THE CATHOLIC UNIVERSITY OF AMERICA

Self-Orientation and Relational-Orientation in Suicidal Risk: Possible Facilitative and Protective Aspects

A DISSERTATION

Submitted to the Faculty of the
Department of Psychology
School of Arts and Sciences
Of The Catholic University of America
In Partial Fulfillment of the Requirements
For the Degree
Doctor of Philosophy

By
Gary Allen Stone

Washington, D.C.
2011
Self-Orientation and Relational-Orientation in Suicidal Risk: Possible Facilitative and Protective Aspects

Gary Allen Stone, Ph.D.

Director: David A. Jobes, Ph.D.

Understanding the mindset of the suicidal patient is still one of the most critical and challenging tasks that a clinician can encounter. Various efforts have been made that help to explain the suicidal person’s motivation via frameworks pertaining to the individual’s self-orientation vs. a relational-orientation (Jobes, 1995). On one hand, various theoretical models and empirical investigations point to such things as a desire to escape negative self-image as a frequent motivator for suicide (e.g., Baumeister, 1990; Jobes & Mann, 1999). Conversely the literature shows that interpersonal relationships play a major role in the thinking of suicidal people. This interpersonal focus has even been shown to function as both a protective factor, in that the individual will refrain from suicide to avoid emotionally harming loved ones (e.g., Harris & McLean, 2007), as well as a facilitative factor in that suicidal acts are often preceded by feelings of thwarted belongingness and perceived burdensomeness to loved ones (Joiner, 2005). The present study attempted to better understand this complex relationship between an orientation towards oneself, an orientation towards others, and suicide risk potential by investigating these constructs in a sample of 108 psychiatric inpatients who had been admitted with suicidal ideation or behaviors at the Mayo Clinic in the Midwestern United States. Participants provided qualitative responses to prompts asking for such things as their
reasons for living, reasons for dying, descriptions of psychological pain and self-hate. These self-generated responses were then reliably coded as either “self-focused” or “relationally-focused,” and then analyzed in association with several key suicide risk factors. Results show that greater self-orientation was significantly, but inconsistently, related to suicide risk level. All self-generated qualitative responses were also coded as either “suicide-facilitating” or “suicide-preventative” to investigate any possible interaction with the self/relational-orientations. Significant interactions were detected, and the suicide-facilitating and suicide-preventative qualitative codes proved to be highly predictive of a patient’s relative risk level in their own right. This factor was significantly related to each of the risk variables it was tested against, suggesting that a person’s qualitative description of their own suicidality could be immensely valuable as a form of risk assessment.
This dissertation by Gary Allen Stone fulfills the dissertation requirement for the doctoral degree in Clinical Psychology approved by David A. Jobes, Ph.D., as Director, and by Barry M. Wagner, Ph.D., and Sandra Barrueco, Ph.D., and Amy K. Conrad, Ph.D. as Readers.

__________________________________
David A. Jobes, Ph.D., Director

__________________________________
Barry M. Wagner, Ph.D., Reader

__________________________________
Sandra Barrueco, Ph.D., Reader

__________________________________
Amy K. Conrad, Ph.D., Reader
Table of Contents

DOCTORAL DISSERTATION APPROVAL PAGE....................................................... I

TABLE OF CONTENTS ..................................................................................... III

LIST OF TABLES ............................................................................................. V

INTRODUCTION ............................................................................................... 1

Typological Approach to Conceptualizing Suicide ........................................... 3

   Self vs. Relational Factors .......................................................................... 6

   Self-Orientatio in suicide ........................................................................... 9

   Relational-Orientatio in suicide ................................................................. 15

Suicide-Facilitating and Suicide-Protective Factors .......................................... 22

   Internal Struggle Hypothesis ...................................................................... 23

   Reasons For Living and Reasons For Dying .............................................. 25

The Present Study ............................................................................................. 29

   Hypotheses ............................................................................................... 30

METHOD ............................................................................................................ 31

   Setting ....................................................................................................... 31

   Participants ............................................................................................... 32

   Measures ................................................................................................... 32

   Administration Procedures ........................................................................ 36

   Statistical Analyses ................................................................................... 36

      Creation of Coded Independent Variables .............................................. 36

      Hypotheses ............................................................................................ 40

      Statistical Testing .................................................................................. 41

RESULTS ......................................................................................................... 43

   Inter-Rater Reliability of Qualitative Coding .............................................. 45
List of Tables and Figures

