible death as well as taking the lives of others. There is an increased risk for suicide for those who have experienced combat trauma, with the highest risk among those who were injured multiple times (Bullman & Kang, 1996), thus increasing their pain tolerance and acquired capability.

Although there has been extensive research on suicide and IPTS risk factors, it is quite limited with veterans. For instance, Pfeiffer et al., (2014) studied predictors of suicidal ideation with depressed veterans and found inconsistent results from similar studies. Contrary to the expectations based on this theory, only burdensomeness and hopelessness were shown to be important factors in developing passive suicidal ideation.
A study of veterans hospitalized for PTSD found the interaction between belongingness and burdensomeness to be significant for predicting current suicidal ideations (Joiner Jr, Van Orden, Witte, & Rudd, 2009; Monteith, Menefee, Pettit, Leopoulos, & Vincent, 2013); however, more research is needed within this population. More information is also needed to fully explain the risks and predictors for suicide, especially among these individuals.

Wenzel and Beck (2008) created a model of suicidal behavior that is based upon the cognitive-behavioral model of emotions and behaviors. This model incorporates cognitive, emotional, and behavioral issues that are correlated with, and risk factors of, suicidal behavior. Wenzel and Beck’s model is comprised of three main constructs. The initial construct is known as dispositional vulnerability factors. These are usually predisposed characteristics that have been known to lead to psychiatric disturbances. Examples of these factors in this theoretical approach include: impulsivity and related constructs, problem solving deficits, an over-general memory style, a trait-like maladaptive cognitive style, and personality. The second construct of the model is titled: cognitive processes associated with psychiatric disturbance. This construct consists of the maladaptive cognitive contents (what people think), as well as information processing biases (how people think), that are most often associated with psychiatric symptoms. Wenzel and Beck (2008) hypothesize that a suicidal act is more likely to occur as the intensity and frequency of these cognitive processes increase. This leads to the third construct: cognitive processes associated with suicidal acts. This construct includes the mental processes that are occurring when an individual is having suicidal ideations or participating in self-injurious behavior. It has been shown that dispositional vulnerability
factors can initiate or exacerbate psychiatric disturbance by creating stress, and/or reduce an individual’s ability to facilitate adaptive ways to cope with cognitive processes during suicidal crisis. Wenzel and Beck (2008) propose that these individuals will engage in a suicidal act when they can no longer manage these cognitions and emotions explained in the model.

The cognitive approach may be useful to apply to veterans in order to investigate the contribution of cognitive factors previously shown to differentiate tiers of risk for suicide in clinical populations. One method that has been tested to differentiate these individuals is the Suicide Index Score (SIS). Kovacs and Beck (1977) hypothesized that many suicidal individuals not only have a wish to die (WTD), but also experience an internal wish to live (WTL) as well. To better treat these individuals, it is imperative that clinicians understand this internal cognitive struggle. Results indicated that half of the sample in this study (hospitalized suicidal patients) experienced an internal struggle between a WTL and a WTD. This research was also helpful in discovering that an ambivalent (AMB; neither a strong WTL or WTD) group displayed lower suicidal intent as compared to the 40% that was on the WTD end of the spectrum.

Despite the importance of this research, there was a significant time lapse after Kovacs and Becks’ (1977) study. Prompted by this inquiry, Brown, Steer, Henriques, and Beck (2005) continued this research to explore whether the dominance of a WTD over a WTL constituted as a risk factor for suicide. After extended research, results confirmed that the WTL/WTD index score represented a unique risk factor for suicide. Furthermore, those reporting an absolute WTD and no WTL were at greatest risk to die among this cohort of depressed patients. O’Connor and colleagues (2012a) interpreted these results
by stating that there are three potential groups or tiers of suicidal orientations: individuals with a strong pull towards death, those dealing with an internal struggle between living and dying, and those who feel a stronger orientation towards living. Further investigation on the SIS showed that those who scored highest rating on the wish to die and lowest on the wish to live had the greatest level of predictive validity for death by suicide (Beck, Brown, & Steer, 1997).

O’Connor et al. (2012b) adapted the methodologies used by Brown et al. (2005) by using the WTL/WTD self-report ratings to trichotomize patients into one of three distinct groups: WTL, AMB about living or dying, or WTD. In this particular study, individuals rated their desire to live and their desire to die on two separate scales from 1 (not at all) to 7 (very much). Suicide index scores were calculated by subtracting the WTL ratings from the WTD ratings for each individual, leaving a range from -6 to +6. The specific range for each group was as follows: -7 to -3 for WTL, -2 to +2 for AMB, and +3 to +7 for WTD. One significant result from this study is that 76.7% of the time individuals are correctly classified into one of the three tiers based upon ratings on other psychological evaluations like the Overall Risk for Suicide (ORS) and the Beck Hopelessness Scale (BHS). This research also indicated that the suicidal tiers’ group means for most assessments were significantly different from one another. These results suggest that the WTL/WTD questions on the Suicide Status Form (SSF) show convergent validity with the other measures like the ORS and the BHS (O'Connor et al., 2012b).

Lento and colleagues also examined trichotomizing patients into distinct groups based upon their wish to live or die measured by the SIS embedded in the SSF (Lento, Ellis, Hinnant, & Jobes, 2013). The aim of this study was to determine the predictive
validity of the SIS by using a linear mixed-model design with actively suicidal inpatients; however, they also examined the ability to distinguish among individuals in each group. These analyses helped to validate that the SIS significantly discriminates individuals based upon their desire to live or die. Suicidal ideation, hopelessness, and depression scores were significantly different for each of the SIS groups at the beginning of treatment. Results also indicated that the scale might also be a predictor of treatment outcome (i.e. patients in the WTL group reported less suicidal ideation and depression throughout treatment than the other groups). Additionally, results indicated that the SIS predicts hopelessness and depression throughout treatment.

It has been found that individuals that have been discharged from a psychiatric facility are at an increased risk for suicide attempts (Bostwick & Pankratz, 2000; Ho, 2003). The SIS has been shown to help when discriminating which individuals are at the greatest risk to remain suicidal after discharge (O'Connor et al., 2012a). O’Connor et al. described this phenomena as entrenched suicidal ideation. They acknowledged that, while individuals with previous suicide attempts are historically at greater risk for suicide, suicidal ambivalence was more useful when determining entrenched suicidal ideation. This was determined by measuring the associations from a series of measurements completed by suicidal inpatients at intake, as well as at months 2, 4, 6, and 12 after the beginning of their treatment. The outcome variables in this study included the Scale for Suicidal Ideation Current (SSI-C), the Outcome Questionnaire-45.2 (OQ-45.2), the Reasons for Living Inventory (RFLI), the Optimism and Hope Scale (OHS), and the Suicide Attempt Self-Injury Count (SASIC). O’Connor and colleagues (2012a) found significant differences between the AMB and the WTD groups on the SSI-C and the
RFLI across each time point. This difference was not seen when focusing on attempt history. When using a dimensional approach of the generalized mixed models design, suicidal ambivalence was additionally significantly associated with the OHS, while no significant associations were shown for history of suicide attempts. These results were especially important because they showed that it is possible to more effectively identify those who are at risk, and continued risk, for suicide by using the SIS.

**Current Study**

While there is an extensive amount of literature on risks for suicide, there is less research focusing on assessing and treating these individuals. Now that there has been a scale designed to classify suicidal individuals into groups based upon the SIS reports, this scale needs to be further validated to ensure its success in identifying these individuals. The purpose of the current study is to build upon previous research by applying this scale to a high-risk population of veterans and replicate previous research using several of the same measures, while applying contemporary theories related to suicide risk.

**Hypotheses**

Hypothesis: Individuals in the WTD group will demonstrate significantly elevated scores compared to individuals in the WTL and AMB groups on suicide-related constructs of perceived burdensomeness, thwarted belongingness, acquired capability, suicidal ideation, history of suicide attempts, and non-suicidal self injury (NSSI).

Exploratory Hypothesis: Individuals in the WTD group will demonstrate significantly elevated scores compared to individuals in the WTL and AMB groups on measures of alcohol use, drug use, anxiety sensitivity, posttraumatic stress, and insomnia.
Similarly, that they will demonstrate significantly lower scores on overall functioning and readiness to change.
Method

Participants

Participants for this study were suicidal veterans hospitalized on the inpatient psychiatric unit of the Robley Rex Veteran Affairs Medical Center (VAMC) in Louisville, Kentucky. These individuals are participating in a larger ongoing study that focuses on group therapy for suicidal veterans discharging from an inpatient psychiatry unit. Inclusion criteria included inpatient admission for suicide attempt or ideation. All veterans on the inpatient psychiatric unit that were admitted for suicidal behaviors or for whom suicidality was a primary precipitant to hospitalization were invited to participate in the suicide prevention group. Exclusion criteria consisted of prominent psychotic symptoms or significant cognitive impairments. The sample consisted of 11 female and 82 male veterans (N = 93 veterans) with a mean age of 48.76 (standard deviation [SD] = 11.60). No significant differences were observed between the two groups on demographic, clinical, or service characteristics (see Table 1); therefore, no additional variables were added to the final statistical models.

Design

This quasi-independent study was conducted using a between-subjects, cross-sectional design. The independent variable was the individuals’ SIS score. The dependent variables included the following constructs: perceived burdensomeness, thwarted belongingness, acquired capability, suicidal ideation, history of suicide attempts, NSSI, overall functioning, readiness to change, alcohol use, drug use, anxiety sensitivity, posttraumatic stress, and insomnia.
Table 1.  
*Demographic Characteristics of the Study Participants*

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Instruments

Suicide-related instruments

Scale for suicidal ideation-current. The SSI-C (Beck et al., 1997; see Appendix A) is a 19-item self-report questionnaire concerning the highest intensity of suicidal ideation within the previous two weeks. Questions cover the individual’s attitudes, behaviors, and plans to commit suicide. Items assess risk factors such as the duration and frequency of suicidal ideation, reasons for making an attempt, potential deterrents, and actualization of the contemplated attempt. Each question has three answer choices with varying anchors ranging from 0 to 2. Scores are summed, with higher scores indicating greater suicidal ideation. This measure takes approximately 10 minutes to complete. The SSI-C displayed high internal consistency (α = .88) in a previous study (O'Connor et al., 2012a) and acceptable criterion and convergent validity in preceding research (Beck et al., 1997). This measure also incorporates the WTL/WTD component of the current study.

Acquired capability scale for suicide. The Acquired Capability Scale for Suicide (ACSS; Van Orden, Witte, Gordon, Bender, & Joiner, 2008; see Appendix B) is a 20-item self-report measure created to assess fearlessness about fatal self-injury and the self-perceived ability to endure the pain involved in self-injury and suicide. The measure includes statements like, “the pain involved in dying frightens me,” and, “I can tolerate a lot more pain than most people.” Individuals are asked to rate from 0 (not at all like me) to 4 (very much like me) how much they identify with the item. Total scores range from 0 to 80, with higher scores indicating greater levels of acquired capability. Previous research indicates that number of past attempts positively correlates with levels of
acquired capability; those who had multiple past attempts reported the highest levels of capability (Van Orden et al., 2010). The ACSS’s internal consistency (α = .71) was adequate in a study measuring two overlapping yet distinct constructs of fearlessness about death and habituation to pain (Bryan et al., 2010). This result was consistent with internal consistencies reported in several previous studies (Bryan, Morrow, Anestis, & Joiner, 2009; Van Orden et al., 2008). Although many use condensed versions of this scale due to multiple factor loadings, the full measure utilized in the current study has demonstrated adequate reliability with alphas ranging from .81 to .88 (Ribeiro et al., 2014). In the current sample, the reliability coefficient for the ACSS was good at α = .78.

**Interpersonal needs questionnaire.** The Interpersonal Needs Questionnaire (INQ; Van Orden, Cukrowicz, Witte, & Joiner, 2012; see Appendix C) was designed to measure thwarted belongingness and perceived burdensomeness. These concepts were measured by statements like, “I feel disconnected from other people” or, “people in my life would be better if I were gone.” Individuals rated each statement on a seven-point Likert scale from, “not at all true for me” to “very true for me.” Scores are coded such that higher scores reflect higher levels of thwarted belongingness and perceived burdensomeness. Results support that thwarted belongingness and perceived burdensomeness are distinct but related constructs that can be reliably measured. Comparable internal consistencies have been found for both the belongingness items (α = .85) and perceived burdensomeness items (α = .89; Van Orden, 2009). Both constructs measured in the INQ demonstrated convergent validity with similar interpersonal constructs including loneliness, social support for belongingness, social worth, and death ideation for burdensomeness. Concurrent and predictive associations were shown between the INQ
and both suicidal desire and ideation (Van Orden et al., 2012). In the current sample, the reliability coefficient for the INQ was excellent at $\alpha = .93$.

**Lifetime-suicide attempt self-injury count.** The Lifetime-Suicide Attempt Self-Injury Count (L-SASI; Linehan & Comtois, 1996; see Appendix D) is a 16-item structured interview used to determine total suicide attempts and non-suicidal self-injury events. This brief instrument measures the extent to which these behaviors were linked to a desire to die, as well as the intent and medical severity of the behaviors. The scoring for this measure is more extensive than most. The numbers of lifetime events are coded and tallied. These events include: different forms of self-injury, self-injury with an intent to die, self-injury with ambivalence, self-injury without suicidal intent, and medical treatment received.

**Additional mental health instruments.**

**Outcome questionnaire-45.2.** The OQ-45.2 (Lambert et al., 1996; see Appendix E) is a 45-item tracking/assessment instrument used to measure the client progress during treatment and afterwards. It also assesses the client’s satisfaction with life and current risk for suicide. Individuals are asked to rate from 0 (*Never*) to 4 (*Almost Always*), how much each statement describes their current situations. For this questionnaire, there is a total score and three subscores that represent: symptom distress, interpersonal relations, and social role. After scores are summed, a total score of 63 or above out of 180 represents clinical significance. A symptom distress score at or above 36 out of a total of 100 indicates clinical significance. The interpersonal relations clinical cut-off score is 15 out of 44. Additionally, the social role clinical cut-off score is 12 or more out of 36. The OQ-45.2 has been supported by decades of research resulting in sound psychometric
properties with adult psychiatric clients (Lambert et al., 1996; Umphress, Lambert, Smart, Barlow, & Clouse, 1997). In this study, it was used to specifically address questions concerned with current, overall symptoms of distress; however, all items were used. In the current sample, the reliability coefficient for the OQ-45.2 was excellent at $\alpha = .90$.

**Stages of change questionnaire.** The Stages of Change Questionnaire (SOCQ; McConnaughy, Prochaska, & Velicer, 1983; see Appendix F) is a measure of participants’ degree of readiness for change. Each item is rated on a Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). This measure is derived from the original 32-item scale and currently has 18 items. The full scale is comprised of four 8-item subscales that measure each stage of change (precontemplation, contemplation, action, and maintenance). Items with negative valence were reverse coded before summing the individual item scores to obtain an overall score for readiness to change. The SOCQ has high internal consistency with subscale alpha coefficients ranging from .88 to .89 in one study (McConnaughy et al., 1983) and from .79 to .84 in an additional study (McConnaughy, DiClemente, Prochaska, & Velicer, 1989). The SOCQ has shown good levels of internal consistency ($\alpha = .75$ to .87) and predictive validity of response to treatment in an additional study (Lewis et al., 2009). In the current sample, the reliability coefficient for the SOCQ was good at $\alpha = .86$.

**Alcohol use disorders identification test.** The Alcohol Use Disorders Identification Test (AUDIT; Bush, Kivlahan, McDonnel, Fihn, & Bradley, 1998; see Appendix G) is a brief, 10-item questionnaire used to determine if an individual’s alcohol consumption should be considered high-risk. After responses are summed, scores above 8
(out of a possible 40) indicate a high risk for alcohol use disorder. The AUDIT has displayed acceptable internal consistency at ($\alpha = .75$ to $.94$; Allen, Litten, Fertig, & Babor, 1997). Furthermore, its validity and reliability have been established in multiple research studies conducted in a variety of settings and nations (Babor, Higgins-Biddle, Saunders, Monteiro, 2001). In the current sample, the reliability coefficient for the AUDIT was excellent at $\alpha = .93$.

**Drug abuse screening test-10.** The Drug Abuse Screening Test-10 (DAST-10; Skinner, 1982; see Appendix H) is a 10-item questionnaire used to identify high risks of substance abuse. After responses are summed, scores greater than 3 indicate a likely substance use disorder. There has been extensive research conducted through outpatient settings that supports high internal validity for this measure ($\alpha = .86$ to $.94$; Cocco & Carey, 1998; French, Roebuck, McGeary, Chitwood, & McCoy, 2001). The initial analyses by Skinner (1982) displayed substantial internal consistency reliability at ($\alpha = .92$), as well as a unidimensional scale determined by using a factor analysis of item intercorrelations. In the current sample, the reliability coefficient for the DAST was good at $\alpha = .88$.

**Additional instruments.**

**Personal identification form.** The Personal Identification Form (PIF; see Appendix I) is a 27-item demographic questionnaire that was created specifically for the larger study from which the current data was derived. This questionnaire contains basic demographic items such as family information, level of education, and drug and alcohol use that were used in the current study, as well as additional questions associated with
deployment to a war zone, the length and severity of combat exposure and number and severity of combat injuries that were not utilized.

**Common data elements.** The Common Data Elements (CDE; see Appendix J) is a 57-item questionnaire that is endorsed in each study that is funded by the Military Suicide Research Consortium. This measure covers a variety of topics such as: associations with suicide, PTSD, substance use, and insomnia. In the current study, suicidal ideation, posttraumatic stress, anxiety sensitivity, and insomnia items were observed. To obtain scores for these constructs, item scores were added up to create a total score for each concept. In the current sample, the reliability coefficient for the ideation items was good at $\alpha = .79$, posttraumatic stress items was excellent at $\alpha = .95$, anxiety sensitivity items was good at $\alpha = .87$, and insomnia items was good at $\alpha = .73$.