Table 1: Numbers of Patients in Each Group and Sub-Group ........................................ 40
Table 2: Means and Standard Deviations for Key Variables of Interest .......................... 44
Table 3: Intercorrelations Among the Key Variables of Interest ................................... 44
Figure 1: Scores on the Beck Hopelessness Scale for Suicide-Preventative/Facilitative Orientation ................................................................. 47
Figure 2: Scores on the Reasons For Living Inventory for Suicide-Preventative/Facilitative Orientation ................................................................. 48
Figure 3: Suicide Index Scores for Suicide-Preventative/Facilitative Orientation .......... 49
Table 4: Relationships Between Suicide-Preventative/Facilitative Orientation and Indices of Suicidal Risk ................................................................. 50
Figure 4: Patients’ Suicide Attempt History for Suicide-Preventative/Facilitative Orientation ....................................................................................... 51
Table 5: Within Factor Comparisons of the Suicide-Preventative/Facilitative Orientation ....................................................................................... 54
Figure 5: Interaction of Self/Relational-Orientation and Suicide-Preventative/Facilitative Orientation for Reasons For Living Inventory ................................. 57
Figure 6: Interaction of Gender and Self/Relational-Orientation for Suicide Index Scores ....................................................................................... 58
Figure 7: Interaction of Self/Relational-Orientation and Suicide-Preventative/Facilitative Orientation linked to Suicide Attempt History ................................. 60
Figure 8: Patients’ Suicide Attempt History for Interaction of Gender X Suicide-Preventative/Facilitative Orientation ....................................................................................... 61
CHAPTER 1

Introduction

There is no denying that suicide is an established major public health concern. The National Center for Health Statistics (2010) reports that, in 2007 alone, there were 34,598 completed suicides in the United States, and this figure is trending upwards. Suicide is thus the 11th leading cause of death in America, far surpassing liver disease, homicide, and AIDS-related deaths. The national statistics are particularly troubling for people between the ages of 15 and 24, for whom suicide is the 3rd leading cause of death – behind only accidental deaths and homicides. Moreover, the prevailing expert view is that official statistics such as these are almost certainly underestimates since many suicides go unreported or are mistaken for accidents (Maris, Berman, & Silverman, 2000).

The official statistics also do not – and really cannot – reflect the true magnitude of the problem when one considers the number of suicide attempts that do not result in a death. Some estimates suggest that there are as many as 25 nonfatal suicide attempts in the United States for every completed suicide (Minino, Arias, Kochanek, Murphy, & Smith, 2002). Calculated out, this would indicate there were over 860,000 suicide attempts just in 2007, another several million living Americans having survived an attempt to take their own life, and an untold number of suicide ideators who may be on the threshold of lethal suicide attempt. The ripple effect of suicide continues to move outward when one takes into consideration the friends and family of the suicidal individual. Westefeld, Range, Rogers, Bromley, Maples, and Alcorn (2000) place the
figure at about six people who are intimately impacted for each completed suicide, meaning that the number of suicide “survivors” grows in this country by about 186,000 each year.

Clearly, such a broad reaching and deeply impactful public health issue needs the best possible understanding so as to better assess and treat individuals at risk. To that end, special attention needs to be paid to any factors that may facilitate or prevent a person from taking his/her own life. From an empirical perspective, far less is known on this topic than one would hope (Jobes, 2006) but there is a sizable body of research that has explored how a variety of traits are frequently associated with suicidality. Maris, Berman, and Silverman (2000) have previously summarized some of the more prominent risk factors, such as psychiatric diagnoses, substance use, previous suicide attempts, hopelessness, and demographic variables (e.g., age, race, gender). But attempting to understand suicide through an approach driven by empirically derived risk factors leaves many clinicians short because an often unwieldy list of characteristics that are not theoretically rooted makes it hard to know who really is at risk and for what. Indeed, psychosocial correlates of suicide that are arrived at individually with little to no consideration for the interaction of key variables make assessment and treatment difficult (Hoffman, 2000). Consequently, appreciating the complex psychological mindset of the suicidal patient is one of the most critical and challenging tasks that a clinician can encounter, but to date the empirical literature offers remarkably limited guidance. That said, there are some efforts that have endeavored to develop cohesive typological theories
that may provide a useful conceptual framework for a more integrative understanding of suicidal thoughts and behaviors.