**Procedure**

After obtaining appropriate Institutional Review Board approval, patients were approached on the inpatient psychiatry unit at Robley Rex VAMC. They were given the opportunity to participate in a larger, ongoing study measuring the effectiveness of a more rigorous assessment process integrated into existing group therapy for suicidal veterans; due to this, the current study is considered archival. Those interested completed an informed consent process with a member of the research team. Enrolled participants then completed a baseline interview with a member of the research team. Individuals then completed the measures for the study followed by randomization to one of two treatment groups. In the larger study, participants were encouraged to attend a weekly group therapy and were contacted by a member of the research team to complete follow up interviews at one and three months. For the purposes of this study, pre-randomized
baseline data was used, as the research aims are independent from those of the larger study.
Results

Based upon previous research (Brown et al., 2005), an empirically-validated method was used to create a SIS for each participant. Participants were assigned to one of three quasi-independent groups based upon individuals’ ratings on the two WTL and WTD items. Individuals were able to choose moderate to strong, weak, or none based upon their desire to live or die on their worst day in the past week. For this particular study, the primary method of assigning participants was to divide them into a WTD, AMB, or WTL group by coding their responses (-1 for a moderate to strong WTL or no WTD; 0 for a weak WTL or weak WTD; 1 for no WTL or a moderate to strong WTD). The ratings for SSI items 1 and 2 were then summed, with -2 representing WTL, -1 to 1 labeled as AMB, and 2 indicating WTD. Given the severity of our sample, participants were skewed towards the more severe end of the SIS spectrum, (WTL = 4; AMB = 49; WTD = 40); therefore, the WTL and AMB groups were merged together and compared to the WTD group for all analyses.

Statistical Analyses

Between-groups differences on demographic, clinical, and service characteristics were examined prior to testing the research hypotheses. A t-test was utilized for the age of participant and chi-square for all nominal outcomes, which included sex, ethnicity, current homelessness, relationship status, education, victim of abuse or neglect, drug or alcohol abuse, and deployment to war zone. Next, t-tests were used to analyze between-groups differences on all outcomes measures with normal distribution of group means, including perceived burdensomeness, thwarted belongingness, acquired capability, overall functioning, readiness to change, alcohol and drug use, suicidal ideation, anxiety,
posttraumatic stress, and insomnia. For count outcomes, including history of suicide attempt behaviors and NSSI, a negative binomial regression was used as indicated by preliminary goodness-of-fit statistics.

**Primary Hypothesis**

As predicted, individuals in the WTD group reported significantly higher levels of thwarted belongingness $t(91) = 2.89, p = .00$, acquired capability $t(91) = 2.64, p = .01$, and suicidal ideation, $t(91) = 3.51, p < .001$ when compared to the WTL/AMB group. Unexpectedly, however, perceived burdensomeness was no higher for those in the WTD group (Table 2).

<table>
<thead>
<tr>
<th></th>
<th>Wish to Live/Ambivalent</th>
<th>Wish to Die</th>
<th>$t(91)$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived burdensomeness</td>
<td>35.13</td>
<td>35.02</td>
<td>0.10</td>
<td>.92</td>
</tr>
<tr>
<td>Thwarted belongingness</td>
<td>36.19</td>
<td>39.62</td>
<td>2.89</td>
<td>.00</td>
</tr>
<tr>
<td>Acquired capability</td>
<td>49.24</td>
<td>56.15</td>
<td>2.64</td>
<td>.01</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>4.66</td>
<td>6.50</td>
<td>3.51</td>
<td>.00</td>
</tr>
</tbody>
</table>

Results indicated that individuals in the WTD group had significantly more suicide attempts (incidence rate ratio [IRR] = 2.08; standard error [SE] = 0.63; 95% confidence interval [CI] 1.14-3.77; $p = .02$) and NSSI (IRR = 3.49; SE = 0.69; 95% CI 2.36-5.16; $p = .00$) than individuals in the WTL/AMB group. Results are reported for the negative binomial regression in Table 3.
### Table 3.
**Negative Binomial Regression Outcomes for Suicide Attempts and Non-Suicidal Self-Injury**

<table>
<thead>
<tr>
<th>Variables</th>
<th>IRR</th>
<th>Std. Error</th>
<th>Z</th>
<th>p</th>
<th>Confidence Interval (Lower &amp; Upper)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide attempts</td>
<td>2.08</td>
<td>0.63</td>
<td>2.40</td>
<td>.02</td>
<td>1.14 - 3.77</td>
</tr>
<tr>
<td>Non-suicidal self injury</td>
<td>3.49</td>
<td>0.69</td>
<td>6.28</td>
<td>.00</td>
<td>2.36 - 5.16</td>
</tr>
</tbody>
</table>

### Exploratory Hypothesis

While the following results were simply exploratory, they showed that individuals in the WTD group reported significantly higher levels of posttraumatic stress when compared to those in the WTL/AMB group \( t(91) = 2.53, p = .01 \). Those in the WTD group did not significantly differ from those in the WTL/AMB group on the any of the remaining variables: alcohol use \( t(91) = 0.86, p = .39 \), drug use \( t(91) = 0.79, p = .43 \), anxiety sensitivity \( t(91) = 1.07, p = .29 \), insomnia \( t(91) = 1.86, p = .07 \), overall functioning \( t(91) = 1.30, p = .20 \), or readiness to change \( t(91) = 0.23, p = .82 \) (Table 4).

### Table 4.
**T-tests Measuring Group Differences on Outcomes of Interests for Exploratory Hypothesis**

<table>
<thead>
<tr>
<th>Wish to Live/Ambivalent</th>
<th>Wish to Die</th>
<th>Wish to Live/Ambivalent</th>
<th>Wish to Die</th>
<th>t(91)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>Standard Deviation</td>
<td>Mean</td>
<td>Standard Deviation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall functioning</td>
<td>92.48</td>
<td>18.23</td>
<td>97.08</td>
<td>15.04</td>
<td>1.30</td>
</tr>
<tr>
<td>Readiness for change</td>
<td>75.70</td>
<td>8.11</td>
<td>75.32</td>
<td>7.77</td>
<td>0.23</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>14.32</td>
<td>12.94</td>
<td>12.10</td>
<td>11.50</td>
<td>0.86</td>
</tr>
<tr>
<td>Drug use</td>
<td>4.19</td>
<td>2.45</td>
<td>4.58</td>
<td>2.16</td>
<td>0.79</td>
</tr>
<tr>
<td>Anxiety</td>
<td>15.28</td>
<td>5.79</td>
<td>16.58</td>
<td>5.71</td>
<td>1.07</td>
</tr>
<tr>
<td>Posttraumatic stress</td>
<td>21.75</td>
<td>10.86</td>
<td>27.18</td>
<td>9.35</td>
<td>2.53</td>
</tr>
<tr>
<td>Insomnia</td>
<td>6.83</td>
<td>2.26</td>
<td>7.79</td>
<td>2.70</td>
<td>1.86</td>
</tr>
</tbody>
</table>
Discussion

There has been extensive research examining risk factors that are associated with suicidality; however, the research in assessing these individuals’ levels of suicidal ideation is far less extensive. This aspect of the field is potentially one of the most important, in that it helps the practitioner understand the patient’s suicidality and how he or she can be best treated. Thus, the purpose of this study was to examine the SIS score and its validity in assessing these individuals. To do this, common risk factors were examined to understand how these individuals scored on similar facets as well as the SIS. It was hypothesized that individuals in the WTD group would report significantly more suicidal ideation, suicide attempts, and NSSI. Furthermore, the most validated theory of suicide, the IPTS, was also used to understand these how these individuals may rate on the SIS scale. It was expected that individuals that reported a complete WTD, would also report higher levels of thwarted belongingness, perceived burdensomeness, and acquired capability than those in the WTL/AMB group.

The results of the t-tests partially supported the above hypotheses. Individuals in the WTD group reported significantly higher levels of thwarted belongingness, acquired capability, and suicidal ideation. It seems quite apparent that individuals in the WTD group would also exhibit significantly higher levels of suicidal ideation; yet, this is an important finding for validating the SIS scale. This result verifies that the SIS is representing the cognitive aspect of suicidality and that it is separating the more severe individuals who are also reporting more severe and higher levels of suicidal thoughts.

Significant between-group differences regarding thwarted belongingness validate previous hypotheses that individuals in the WTD category do not feel a sense of
belongingness and attachment to others. These individuals often systematically remove reasons for living by isolating and detaching from family, friends, and society. It is believed that, after individuals experience thwarted belongingness, suicidal ideation develops (Van Orden et al., 2010) and it appears that there is a significant relationship between these two concepts; however, directionality cannot be assumed. Future researchers should implement a longitudinal design to further investigate this, and other relationships.

Van Orden and colleagues (2010) explained that acquired capability requires a cognitive appraisal that the pain involved in self-harm is tolerable. As proposed by O’Connor and colleagues (2012b), it appears that this cognitive aspect of acquired capability may be reflected in the SIS. It is especially interesting that acquired capability was higher in those in the WTD group since this is a veteran population. This elevation could be a reflection of their exposure to the possibility of their own death, as well as the death of others. This supports the idea that acquired capability may not only be a physical, but also a mental concept.

Unexpectedly, that the concept of perceived burdensomeness was not higher in those who were in the WTD group. It was hypothesized that these individuals feel that they are so flawed that they are liability to others and that others are better off if they were dead (Van Orden et al., 2010). When this is felt, it appears that individuals with a sense of perceived burdensomeness have lost many of their reasons for living, which would lead to higher suicidal ideation; however, this process was not shown in the current population but has been supported in previous studies with veterans (Joiner Jr et al., 2009; Monteith et al., 2013; Pfeiffer et al., 2014). One has to consider why these
individuals are not exhibiting the same features of suicidality. Since these are the same individuals that are experiencing thwarted belongingness, it could potentially be that they are not feeling this sense of perceived burdensomeness because they are not connected with many people to be a burden on. This hypothesis is beyond the realm of the current study, but could be an interesting area to research in the future.

As predicted, the individuals that fell within the WTD group also reported higher rates of suicide attempts and NSSI. Although this seems somewhat obvious, it is an important indicator that the SIS scale differentiates between those with more severe and long-term suicidal ideation. While both are cognitive components of suicidality, attempts are more of an active experience than what the WTD item assess. It also seems that a WTD may be more of an attachment to suicide than suicidal ideation; however, these are simply philosophies and need further research.

In addition to the primary hypotheses, the findings also partially support the exploratory hypothesis in that individuals in the WTD group exhibited higher levels of posttraumatic stress. This was consistent with many studies that showed higher rates of suicide and suicidal ideation among veterans with PTSD and/or other comorbid disorders (Jakupcak et al., 2009). Although significant differences were not shown on measures of alcohol use, drug use, anxiety sensitivity, insomnia, overall functioning, or readiness to change, these were exploratory and need to be further examined before making a confident conclusion. It appears that while these may not be significantly different for the two groups examined, it is possible that these are risk factors that mediate a severe WTD, and may lead to more active suicidal thoughts or concepts such as: thwarted belongingness, acquired capability, or suicidal ideation over time.
The current results provide encouraging support that the SIS is valid in determining tiers of risk in severe patient populations; however, there are limitations that must be considered. First, the sample size of 93 was adequate for our research purposes, but potentially confounding due to the sample characteristics. It was solely a veteran population composed of 88% males and approximately 70% Caucasians. Additionally, the sample was derived from an inpatient psychiatric unit. Although this specific veteran population was useful in determining generalization, it may not be representative of the broader spectrum of patients treated in outpatient and other clinics. This was also a very severe population. Due to the lack of dispersion among the three groups, two were merged; this methodological concern must be kept in mind. While the focus was to respect and examine each group as a different level of suicidality, it was not practical to do so in the current study. It is important to view these three groups as distinct entities with varying levels of severity. The current study simply focuses on the most severe group and those individuals’ differences compared to all others. Despite a relatively small difference in total score on the SIS, individuals who reported a complete WTD and no WTL were characterized by greater severity for multiple risk factors associated with suicide as compared to those classified in the WTL and AMB groups.

The implications from this study are potentially the most important aspect to observe. While the results were influential in validating this scale, they were also useful in a clinical setting. It appears that, especially in a veteran population, the more prevalent aspects of suicidality to examine are thwarted belongingness and acquired capability, along with increased suicide attempts, NSSI, ideation, and posttraumatic stress. It is important to measure and to continue monitoring these risk factors while assessing and
treating these individuals. If one is exhibiting some aspects of thwarted belongingness, it is important to further investigate this and work on integrating family and potential reasons for living back into this individual’s life. Acquired capability, on the other hand, will not be as easy to target in therapy but is important to measure and consider when understanding the client’s risk for suicide. Posttraumatic stress is often higher among veterans and should most definitely be assessed, especially now that it has been shown to be higher among those with a more severe WTD. Furthermore, it is now more obvious than ever to assess the client’s number of past suicide attempts and NSSI, along with levels of ideation to assess the individual’s increased potential to be in the most severe WTD group. One of the most important messages to remember from this study is that not all suicidal individuals want to die; suicidality is a complex struggle between a WTL and a WTD that needs to be treated as such.

**Conclusion**

Overall, the SIS classification system continues to demonstrate clinical utility in determining tiers of risk in severe patient populations. Individuals that report a complete WTD and no ambivalence or WTL, also report higher levels of thwarted belongingness, acquired capability, suicidal ideation, and posttraumatic stress. The most severe group also reported more accounts of suicide attempts and NSSI. Continued research with larger and more diverse populations would be useful to determine if the SIS is a valid tool for assessment and treatment. Modeling approaches utilizing longitudinal data would also provide an opportunity to study the relationship between the SIS and other outcomes of interest across time. Matching with non-suicidal individuals as a control group would also be a useful addition to a future study. The significance of the SIS in helping identify
the severity of suicidal ideation is immense. This research has added value to suicide risk assessment and can be extremely useful in the clinical setting when choosing therapy focus, which will confidently result in helping these individuals.
Appendix A: The Scale for Suicidal Ideation-Current (SSI-C)

Interviewer: “Think about a time in the last two weeks (or day things were so bad it brought you to the hospital- if admitted longer than 2 weeks ago) that you felt the most suicidal or the worst off emotionally. Think about that day and answer all of the following questions how you would have answered that day:” (If answers for SSI01-SSI05 are “0”, code SSI06-SSI19 “8” and skip to next measure.)

1. CHARACTERISTICS TOWARD LIVING/DYING

*SSI01_____ WISH TO LIVE
INT: “Can you tell me about your desire to live, your wish to live on that day? Was it moderate to strong? Weak? Or None?”

0 = Moderate to strong
1 = Weak
2 = None

*SSI02_____ WISH TO DIE
INT: “Can you tell me about your desire to die, your wish to die on that day? Was it moderate to strong? Weak? Or None?”

0 = None
1 = Weak
2 = Moderate to strong

*SSI03_____ REASONS FOR LIVING AND DYING
INT: “Would you say that your reasons for living outweighed your reasons for dying? Would you say that your reasons for dying outweighed your reasons for living? Or were they about equal?”

0 = For living outweigh for dying
1 = About equal
2 = For dying outweigh for living

*SSI04_____ DESIRE TO MAKE ACTIVE SUICIDE ATTEMPT
INT: “(On that day) what was your desire to make an active suicide attempt, to actively harm yourself, actively kill yourself? Was there no desire at all? Was it a weak desire, or moderate to strong?”

0 = None
1 = Weak
2 = Moderate to strong

*SSI05_____ PASSIVE SUICIDAL ATTEMPT
INT: “On that day did you have any passive suicidal feelings? For instance would you, in fact, take precautions necessary to save your life? Would you take medicine to save your life? Would you drive safely to keep yourself alive? Or, would you be deliberately careless, leaving life and death to chance? An example might be, crossing the street without looking, having a fatalistic attitude that if you live, you live; if you get hit, it was meant to be, i.e. not really caring what happens; being very careless with your life. Or, would you actively avoid steps to save or maintain your life, i.e. if you were diabetic,
would you deliberately avoid taking your insulin as a way of showing that you didn’t care
about life or death?”

0 = Would take precautions
1 = Would leave life/death to chance
2 = Would avoid steps necessary to save or maintain life

**INT: If subject scores “0” for SSI04-SSI05, STOP interview and code the rest “-17”.**

**II. CHARACTERISTICS OF SUICIDE IDEATION/WISH**

**SSI06_____ TIME DIMENSION: DURATION**

**INT:** “Did you have thoughts of suicide for brief, fleeting periods, i.e. momentary
thoughts or images that come and go in a few seconds and do not interfere with the your
ability to concentrate, solve problems, or attend to tasks? Were they longer than that, i.e.
suicidal thoughts that last a few minutes at a time and occupy your full attention but the
thoughts do not last long enough to disrupt your activities? Or were they continuous, i.e.
you are often absorbed in thoughts of suicide, thoughts pre-occupy you for many hours of
the day and markedly disrupt your ability to concentrate and to attend to tasks?”

0 = Brief, fleeting periods
1 = Longer periods
2 = Continuous (chronic), or almost continuous

**SSI07_____ TIME DIMENSION: FREQUENCY**

**INT:** “How often did you have thoughts of suicide? Did they occur rarely, occasionally,
i.e. you thought about suicide once or twice (at most) during a depressive episode, and no
more than three or four times in a year? Did the thoughts occur more frequently, that is,
intermittently, i.e. you did not think of suicide more than once a day (on average) during
a depressive episode or more than once a week (on average) during one year? Or, did you
have the thoughts all of the time or most of the time, i.e. you think of suicide at least once
a day?”

0 = Rare, occasional
1 = Intermittent
2 = Persistent or continuous

**SSI08_____ ATTITUDE TOWARD IDEATION/WISH**

**INT:** “What were your attitudes toward suicide? Did you reject the notion of suicide,
meaning that you feel that suicide is not a good option; it’s not okay to do; it’s wrong? Or
was your attitude uncertain; you feel generally suicide may be wrong, but in some cases
it’s okay, that if you are depressed enough, it makes sense…it’s understandable, but it
could be a tragic mistake; you’re not sure? Or did you feel that suicide is your right; it’s
okay to do; it’s something that you have choice about, and you accept that choice?”