**Typological Approach to Conceptualizing Suicide**

Suicidal typologies have been a part of the field for far longer than one might guess. One of the earliest models for categorizing types of suicides was created by Durkheim (1897/1951). As a sociologist, Durkheim put heavy emphasis on the individual’s relationship with society and all four of his suicidal sub-types reflect this. The first of these different types are egoistic suicides, which occur when a person experiences a detachment from society referred to as an excessive individuation. Durkheim posited that society has a naturally suicide-inhibiting effect on citizens and that excessive detachment from society can lead to suicide. The stark opposite of this would be an altruistic suicide. In this type, Durkheim says that a suicide occurs because of insufficient individuation from society where the individual dies because he/she believes it is for a greater good. Then there are anomic suicides which occur when the collective order of a society is disrupted by some form of political, economic, or national crisis. After this kind of societal breakdown, people are more susceptible to suicide, such as with the classic notion of the businessman jumping out of an office building after the stock market crash of 1929. Lastly there are fatalistic suicides. Durkheim proposed that these suicides occur when the regulation of society is too strong, and an individual feels oppressed to the point that suicide is seen as the best possible escape.

Decades later, Schwartz (1979) also used a typological approach to understand suicide, but this model went down an entirely different avenue. Unlike Durkheim’s
typologies (1897/1951) Schwartz’s model was far more psychologically-based and used dichotomous sub-types. According to Schwartz, the fundamental distinction is between those whose suicidality is egodystonic and the people for whom suicidality has become egosyntonic. Suicidal ideation and behaviors had generally been considered to be brief, intense, symptomatic and, thus, inconsistent with the basic personality structure of the individual. In contrast to this, Schwartz suggested that there is also a second typology in which a person’s suicidality can persist long enough to the point where it becomes characterological in nature and, thus, egosyntonic. This typological model overlaps heavily with larger efforts that break down suicidality into acute and chronic groups.

Essentially, if one’s distress is egodystonic then the brief and intense nature of this pain means the risk of suicide is acute. And as part of Schwartz’s argument, when the distress is egosyntonic it is likely the result of the person’s habitual use of suicidal threats and/or attempts to gain nurturance from others. This behavioral pattern is developed over a long-term period and is associated with a less severe risk of suicide; hence, the chronic typology. Several studies in recent years have been able to detect phenomenological differences within suicidal samples that were attributed to the acute vs. chronic subtypes of suicidality (e.g., Jobes, Jacoby, Cimbolic, & Hustead, 1997; Conrad et al., 2009; Grohmann, 2009).

More recently, Ellis (1988) attempted to integrate a considerable number of suicide typologies into one, more overarching classification system using “higher-order categories of variables” (p. 358). In Ellis’ system, all suicides can be summarized using four “dimensions”: Descriptive, Situational, Psychological/Behavioral, and Teleological.
The Descriptive dimension pertains to the precise nature of a person’s suicidal activity (i.e., parasuicidal behavior, ideation only, the method of an attempted suicide, the lethality of means). The Situational dimension is used to help describe any precipitating circumstances such as an interpersonal loss or an intrapersonal failing of some kind. The Psychological/Behavioral dimension covers what Ellis refers to as mediational variables. It is this dimension that covers such pertinent details as whether or not the suicidal individual is suffering from a mood disorder, is engaging in any substance use, or is experiencing any cognitive distortions such as hopelessness. And lastly, a person’s motivations for being suicidal are addressed using the Teleological dimension. These motivational factors can include almost anything, of course, but often consist of a desire to eliminate physical/emotional pain. It should be noted, though, that while Ellis’ system is aimed to tying together disparate typologies, it is difficult to truly consider it a typological system unto itself as all four dimensions are used to help conceptualize all suicidality.

All of these typologies and classifications have important clinical and legal implications. But a careful review of the literature reveals other important theoretical constructs that can easily be applied in a typological approach but are under-utilized in this regard. Much of the suicidology literature can be put in the contexts of the individuals who have a self-orientation vs. relational-orientation, and the individuals whose natural focus is more suicide-facilitating, suicide-preventative, or ambivalent. These constructs have been frequently studied and discussed but seldom as fundamental and overarching suicide typologies.
Self vs. Relational factors.

Several models of comprehending suicide and intense psychological pain are built around the differences between those with greater focus on the self and those more inclined to focus on relationships. The roots of these kinds of typologies can be traced back to Bakan’s (1966) commentary on the most fundamental human duality. Though Bakan’s work examines human nature in general rather than suicidality specifically, it has become the bedrock theory for subsequent works interested in the predominantly self-oriented or relationally-oriented. For Bakan, the two most basic dimensions of human existence could be thought of as agency and communion. At their core, agency is “the existence of an organism as an individual and communion [is] the participation of the individual in some larger organism of which the individual is part” (pp. 14-15). This means that agency consists of one’s tendency towards individuation, self-affirmation, self-protection, self-assertion, ambition, and goal attainment. Conversely, communion is made up of the desire to integrate the self in a social network through the caring for others and the efforts to fulfill this desire come in the form of such qualities as cooperativeness, empathy, sharing, and nurturance.