0 = Rejecting
1 = Ambivalent; indifferent
2 = Accepting

**SSI09_____ CONTROL OVER SUICIDAL ACTION/ACTING-OUT WISH**

**INT:** “With regard to your suicidal thoughts, did you feel that you have control over
those thoughts? Can you have the thoughts without doing anything to harm yourself? Or,
were you not sure whether or not you could control your actions? Are your thoughts so strong that you might act on them? Did you feel that your thoughts about suicide are so strong that you have no sense of control over your actions, that you are in danger of harming yourself or killing yourself at any time?”

\[
\begin{align*}
0 & = \text{Has sense of control} \\
1 & = \text{Unsure of control} \\
2 & = \text{Has no sense of control}
\end{align*}
\]

SSI10_____ DETERRENTS TO ACTIVE ATTEMPT (e.g., family, religion; serious injury if unsuccessful; irreversible) Indicate deterrents, if any:

INT: “Did thinking about anyone or anything prevent you from taking your own life, (i.e. family concerns; religious beliefs; the possibility of serious, irreparable injury if the attempt is unsuccessful; the pain and suffering involved in a suicide attempt; the fear of hurting or disturbing significant others; the belief that others need you; the fear of death; responsibility for a job)? Would [deterrents] absolutely prevent you from attempting suicide? Or, are you unsure that your concern about [deterrents] would absolutely prevent you from attempting suicide?”

\[
\begin{align*}
0 & = \text{Would not suicide because of deterrent} \\
1 & = \text{Some concern about deterrents} \\
2 & = \text{Minimal or no concern about deterrents}
\end{align*}
\]

SSI11_____ REASON FOR CONTEMPLATED ATTEMPT

INT: “When you thought about killing yourself, what were the main reasons? Was the main reason in order to get attention, to get revenge on someone who has hurt you, in order to let the world know how hurt you are or how much help you need? Or was the main reason to escape, to solve problems, to leave all the problems behind, to just end it all and get away from everything? Was it a combination of both: part of you wants help, wants to cry for help, wants to show that you need attention but part of you would also like to end all your problems and escape?”

\[
\begin{align*}
0 & = \text{To manipulate the environment, get attention, revenge} \\
1 & = \text{Combination of “0” and “2”} \\
2 & = \text{Escape, surcease, solve problems}
\end{align*}
\]

III.CHARACTERISTICS OF CONTEMPLATED ATTEMPT

SSI12_____ METHOD: SPECIFICITY/PLANNING

INT: “Had you thought of ways to kill yourself?” (If ‘No’ score 0, skip to SSI13) If ‘Yes’: “How would you have killed yourself? (Ask additional questions to ascertain whether or not the subject has a specific suicide plan. If the subject cannot state the location or the height of the window from which she plans to jump, or if the subject does not know what kind of pills she would use, or how many pills she would need take, or where she would get the pills, score 1. If the subject reveals a specific plan, such as ’I’d take out my gun and shoot myself in the head,’ or ’I’d take all of my Benadryl, drink a fifth of whiskey, get into my car in the garage, turn on the engine and go to sleep forever,’ score 2.
0 = Not considered
1 = Considered but details not worked out
2 = Details worked out/well-formulated

*SSI13_____ METHOD: AVAILABILITY/OPPORTUNITY

INT: “Had you worked out the way to carry out your thoughts of suicide? Did you have the chance right then? Did you think that you would have the chance to kill yourself soon?” (If subject answers i.e., ‘I’d shoot myself, but I don’t own a gun, and besides, with all my business and family obligation, I’d never get the chance to pull it off without someone noticing that something was wrong’ etc. score 0, skip to SSI14. If the subject believes that he could obtain the means to kill himself and that he could find the opportunity but the actions would require him to make special efforts i.e. ‘I’d have to make sure that I sent my kids away to my mother’s place upstate for the weekend, then I’d have to get a prescription for sleeping pills, and then I’d have to drive to a motel far away where nobody could call me or find me’ etc. score 1. If the subject has both the means and the opportunity readily available i.e. owns a gun and ammunition and lives alone score 2a. If the means and the opportunity will be available soon i.e. subject’s parents will be on vacation next week and the subject will be left alone with a medicine cabinet full of the parents’ medications score 2b.)

0 = Method not available; no opportunity
1 = Method would take time/effort; opportunity not really available
2a = Method/cheap opportunity available
2b = Future opportunity or availability of method anticipated

*SSI14_____ SENSE OF “CAPABILITY” TO CARRY OUT ATTEMPT

INT: “Did you believe that you had the know-how, the ability, and the motivation to commit suicide? Did you know exactly what you’d have to do to cause your own death, and did you feel sure that you would not hesitate to harm yourself?”

0 = No courage, weak, afraid, incompetent
1 = Unsure of courage, competence
2 = Sure of competence, courage

*SSI15_____ EXPECTENCY/ANTICIPATION OF ACTUAL ATTEMPT

INT: “Did you expect or anticipate at some point in the future that you will actually make a suicide attempt? Were you certain that you will not make an attempt? Were you unsure? Or, were you absolutely sure that at some point in the future you will make an attempt?”

0 = No
1 = Uncertain, not sure
2 = Yes

IV. ACTUALIZATION OF COMTEMPLATED ATTEMPT

*SSI16_____ ACTUAL PREPARATION

INT: “Did you take any steps to make it possible for you to take your own life? In other words: had you actually put your method into place?” (Has not made any preparations,
score 0. Preparations are not quite complete, i.e. has started collecting pills, score 1. Preparations are complete, i.e. the subject has acquired a sufficient quantity of pills to take his own life; the subject possesses a loaded gun, score 2.)

0 = None
1 = Partial (e.g. starting to collect pills)
2 = Complete (e.g. had pills, razor, loaded gun)

SSI17 SUICIDE NOTE

INT: “Did you start or finish writing a suicide note? What were the contents of the note?”

0 = None
1 = Started but not yet completed or deposited; only thought about
2 = Completed; deposited

SSI18 FINAL ACTS IN ANTICIPATION OF DEATH (insurance, will, gifts, etc.)

INT: “Did you tie up loose ends because you anticipated dying? For example, did you take out an insurance policy or prepare a will?”

0 = None
1 = Thought about or made some arrangements
2 = Made definite plans or completed arrangements

SSI19 DECEPTION/CONCEALMENT OF CONTEMPLATED ATTEMPT

INT: “Sometimes people hesitate to talk about their suicidal thoughts because other people will think they’re crazy or they will have to stay in the hospital. Could this have gone on with you? With your thoughts about suicide, did you tell someone close to you? Or did you hesitate? Did you deliberately not tell anybody so that no one could stop you?”

0 = Revealed ideas openly
1 = Held back on revealing
2 = Attempted to deceive
Appendix B: The Acquired Capability Scale for Suicide (ACSS)

Please read each item below and indicate to what extent you feel the statement describes you. Rate each statement using the scale below and indicate your responses on your answer sheet.

0   1   2   3   4
Not at all like  Much  Me  Very like

______ ACSS 1. Things that scare most people do not scare me.
______ ACSS 2. The sight of my own blood does not bother me.
______ ACSS 3. I avoid certain situations (e.g., certain sports) because of the possibility of injury.
______ ACSS 4. I can tolerate a lot more pain than most people.
______ ACSS 5. People describe me as fearless.
______ ACSS 6. The sight of blood bothers me a great deal.
______ ACSS 7. The fact that I am going to die does not affect me.
______ ACSS 8. The pain involved in dying frightens me.
______ ACSS 9. Killing animals in a science course would not bother me.
______ ACSS 10. I am very much afraid to die.
______ ACSS 11. It does not make me nervous when people talk about death.
______ ACSS 12. The sight of a dead body is horrifying to me.
______ ACSS 13. The prospect of my own death arouses anxiety in me.
______ ACSS 14. I am not disturbed by death being the end of life as I know it.
______ ACSS 15. I like watching the aggressive contact in sports games.
______ ACSS 16. The best parts of hockey games are the fights.
______ ACSS 17. When I see a fight, I stop to watch.
______ ACSS 18. I prefer to shut my eyes during the violent parts of movies.
______ ACSS 19. I am not at all afraid to die.
______ ACSS 20. I could kill myself if I wanted to. (Even if you have never wanted to kill yourself, please answer this question.)
Appendix C: The Interpersonal Needs Questionnaire (INQ)

The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you’ve been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what you think and feel.

1. Not at all true for me
2. Somewhat true for me
3. Very true for me

_____ INQ1. These days the people in my life would be better off if I were gone.
_____ INQ2. These days I think I give back to society.
_____ INQ 3. These days the people in my life would be happier without me.
_____ INQ 4. These days I think I have failed the people in my life.
_____ INQ 5. These days I think people in my life would miss me if I went away.
_____ INQ 6. These days I think I am a burden on society.
_____ INQ 7. These days I think I am an asset to the people in my life.
_____ INQ 8. These days I think my ideas, skills, or energy make a difference.
_____ INQ 9. These days I think my death would be a relief to the people in my life.
_____ INQ 10. These days I think I contribute to the well-being of the people in my life.
_____ INQ 11. These days I feel like a burden on the people in my life.
_____ INQ 12. These days I think the people in my life wish they could be rid of me.
_____ INQ 13. These days I think I contribute to my community.
_____ INQ 14. These days I think I make things worse for the people in my life.
_____ INQ 15. These days I think I matter to the people in my life.
_____ INQ 16. These days, other people care about me.
_____ INQ 17. These days, I feel like I belong.
_____ INQ 18. These days, I rarely interact with people who care about me.
_____ INQ 19. These days, I feel unwelcome in most social situations.
_____ INQ 20. These days, I am fortunate to have many caring and supportive friends.
_____ INQ 21. These days, I often feel like an outsider in social gatherings.
_____ INQ 22. These days, I feel that there are people I can turn to in times of need.
_____ INQ 23. These days, I feel unwelcome in most social situations.
_____ INQ 24. These days, I am close to other people.
_____ INQ 25. These days, I have at least one satisfying interaction every day.
Appendix D: The Lifetime-Suicide Attempt Self-Injury Count (L-SASI)

Now we’re going to talk about self-injury (i.e. times when you have hurt yourself) or suicide attempts. For this, I want you to think about any time you have intentionally harmed yourself. This can include a number of different things such as cutting or burning yourself, taking an overdose of pills, or banging your head. It does not include such things as smoking, drinking, or anorexia which you may do knowing it is harmful to you but are not acute. However, deliberately starving yourself in order to cause an acute electrolyte imbalance would count as a self-injury. I want you to include in what we talk about, any self-injury whether or not it was an attempt to kill yourself.