These factors are seen by some to be so fundamental to human nature that they have even grown to be seen as fairly ubiquitous in some regards. Personality research has found evidence that agency and communion work as two superordinate factors to the Big Five traits that are believed by many to account for the whole of personality (Digman, 1997; Blackburn, Renwick, Donnelly, & Logan, 2004). Additionally, Bakan’s original presentation of this duality suggested that they play a significant role in making up the
constructs of masculinity and femininity. Masculinity is more agentic, Bakan said, because the male “makes himself and his pleasures and his activities the center of the world in which he lives”, while femininity is more communal in that the female “centers her feelings, her enjoyment, her ambition in something outside herself; she makes not herself but another person, or even things surrounding her, the center of her emotions” (Bakan, 1966, pp. 5-6). Empirical findings have lent support to this argument by showing that measurement of masculine and feminine personality traits are more accurately detecting agency and communion (Spence, 1984). Instrumental and expressive traits, which Bem (1974, 1975, & 1976) showed are the underlying building blocks of masculinity and femininity, respectively, can very easily be thought of as synonymous with agency and communion. Common instrumental traits such as assertiveness, self-reliance, and independence fly straight to the heart of agency, while expressive traits like understanding, compassion, and affection map on perfectly to communion.

Bakan also believed that within the agentic typology there is a state where agency is unbalanced by any simultaneous sense of communion (i.e., “unmitigated agency”). Helgeson (1994) expanded on Bakan’s theory by suggesting the alternative state of “unmitigated communion” (i.e., a state of communion that is unbalanced by the presence of agency). This effectively creates a continuum with unmitigated agency at one pole, unmitigated communion at the other pole, and varying degrees of agency and communion in between. Both Bakan and Helgeson indicated that these typologies are linked to psychological and physical well-being, particularly at the extremes where the effects on overall health can be deleterious. Unmitigated agency has been found to be associated
with drug and alcohol abuse (Snell, Belk, & Hawkins, 1987), more intense pathology in psychiatric inpatients (Evans & Dinning, 1982), poor physical health (Stewart & Malley, 1987), and in a study of cardiac patients unmitigated agency was related to more severe heart attacks and longer delays before seeking help for symptoms (Helgeson, 1990). At the other end of the spectrum, unmitigated communion has been linked to greater distress in both physical and psychological health (Helgeson, Escobar, Simineric, & Becker, 2007), low self-esteem and susceptibility to being exploited by others (Fritz & Helgeson, 1998), and self-subjugation to the maintenance of a group in the form of tolerating insults, accepting verbal abuse, and excessive apologizing (Buss, 1990).

While Bakan’s (1966) and Helgeson’s (1994) continuum that spans from unmitigated agency at one pole to unmitigated communion at the other pole was related to psychological and physical health generally, a similar continuum was proposed that pertains exclusively to suicide. Jobes (1995) asserted that suicide may be primarily intrapsychic or interpsychic in nature, and that all suicidal people exist somewhere on a continuum between these two polar typologies. Jobes describes an intrapsychically suicidal person as one in whom the focus of the pain and life-or-death struggle is heavily internal. These suicides occur as a means of bringing about the end of the self’s misery, and often occur in private with few others even aware of the life-threatening pain. Contrary to this kind of individual would be the interpsychically suicidal person, whose suicidality was described as being intrinsically linked to interpersonal difficulties. Such suicides may be intended to express some relational pain or frustration, and may even be carried out for the explicit purpose of hurting or otherwise impacting others. This model
by Jobes goes on to suggest other key differences between these two groups – the intrapsychically suicidal individual may be more prone to Axis I disorders, while those who are interpsychically suicidal may be more likely to suffer from Axis II disorders, particularly borderline and dependent personality types; and those at the intrapsychic pole were hypothesized as being more acutely suicidal while people at the interpsychic pole were believed to be suicidal in a more chronic and characterological way. But at the heart of the model is an appreciation of how self-orientation and relational-orientation can make for elegant and pertinent typologies of suicidality. These typologies are strikingly reminiscent of Bakan’s (1966) explanation of the more overarching human duality. They are also indicative of a growing desire to tailor therapeutic interventions to the psychic orientation of the client rather than the specific characteristics of the psychopathology (Bonanno & Castonguay, 1994), and they are highly informative in the understanding and integration of other theories of suicidality.

Self-Orientation in suicide.

Self- and relational-orientations often appear in theories of suicide without any deliberate attempts whatsoever to describe them as typologies. Baumeister’s (1990) theory of suicide as a means of escape serves as a good example of a model of suicidality that is consistent with the proposed self-oriented and relationally-oriented dualities even though Baumeister does not present a typological model. He proposes that suicide is the result of a process in which the individual is trying to escape from aversive self-awareness. This process is broken down into six steps. Firstly, some recent hardship or a person’s unrealistically high expectations (or both) bring about a stinging sense in the
individual that current circumstances fall far short of desired standards. Second, internal attributions are made such that the discrepancy is blamed on the self and negative implications about the self take hold. Next, the internalization gives rise to an aversive self-awareness of any inadequacies, deficiencies, failings, and the like. Fourth, the cumulative effects of the preceding steps help to facilitate acute negative affect. Fifth, the individual responds to all of this by attempting to escape this aversive self-awareness through “cognitive deconstruction” (p. 91). Specifically, Baumeister defines this deconstruction as an intentional shift to less meaningful and less integrative levels of thought and awareness. This deconstruction is primarily carried out through a constricted and narrow focus on the present, a concrete focus on immediate movements and sensations rather than more general thoughts and emotions, and an absence of any realistic long-term goals. These tactics are adopted by the individual in order to keep from fully appreciating the extent of his or her dissatisfaction. And the final step comes when a sense of disinhibition is produced as a byproduct of cognitive deconstruction, and this disinhibition allows the individual to pursue a far more complete escape from the aversive self-awareness in the form of suicide.

This whole model, and the mechanisms that drive it, consist of an overwhelming self-orientation. For Baumeister’s (1990) process to begin, the individual must come to believe that current circumstances do not meet desired standards. Baumeister asserts that the stimulus for this belief may come from one source or another. But only the self can come to hold this belief; it cannot simply be handed to the individual from some outside party. The following two steps might be clearly the most self-oriented. A person’s
dissatisfaction must be internalized so that it is the self that is to blame and not any external force, and then an aversive self-consciousness grows to the point of hypervigilance. The next step in Baumeister’s escape theory – the increase in acute negative affect – may not necessarily seem self-oriented at first glance, but a closer inspection reveals a bias in that direction. Much of Baumeister’s discussion of negative affect is devoted to the roles of guilt and shame: Guilt over failing to live up to the desired standards, and shame over the substantial inadequacies of the self. The theory’s application of these two aversive emotions fits very well with the existing literature of shame and guilt as two prominent “self-conscious emotions” (Tangney & Dearing, 2002, p. 140). In the extant research, guilt has been found to be a targeted condemnation by the self of a specific behavior and is associated with a desire to apologize or make reparations; and shame has been shown to be a more global condemnation by the self of the self and is often associated with a desire to hide or escape (Lewis, 1971; Lindsay-Hartz, 1984; Tangney, Miller, Flicker, & Barlow, 1996). With this in mind, the whole theory can be thought of as an elaborate shame reaction with the cognitive deconstruction process and the suicide itself providing the escape from this overwhelmingly painful self-focus.

A variant of depression with a distinct self-orientation has also been examined in association with suicide. Referred to as introjective depression, this construct was born out of Freudian and object-relations theories of personality development. This form of depression is theorized to evolve during the phallic stage as the result of especially ambivalent, demanding, demeaning, or hostile parent-child relationships. The individual
then identifies with the parent, and integrates the demeaning nature of the relationship into his/her own sense of self. In short, the struggles that were originally between the person and the loved object come to exist mainly within the person (Freud, 1959a). Someone with this type of depression will often feel unworthy and unlovable, have an overly harsh superego, engage in constant self-scrutiny and evaluation, and have a sense of failure in living up to personal expectations; these elements then elicit negative self-judgments (Blatt, 1974; Jacobson, 1953; Jarvie, 1950; Zetzel, 1953). All of these characteristics are consistent with a pervasive self-orientation.