___ LPC1. Have you ever intentionally harmed yourself? (1=Yes, 0=No) (If no, -8 for all other questions)

___/___/___ LPC1a. When was the most recent time you intentionally harmed yourself with an intent to die (true intent or ambivalent)?
What did you do [CODE METHOD (5-16)]? Did you intend to die? (CIRCLE YES/NO/AMBIVALENT)?
What happened next? Did you receive medical treatment (CIRCLE MOST INTENSIVE TREATMENT: NONE/DOCTOR VISIT/ER/MED FLOOR/ICU)?
___How accurate is this date (1=Exact, 2=Within two weeks, 3=Within one month, 4=No idea, 5=Within 1 year)

___/___/___ LPC 2. When was the very first time in your life you intentionally harmed yourself? What did you do [CODE METHOD (5-16)]? Did you intend to die? (CIRCLE YES/NO/AMBIVALENT)?
What happened next? Did you receive medical treatment (CIRCLE MOST INTENSIVE TREATMENT: NONE/DOCTOR VISIT/ER/MED FLOOR/ICU)?
___How accurate is this date (1=Exact, 2=Within two weeks, 3=Within one month, 4=No idea, 5=Within 1 year)

___/___/___ LPC 3. When was the most recent time you intentionally harmed yourself? What did you do [CODE METHOD (5-16)]? Did you intend to die? (CIRCLE YES/NO/AMBIVALENT)?
What happened next? Did you receive medical treatment (CIRCLE MOST INTENSIVE TREATMENT: NONE/DOCTOR VISIT/ER/MED FLOOR/ICU)?
___How accurate is this date (1=Exact, 2=Within two weeks, 3=Within one month, 4=No idea, 5=Within 1 year)
4. When was the time that you most severely harmed yourself? What did you do [CODE METHOD (5-16)]? Did you intend to die? (CIRCLE YES/NO/AMBIVALENT)? What happened next? Did you receive medical treatment (CIRCLE MOST INTENSIVE TREATMENT: NONE/DOCTOR VISIT/ER/MED FLOOR/ICU)? How accurate is this date (1=Exact, 2=Within two weeks, 3=Within one month, 4=No idea, 5=Within 1 year)

It is important for us to get a better understanding of different things you may have done to hurt yourself, what prompted the self-injury, and when you might have needed medical treatment. What I’d like to do is go through different types of self injury and have you tell me how many times you have harmed yourself using various methods and were (a) intending to die, (b) ambivalent (i.e. had mixed feelings), or (c) not intending to die and how many times you received medical treatment for the self-injury and what medical treatment(s) you got.
**Appendix E: The Outcome Questionnaire-45.2 (OQ-45.2)**

Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
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</thead>
<tbody>
<tr>
<td>QO1. I get along well with others.</td>
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<td>QO 2. I tire quickly.</td>
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<td>QO 3. I feel no interest in things.</td>
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<td>QO 4. I feel stressed at work/school.</td>
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<td>QO 5. I blame myself for things.</td>
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<td>QO 6. I feel irritated.</td>
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<td>QO 7. I feel unhappy in my marriage/significant relationship.</td>
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<td>QO 8. I have thoughts of ending my life.</td>
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<td>QO 9. I feel weak.</td>
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<td>QO10. I feel fearful.</td>
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<td>QO11. After heavy drinking, I need a drink the next morning to get going.</td>
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<td>(If you do not drink, mark “never”.)</td>
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<td>QO12. I find my work/school satisfying.</td>
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<td>QO13. I am a happy person.</td>
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<td>QO14. I work/study too much.</td>
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<td>QO15. I feel worthless.</td>
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<td>QO16. I am concerned about family troubles.</td>
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<td>QO17. I have an unfulfilling sex life.</td>
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<td>QO18. I feel lonely.</td>
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<td>QO19. I have frequent arguments.</td>
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<td>QO20. I feel loved and wanted.</td>
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<td>QO21. I enjoy my spare time.</td>
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<td>QO22. I have difficulty concentrating.</td>
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<td>QO23. I feel hopeless about the future.</td>
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<td>QO24. I like myself.</td>
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<td>QO25. Disturbing thoughts come into my mind that I cannot get rid of.</td>
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<td>QO26. I feel annoyed by people who criticize my drinking (or drug use)....</td>
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<td>(If not applicable, mark “never”.)</td>
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<td>QO27. I have an upset stomach.</td>
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<td>QO28. I am not working/studying as well as I used to.</td>
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<td>QO29. My heart pounds too much.</td>
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<td>QO30. I have trouble getting along with friends and close acquaintances.</td>
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<td>QO31. I am satisfied with my life.</td>
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<td>Question</td>
<td>Never</td>
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<td>Sometimes</td>
<td>Frequently</td>
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<td>OQ32. I have trouble at work/school because of drinking or drug use.... (If not applicable, mark “never.”)</td>
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<td>OQ33. I feel that something bad is going to happen.</td>
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<td>OQ34. I have sore muscles.</td>
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<td>OQ35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.</td>
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<td>OQ36. I feel nervous...........................................................................</td>
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<td>OQ37. I feel my love relationships are full and complete.</td>
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<td>OQ38. I feel that I am not doing well at work/school......................</td>
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<td>OQ39. I have too many disagreements at work/school.</td>
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<td>OQ40. I feel something is wrong with my mind.................................</td>
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<td>OQ41. I have trouble falling asleep or staying asleep.</td>
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<td>OQ42. I feel blue..................................................................................</td>
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<td>OQ43. I am satisfied with my relationships with others.</td>
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<td>OQ44. I feel angry enough at work/school to do something I might regret...</td>
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<td>OQ45. I have headaches.</td>
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Appendix F: The Stages of Change Questionnaire (SOCQ)

This questionnaire is to help us improve services. Each statement describes how a person might feel when starting therapy or approaching problems in their lives. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel.

There are FIVE possible responses to each of the items in the questionnaire:

1 = Strongly Disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly Agree

SOC1. I think I might be ready to improve myself 1 2 3 4 5

SOC2. I am doing something about the problems that have been bothering me. 1 2 3 4 5

SOC3. It might be a good thing and worth it to work on my problems. 1 2 3 4 5

SOC4. I’m not the one with the problem. It doesn’t make much sense for me to be here. 1 2 3 4 5

SOC5. It worries me that problems that I have already changed might come back, so I am here to get help. 1 2 3 4 5

SOC6. I am finally doing some work on the problems. 1 2 3 4 5

SOC7. I’ve been thinking that I might want to change something about myself. 1 2 3 4 5

SOC8. Being here is pretty much a waste of time for me because problems don’t have to do with me. 1 2 3 4 5

SOC9. I guess I have faults, but there is nothing I really need to change. 1 2 3 4 5

SOC10. I have a problem and I really think I should work on it. 1 2 3 4 5

SOC11. Even though sometimes I have trouble changing, at least I am working on my problems. 1 2 3 4 5

SOC12. I might need help right now for me to keep up the changes I’ve already made. 1 2 3 4 5

SOC13. I may be part of the problem, but I don’t really think I am. 1 2 3 4 5
SOC14. Anyone can talk about changing, but I’m really doing something about it.

SOC15. All this talk about behavior is boring. Why can’t people just forget about their problems?

SOC16. I’m here to keep my problems from coming back.

SOC17. I am actively working on my problems.

SOC18. After all I have done to change my problems, they sometimes come back to bother me.
Appendix G: The Alcohol Use Disorders Identification Test (AUDIT)

Please circle the answer that is correct for you

ADT1. How often do you have a drink containing alcohol?
   0. Never
   1. Monthly or less
   2. 2-4 times a month
   3. 2-3 times a week
   4. 4 or more times a week

ADT2. How many standard drinks containing alcohol do you have on a typical day when drinking?
   0a. 0
   0. 1 or 2
   1. 3 or 4
   2. 5 or 6
   3. 7 to 9
   4. 10 or more

ADT3. How often do you have six or more drinks on one occasion?
   0. Never
   1. Less than monthly
   2. Monthly
   3. Weekly
   4. Daily or almost daily

ADT4. During the past year, how often have you found that you were not able to stop drinking once you had started?
   0. Never
   1. Less than monthly
   2. Monthly
   3. Weekly
   4. Daily or almost daily

ADT5. During the past year, how often have you failed to do what was normally expected of you because of drinking?
   0. Never
   1. Less than monthly
   2. Monthly
   3. Weekly
   4. Daily or almost daily
ADT6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?
   0. Never
   1. Less than monthly
   2. Monthly
   3. Weekly
   4. Daily or almost daily

ADT7. During the past year, how often have you had a feeling of guilt or remorse after drinking?
   0. Never
   1. Less than monthly
   2. Monthly
   3. Weekly
   4. Daily or almost daily

ADT8. During the past year, have you been unable to remember what happened the night before because you had been drinking?
   0. Never
   1. Less than monthly
   2. Monthly
   3. Weekly
   4. Daily or almost daily

ADT9. Have you or someone else been injured as a result of your drinking?
   0. No
   1. Yes, but not in the past year
   2. Yes, during the past year

ADT10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?
   0. No
   1. Yes, but not in the past year
   2. Yes, during the past year
Appendix H: The Drug Abuse Screening Test-10 (DAST-10)

The following questions concern information about your potential involvement with drugs excluding alcohol and tobacco during the past 12 months. Carefully consider each question and decide if the answer is “Yes” or “No.”