A small handful of studies have examined introjective depression in relation to various indices of suicidal risk using the self-criticism scale from the Depressive Experiences Questionnaire (DEQ; Blatt, D’Afflitti, & Quinlan, 1976). The self-criticism factor – just as the name suggests – measures internally directed feelings of guilt, dissatisfaction, and insecurity. Items from the self-criticism scale include “There is a considerable difference between how I am now and how I would like to be,” “I often feel guilty,” and “I often find that I don’t live up to my own standards or ideals.” Grilo, Sanislow, Fehon, Lipschitz, Martino, and McGlashan (1999) examined self-criticism in a sample of psychiatrically hospitalized adolescents and found it to be significantly positively correlated to suicidal ideation. Donaldson, Spirito, and Farnett (2000) looked at self-criticism in relation to hopelessness scores. While this study did not examine any explicitly suicide-focused variables, it was conducted with a group of adolescents who were all suicide attempters and who were all assessed within 48 hours of a hospitalization. Results showed that self-criticism was significantly correlated with
hopelessness to such a degree that it was the single best predictor of levels of hopelessness. A similar study was conducted by Enns, Cox, and Inayatulla (2003). Here the authors looked at introjective depression in adolescents who were hospitalized for suicidal ideation or behavior, and results showed that scores on the self-critical depression scale were significantly correlated to increased levels of global depression, hopelessness, and suicidal ideation. The single most extensive study to look at how an introjective depressive style relates to suicidal risk was probably the one conducted by Fazaa and Page (2003). This study was more detailed than the others mentioned because it was able to assess for lethality of the means of suicide attempts, the individual’s motivation for making the suicide attempt, the level of the person’s intent to die, and precipitating life events. It was also unique from the other studies mentioned in that it looked at college students who had acknowledged past suicide attempts rather than adolescents. According to Fazaa and Page, the more self-critical suicide attempters engaged in more lethal acts than other attempters, they expressed a decisive intent to end their lives, and they considered suicide a means to escape. To this end, they planned their suicide attempt more deliberately, took more precautions to prevent discovery, and engaged in the attempt following intrapersonal stressors. Taken together, these studies show a common theme in which self-oriented depression translates into heightened risk for suicide.

While the discussion thus far has been devoted to overarching theoretical models, there have been recent empirical studies of several elements of self-related suicide risk (e.g., O’Connor, Fraser, Whyte, MacHale, & Masterton, 2008, 2009; O’Connor & Noyce,
In the youth suicide literature, there are quite a number of studies that have looked at self-concept and self-esteem as they pertain to suicide risk (e.g., Reinherz et al., 1995). In this longitudinal study the impact of an individual’s self-concept was investigated to identify early risk factors of suicidal ideation and attempts. Obtaining data from children, parents, and teachers when children were 5-, 9-, 15-, and 18-years-old, the authors found females with a poor self-concept by age 9 had significantly greater suicidal ideation by age 15. For a more full review of youth suicide and related behaviors, refer to Wagner (2009).

An individual’s degree of impulsivity could be another inherently self-oriented characteristic that may impact suicidal ideation, suicide attempt, and completed suicide. Some have thought of impulsivity as a behavioral style, akin to a personality trait, which would mean a person’s degree of impulsivity is at least loosely tied to the self (Joiner, Walker, Rudd, & Jobes, 1995). Greater impulsivity has been linked to heightened suicidal risk in psychiatric inpatients in a study by Apter, Plutchik, and van Praag (1993), as well as a longitudinal study of suicidal children conducted by Pfeffer, Hurt, Peskin, and Siefker (1995).

Some investigation has been done that shows a prominent self-orientation may underlie risk factors for suicide in a way that is not immediately apparent or expected. McIntosh and Fischer (2000) performed a factor analysis to examine the validity of Beck’s cognitive triad and obtained results that were not entirely consistent with the three well-known components. Beck’s cognitive theory of depression is most easily summarized by the notion that those who are depressed think more negatively about
themselves, their world, and their future in a constellation referred to as the cognitive triad of depression (Beck, 1970, 1987). However, Hagaa, Dyck, and Ernst (1991) expressed doubts about the discriminant validity of Beck’s model by saying that “the triad refers to views of the self as a whole and two aspects of the self (i.e., the self’s world and future rather than the world and future per se), not three completely distinct entities” (p. 218). McIntosh and Fischer lent some empirical support to this concern with a factor analysis of the Cognitive Triad Inventory (Beckham, Leber, Watkins, Boyer, & Cook, 1986) and failed to detect the three distinct factors of the cognitive triad. Instead, the results best supported a single-factor model consisting of nearly all of the inventory’s items (23 out of 30). This factor was dubbed “self-relevant negative attitude” and provides further credence to the belief that suicidal risk factors – and suicidality more generally – might have uniquely self-oriented aspects.

Relational-Orientation in suicide.

In one form or another, a relational-orientation has been shown to be a large part of suicidality. Just as with self-orientation, a powerful focus on relational factors can be found even in broad theories of suicide. If Baumeister’s (1990) escape model represents the extreme self-oriented end of the spectrum when it comes to general theories explaining suicidality, then Joiner’s (2005) Interpersonal-Psychological theory of suicide may represent the relationally-oriented end of that spectrum. This theory proposes that there are three specific components that are present in all completed suicides. These components are the acquired capability to carry out a lethal self-injury, the sense that one is a burden on loved ones or society, and the sense that one does not belong or feel
connected to a valued group or relationship. The inclusion of disinhibition as a prerequisite of a completed suicide is not uncommon (as evidenced by Baumeister’s escape theory described above). What makes Joiner’s theory unique is its insistence on the necessity of these two decisively relationally-oriented factors which, up until the presentation of Joiner’s theory, had mostly been thought of as moderately predictive risk factors.

There have been strong empirical findings produced by Joiner and his colleagues that show the influence of perceived burdensomeness and thwarted belongingness in suicidality. In two studies of suicide notes, Joiner et al. (2002) had trained raters examine suicide notes for perceived burdensomeness, hopelessness and general emotional pain. In the first of these two studies, results showed that suicide notes written by those who had died in their suicide attempt contained more perceived burdensomeness than notes written by those who had attempted suicide and survived, but no significant differences were found regarding hopelessness and emotional pain. In the second study, all of the suicide notes examined were from completed suicides, and only perceived burdensomeness was found to be predictive of the lethality of the method of suicide. Also, Van Orden, Lynam, Hollar, and Joiner (2006) were able to link perceived burdensomeness to suicidal risk in a sample of outpatients from a psychological clinic. The authors found that outpatients’ ratings of perceived burdensomeness on relatives were significantly associated with increased suicidal ideation and greater numbers of past suicide attempts even after accounting for scores of depression and hopelessness. Although, it should be noted that items focusing on burdensomeness are found on
common measures of suicidal ideation. For example, “Have you felt that others would be better off without you?” is an item on the Diagnostic Interview Schedule for Children (DISC; Schaffer et al., 1996) depression scale and is used to assess suicidal ideation (one aspect of so-called “passive ideation”). Thus, burdensomeness is not an entirely overlooked concept, but Joiner has made it an essential one.

Thwarted belongingness has received more attention than burdensomeness in the suicidality literature and has been considered an established risk factor for decades. For example, Maris (1981) reported that 42% of suicidal depressives lived alone, as opposed to only 7% of non-suicidal depressives, and that 50% of individuals who had completed suicide had no close friends. Again, this factor was examined by Joiner and colleagues as part of the Interpersonal-Psychology theory. Conner, Britton, Sworts, and Joiner (2007) included a self-report measure of perceived belongingness in their study of suicide attempts in methadone patients. In this case, results showed that feelings of low belongingness were predictive of suicide attempts but not associated with instances of unintentional overdose. This seems fairly consistent with the Interpersonal-Psychological theory of suicide in that thwarted belongingness seems to be uniquely emotionally charged to where it can distinguish suicide from other life-threatening behaviors. While these studies examined burdensomeness and thwarted belongingness individually, this is not consistent with the theory itself, which insists on these factors – along with the acquired ability to self-injure – to be present in unison. The interactive nature of these dimensions was looked at in subsequent studies that measured both variables (Van Orden, Witte, Gordon, Bender, & Joiner, 2008; Joiner et al., 2009). In these cases,
statistical interactions between a high sense of burdensomeness and a low sense of belongingness were predictive of current suicidal ideation even after controlling for indices of depression. Joiner’s theory places great emphasis on the interactive effect of all three key factors in facilitating suicide. Burdensomeness and thwarted belongingness are believed to produce the sufficient desire to die, and the acquired ability to self-injure allows that desire to turn lethal. Thus, from this perspective, the fundamental underpinnings of all suicidal intent are relationally-oriented.

Just as a self-oriented, introjective, form of depression has been linked to suicide, so too has an analogous form of depression that is more relationally-oriented. This type of depression is referred to as anaclitic and has been characterized as stemming from the oral stage of development and related to early childhood reactions of loss of love, and fear of impoverishment and starvation (Freud, 1959a, 1959b; Rado, 1928; Weiss, 1944). The relational object of interest (often believed to be the mother) is valued only for its capacity to provide need gratification. The absence or removal of this object can be thought of as an injury to the relationship, and a depressive state then sets in which is characterized by feelings of being unloved, helpless, dejected, and worthless (Blatt, 1974). The same studies that investigated introjective depression in suicide were also able to examine the role of anaclitic depression. These studies used the dependency factor from the DEQ (Blatt, D’Afflitti, & Quinlan, 1976) as an index of anaclitic depression because it consists of items that are externally directed, refer to interpersonal relationships, and contain themes of abandonment, loneliness, and the like. Some of the items from the dependence scale are “I often think about the danger of losing someone
close to me,” “I am very sensitive to others for signs of rejection,” and “I worry a lot about offending or hurting someone who is close to me.”