When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter medications used in excess of the directions and any non-medical use of any drugs. The various classes of drugs may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints, etc…), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed), hallucinogens (e.g., LSD), or narcotics (e.g., Heroin). Remember that the questions do not include alcohol or tobacco. Please answer every question. If you are difficulty with a question, then choose the response that is mostly right.

These questions refer to the last 12 months only.
1. Have you used drugs other than those required for medical reasons? Yes No
2. Do you abuse more than one drug at a time? Yes No
3. Are you always able to stop using drugs if you want to? Yes No
4. Have you had “blackouts” or “flashbacks” as a result of drug use? Yes No
5. Do you ever feel bad or guilty about your drug use? Yes No
6. Does your spouse (or parent) ever complain about your involvement with drugs? Yes No
7. Have you neglected your family because of your drug use? Yes No
8. Have you engaged in illegal activities in order to obtain drugs? Yes No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? Yes No
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc…)? Yes No
Appendix I: The Personal Identification Form (PIF)

PIF1. ___ Sex: 1=Female, 2=Male, 3=Transgendered

PIF2.__/______/______ Date of Birth

PIF3. ______ Age (in years)

PIF4. ______ Is your ethnic background Hispanic or Latino? 1=Yes, 0=Not Hispanic or Latino

PIF5. ______ What is your racial background?
   1=White/Caucasian (includes Middle Eastern and North African origins)
   2=Native American, American Indian, or Alaska Native
   3=Black or African American (except North African origins is counted as White)
   4=Chinese or Chinese American
   5=Japanese or Japanese American
   6=Korean or Korean American
   7=Other Asian or other Asian American (includes India, Malaysia, Pakistan, Philippines)
   8=Mexican, Mexican American or Chicano
   9=Puerto Rican
   10=Other Hispanic/Latino
   11=East Indian
   12=Middle Eastern/Arab
   13=Native Hawaiian or other Pacific Islander
   14=Other
   (5a. Please specify__________________________________)

PIF6. ______ If bi-racial, select a second answer from the following choices.
   1=White/Caucasian (includes Middle Eastern and North African origins)
   2=Native American, American Indian, or Alaska Native
   3=Black or African American (except North African origins is counted as White)
   4=Chinese or Chinese American
   5=Japanese or Japanese American
   6=Korean or Korean American
   7=Other Asian or other Asian American (includes India, Malaysia, Pakistan, Philippines)
   8=Mexican, Mexican American or Chicano
   9=Puerto Rican
   10=Other Hispanic/Latino
   11=East Indian
   12=Middle Eastern/Arab
   13=Native Hawaiian or other Pacific Islander
   14=Other
   (6a Please specify__________________________________)

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PIF7. ______ Have you ever been homeless? 0=No 1=Yes
If Yes: how old were you? PIFa.______ 0-10 PIF7a1.____ with a parent (0=No, 1=Yes)
PIF7b.______ 11-17 PIF7b1.____ with a parent (0=No, 1=Yes)
PIF7c.______ 18 and up
PIF8. Are you currently homeless? 0=No 1=Yes
PIF9.______ Have you ever been married? 0=No 1=Yes
PIF10. ______ What is your current relationship status?
1. Single (aka not dating anyone currently)
2. Dating casually, not living with a partner
3. In a monogamous relationship, living apart
4. In a monogamous relationship, living together
5. Other, describe
   10a)_____________________________________________________
PIF11.______ Have you ever been divorced? 0=No 1=Yes
   PIF11a. If so, how many times?______
   PIF11b. Length of first marriage: ________
   PIF11c. Length of second marriage: ________
   PIF11d. Length of third marriage: ________
   PIF11e. Length of fourth marriage: ________
PIF12. ______ Have you ever been in a legal domestic partnership or nonlegalized marriage?
   0=No 1=Yes
PIF13. ______ Have you ever ended a domestic partnership or nonlegalized marriage.
   PIF13a. Length of first domestic partnership: ________
   PIF13b. Length of second domestic partnership: ________
   PIF13b. Length of third domestic partnership: ________
PIF14. ______ Have you ever been widowed? 0=No 1=Yes
   PIF14a. If so, how many times? ________
   Please list your spouse’s age at death and cause of death:
   PIF14b. First spouse's age at death: ________
   PIF14c. First spouse's cause of death: ________________________
   PIF14d. Second spouse's age at death: ________
   PIF14e. Second spouse's cause of death: ________________________
PIF15.______ What is your current marital status
1. Single, never married
2. Widowed
3. Married
4. Separated
5. Divorced
PIF16. ______ What is your highest grade of formal education completed?
   1=eight grade or less
   2=some high school
   3=GED
   4=high school graduate
   5=business or technical training beyond high school
   6=some college
   7=college graduate
   8=some graduate or professional school beyond college
   9=masters degree
   10=doctoral degree

PIF17. What are your currently prescribed psychiatric medications?

PIF18. ______ Have you ever been a victim of abuse or neglect? 0=No 1=Yes
   PIF18a. Physical: ______ 0=No 1=Yes
   PIF18b. Sexual: ______ 0=No 1=Yes
   PIF18c. Emotional: ______ 0=No 1=Yes
   PIF18d. Neglect: ______ 0=No 1=Yes

PIF19. ______ Have you EVER abused drugs or alcohol? (Abuse is defined as: use of a mood or behavior-altering substance in a maladaptive pattern resulting in significant impairment or distress, such as failure to fulfill social or occupational obligations or recurrent use in situations in which it is physically dangerous to do so or which end in legal problems)  0=No 1=Yes
   PIF19a1. First period of abuse (Years and Months):____________________
   PIF19a2. Substances abused:____________________________________
   PIF19b1. Second period of abuse (Years and Months):____________________
   PIF19b2. Substances abused:____________________________________
   PIF19c1. Third period of abuse (Years and Months):____________________
   PIF19c2. Substances abused:____________________________________
   PIF19d1. Fourth period of abuse (Years and Months):____________________
   PIF19d2. Substances abused:____________________________________
   PIF19e1. Fifth period of abuse (Years and Months):____________________
   PIF19e2. Substances abused:____________________________________

PIF20. ______ Do you generally think of your family as being supportive of you? 0=No 1=Yes

PIF21. ______ Do you generally think of there being a good deal of conflict in your family? 0=No 1=Yes
PIF22. With what psychiatric or mental health problems have you been diagnosed?

____________________________________________________

PIF23. _______Has anyone in your family been diagnosed with psychiatric or mental health problems? 0=No 1=Yes
   PIF23a. List conditions:
      PIF23a1. Mother:__________________________________________
      PIF23a2. Father:__________________________________________
      PIF23a3. Siblings:__________________________________________
      PIF23a4. Biological Grandparents:______________________________
      PIF23a5. Biological Aunts/Uncles:______________________________
      PIF23a6. Biological Cousins:______________________________
      PIF23a7: Biological Children:____________________________________

PIF24. _______Have you been deployed to a war zone? 0=No 1=Yes
   PIF24a. Total number of deployments to war zone: ______
   PIF24b. Total months deployed to war zone: ___________

PIF25. _______Have you been in combat? (Combat includes actual engagement in conflict with armed, hostile forces, as well as witnessing such conflict) 0=No 1=Yes
   PIF25a. Number of deployments including combat exposure: _________
   PIF25b. Total months of combat exposure: ___________

PIF26. _______Have you sustained combat injuries? 0=No 1=Yes

      PIF26a. Injury:________________________________________________
      PIF26b. Injury:________________________________________________
      PIF26c. Injury:________________________________________________
      PIF26d. Injury:________________________________________________
      PIF26e. Injury:________________________________________________
      PIF26f. Injury:________________________________________________

PIF27. Service:
   PIF27a1. Branch:________________________________________________
   PIF27a2. Dates:________________________________________________
   PIF27b1. Branch:________________________________________________
   PIF27b2. Dates:________________________________________________
   PIF28a1. Branch:________________________________________________
   PIF28a2. Dates:________________________________________________
Appendix J: The Common Data Elements (CDE)

INSTRUCTIONS: Please read all of the statements in a given group. Pick out and circle the one statement in each group that describes you best for the past TWO weeks. If several statements in a group seem to apply to you, pick the one with the higher number. BE SURE TO READ ALL OF THE STATEMENTS IN EACH GROUP BEFORE MAKING YOUR CHOICE.

1. (0) I do not have thoughts of killing myself.
   (1) Sometimes I have thoughts of killing myself.
   (2) Most of the time I have thoughts of killing myself.
   (3) I always have thoughts of killing myself.

2. (0) I am not having thoughts about suicide.
   (1) I am having thoughts about suicide but have not formulated any plans.
   (2) I am having thoughts about suicide and am considering possible ways of doing it.
   (3) I am having thoughts about suicide and have formulated a definite plan.

3. (0) I am not having thoughts about suicide.
   (1) I am having thoughts about suicide but have these thoughts completely under my control.
   (2) I am having thoughts about suicide but have these thoughts somewhat under my control.
   (3) I am having thoughts about suicide but have little or no control over these thoughts.

4. (0) I am not having impulses to kill myself.
   (1) In some situations I have impulses to kill myself.
   (2) In most situations I have impulses to kill myself.
   (3) In all situations I have impulses to kill myself.

INSTRUCTIONS: Please circle the number beside the statement or phrase that best applies to you. CIRCLE ONLY ONE ANSWER for each question.

5. Have you ever thought about or attempted to kill yourself?
   (1) Never
   (2) It was just a brief passing thought
   (3) I have had a plan at least once to kill myself but did not try to do it
   (4) I have had a plan at least once to kill myself and really wanted to die
   (5) I have attempted to kill myself, but did not want to die
   (6) I have attempted to kill myself, and really hoped to die

6. How often have you thought about killing yourself in the past year?
   (0) Never
   (1) Rarely (1 time)
   (2) Sometimes (2 times)
   (3) Often (3-4 times)
   (4) Very Often (5 or more times)

7. Have you ever told someone that you were going to commit suicide, or that you might do it?
   (1) No
   (2) Yes, at one time, but did not really want to die
   (3) Yes, at one time, and really wanted to do it
   (4) Yes, more than once, but did not want to do it
   (5) Yes, more than once, and really wanted to do it
8. How likely is it that you will attempt suicide someday?
   (0) Never
   (1) No chance at all
   (2) Rather Unlikely
   (3) Unlikely
   (4) Likely
   (5) Rather Likely
   (6) Very Likely

INSTRUCTIONS: Thinking about the MOST RECENT TIME YOU HURT YOURSELF ON PURPOSE WITH SOME INTENTION OF DYING, please select the choice that best reflects what you were thinking or feeling at the time. CIRCLE ONLY ONE ANSWER for each question. If you have never hurt yourself on purpose with some intention of dying, leave the next 4 questions blank.

9. How certain were you that what you had done would be fatal?
   (0) I thought that death was unlikely
   (1) I thought that death was possible but not probable
   (2) I thought that death was probable or certain

10. How certain were you that the method you had chosen would be lethal?
    (0) I did not think that what I did would be lethal
    (1) I wasn't sure if what I did would be lethal
    (2) I believed that what I did equaled or exceeded what would be lethal

11. At the time, to what extent did you intend to die?
    (0) I did not intend to die
    (1) Part of me intended to die and part of me did not
    (2) I intended to die

12. To what extent did you believe that what you had done could be fixed with medical attention?
    (0) I thought that death was unlikely if I had received medical attention
    (1) I was uncertain whether death could be avoided by medical attention
    (2) I was certain of death even if I received medical attention

INSTRUCTIONS: Please respond to the following questions by considering your own past experiences. Place your response on the line to the right of each question.

13. How many times in your lifetime have you made an attempt to kill yourself during which you had at least some intent to die? ________

14. Since you enrolled in this study or the last assessment (whichever is most recent), how many times have you made an attempt to kill yourself during which you had at least some intent to die? ________

15. Thinking about the most lethal attempt, describe the details of the plan and method used. Use the space below. If you have never attempted to kill yourself with at least some intent to die, please leave the space below blank.
16. Thinking about the most lethal attempt, describe the level of medical attention it required (If you have never attempted to kill yourself with at least some intent to die, please leave this question blank):
   (0) No medical attention required
   (1) Primary care doctor or nurse visit
   (2) Emergency room visit
   (3) Hospital admission to a general medical floor
   (4) Hospital admission to an Intensive Care Unit (ICU)

17. How many times in your lifetime have you purposefully hurt yourself without wanting to die? ______

18. Since you enrolled in this study or the last assessment (whichever is most recent), how many separate times have you purposefully hurt yourself without wanting to die? ______

INSTRUCTIONS: Please carefully read each group of statements below. Circle the one statement in each group that BEST describes how you have been feeling for the PAST WEEK, INCLUDING TODAY. Be sure to read all the statements in each group before making a choice.

19. (0) I have a moderate to strong wish to live.
    (1) I have a weak wish to live.
    (2) I have no wish to live.

20. (0) I have no wish to die.
    (1) I have a weak wish to die.
    (2) I have a moderate to strong wish to live.

INSTRUCTIONS: Please read the statements carefully one by one. If the statement describes your attitude for the PAST WEEK INCLUDING TODAY, circle “True” in the column next to the statement. If the statement does not describe your attitude, circle “False” in the column next to this statement. PLEASE BE SURE TO READ EACH STATEMENT CAREFULLY.

21. I happen to be particularly lucky, and I expect to get more of the good things in life than the average person. True False

22. I don’t expect to get what I really want. True False

23. Things just won’t work out the way I want them to. True False

INSTRUCTIONS: The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you’ve been feeling RECENTLY. Use the rating scale to find the number from 1 to 7 that best matches how you feel and write that number to the left of each question. There are no right or wrong answers: we are interested in what you think and feel.

Not at all true for me Somewhat true for me Very True for me
1 2 3 4 5 6 7

28. ______ These days, I have many supportive friends.
INSTRUCTIONS: Choose ONE PHRASE that best represents the extent to which you agree with the item. If any of the items concern something that is not part of your experience, answer on the basis of how you think you might feel if you had such an experience. Otherwise, answer all items on the basis of your own experience. Write the number of the corresponding phrase in the space provided.

29. _____ When my thoughts seem to speed up, I worry that I might be going crazy.
30. _____ When my mind goes blank, I worry that there is something terribly wrong with me.
31. _____ When I feel “spacey” or spaced out, I worry that I may be mentally ill.
32. _____ When I have trouble thinking clearly, I worry that there is something wrong with me.
33. _____ When I cannot keep my mind on a task, I worry that I might be going crazy.

INSTRUCTIONS: Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully then write in the corresponding number of the phrase that describes how much you have been bothered by that problem in the PAST MONTH.

Not at all   A little bit   Moderately   Quite a bit   Extremely
1           2           3           4           5
34. _____ Repeated, disturbing memories, thoughts, or images of a stressful military experience?
35. _____ Repeated, disturbing dreams of a stressful military experience?
36. _____ Suddenly acting or feeling as if a stressful military experience were happening again (as if you were reliving it)?
37. _____ Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful military experience?
38. _____ Avoiding thinking about or talking about a stressful military experience or avoiding having feelings related to it?
39. _____ Avoiding activities or situations because they reminded you of a stressful military experience?
40. _____ Being “super alert” or watchful or on guard?
41. _____ Feeling jumpy or easily startled?

INSTRUCTIONS: Please consider your own personal experience when responding to these questions.

42. Have you ever been hospitalized or treated in an emergency room following a head or neck injury?  Yes  No
43. Have you ever been knocked out or unconscious following an accident or injury?  Yes  No
44. Have you ever injured your head or neck in a car accident or from some other moving vehicle accident?  
   Yes  No

45. Have you ever injured your head or neck in a fight or a fall?  
   Yes  No

49. How often do you use prescription drugs more often or at greater quantities than prescribed?
   (0) Never
   (1) Monthly or less
   (2) 2-4 times a month
   (3) 2-3 times a week
   (4) 4 or more times a week

50. How often do you use other substances (e.g., marijuana, cocaine, heroin, meth, pills, etc.)?
   (0) Never
   (1) Monthly or less
   (2) 2-4 times a month
   (3) 2-3 times a week
   (4) 4 or more times a week

51. How many behavioral health treatment sessions have you attended in the past 3 months?

INSTRUCTIONS: Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s). Circle the number that best represents your response.

<table>
<thead>
<tr>
<th>Difficulty falling asleep</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very Severe</th>
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<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<table>
<thead>
<tr>
<th>Difficulty staying asleep</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very Severe</th>
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<tbody>
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<td>2</td>
<td>3</td>
<td>4</td>
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<table>
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<tr>
<th>Problems waking</th>
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<th>Moderate</th>
<th>Severe</th>
<th>Very Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</table>

55. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?
   (0) Very satisfied
   (1) Satisfied
   (2) Moderately satisfied
   (3) Dissatisfied
   (4) Very Dissatisfied

56. To what extent do you consider your sleep problems to INTERFERE with your daily functioning (e.g., daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood etc.) CURRENTLY?
   (0) Not at all Interfering
   (1) A little
   (2) Somewhat
   (3) Much
   (4) Very Much Interfering

57. Do you know anyone who has died by suicide? YES NO (Circle one)

If yes?

a. Did the death occur during your military career? YES NO (Circle one)
b. What was your relationship to the person who died by suicide?

They were my:_________________________

c. How close would you describe your relationship with this person? (Circle one)

<table>
<thead>
<tr>
<th>Not close</th>
<th>Somewhat Close</th>
<th>Very Close</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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</table>

d. Thinking about the effect of the person’s suicide on your life, please circle the most appropriate number below:

1. the death had little effect on my life
2. the death had somewhat of an effect on me but did not disrupt my life
3. the death disrupted my life for a short time
4. the death disrupted my life in a significant or devastating way, but I no longer feel that way
5. the death had a significant or devastating effect on me that I still feel
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