The connection between anaclitic depression and suicidality has not been found to be as consistent as the relationship between introjective depression and suicidality, but there is a link nonetheless. Grilo et al. (1999) was unable to detect a significant correlation between the DEQ’s dependency scale and suicidal ideation, and Donaldson et al. (2000) found that dependency scores were unrelated to levels of hopelessness. However, Enns et al. (2003) found that dependency was significantly correlated with increased levels of global depression, hopelessness, and suicidal ideation. Thus a person who is depressed in a relationally-oriented way can still be seen as being at an elevated risk for suicide.

Turning toward specific risk factors for suicide, one can see that some of these variables that have been accepted for years as hallmark indicators of suicidal risk can easily be considered to be relationally-oriented. One such factor that has already been alluded to as part of the explanation of Joiner’s Interpersonal-Psychological theory of suicide (Joiner et al., 2002) is thwarted belongingness. More commonly thought of in terms of social isolation or interpersonal dysfunction (Maris, Berman, & Silverman, 2000), this kind of relationally-oriented risk factor exists in a variety of forms. The simple presence of relational others is often noted as a protective factor against suicide. Bangor, Goldberg, Cleary, and Brown (2000) reported that rates of suicide in the United States are generally highest among individuals who are widowed, and decrease among those who were divorced, and then continuing to decrease in those who are single, then
those who are married, and finally those who are married with children. A similar pattern was detected internationally in by Heikkinen, Isometsa, Marttunen, and Aro (1997) who found that individuals in a Finnish sample who completed suicide were more likely to have been never married, divorced, widowed, or living alone. It would seem that with the greater relational connectedness comes a greater insulation from risk of suicide, while increased social isolation comes with an increased risk of suicide.

As one might expect, the quantity of a person’s relationships is not enough to fully appreciate the total picture. The quality of the relationships is important as well, particularly within the family environment for young people. Asarnow, Carlson, and Guthrie (1987) examined patterns of suicidality in a sample of children in a psychiatric inpatient unit. Compared to the children who had never made a suicide attempt, those who had attempted suicide considered their families to be less cohesive, higher in levels of conflict, and less controlled by rules and procedures. Furthermore, these relationally-oriented factors were found to be the best predictors of suicide attempt history, even outperforming levels of hopelessness.

The true predictive value of such isolated relationally-oriented factors (both family-focused and peer-focused) was put to the test by Reinherz et al. (1995) in the longitudinal study briefly mentioned above. This study spanned 14 years and found that several of the more relationally-themed variables were predictive of suicidality from childhood into adolescence. The results showed that severity of family arguments as measured at 9-years-old was significantly predictive of suicidal ideation by age 15. For males, a mother’s report of relationally-dependent behavioral problems at 5-years-old and
teacher’s report of poor social relations at 9-years-old were each able to predict thoughts of suicide at age 15. And, for females, a self-report at 9-years-old of weaker perceptions of one’s role within the family was predictive of suicidal ideation measured at 15-years-old. These kinds of relationally-oriented risk factors within the family environment have been found repeatedly throughout the literature; be it for family intactness (Johnson et al., 2002), family discord (Ferguson & Lynskey, 1995), poor communication with parents (Gould, Fisher, Parides, Flory, & Shaffer, 1996), or low parental supervision (Resnick et al., 1997).

Upon reflection, a strictly self-oriented or relationally-oriented typological can be overly simplistic and perhaps cumbersome when it comes to broad variability that may be seen in complex suicidal behaviors. An example can be made using some of the typological models already discussed. On one hand, Jobes (1995) proposed that some relationally-oriented suicides are carried out explicitly to communicate interpersonal pain while others are present as an audience in what amounts to a final message of “Look at what you’re making me do.” This is quite different from Joiner’s (2005) model that says relationally-oriented suicides are carried out to help unburden loved ones in what is meant to be a final gesture of magnanimity. The suicidal experiences of two people in these situations are worlds apart despite both being relationally-oriented. Furthermore, self- and relationally-oriented models of suicidality generally do not account for the possible bi-directionality of each orientation and the resulting clinical implications for managing suicidal risk. As has already been described above, a person’s orientation can work both ways. A relational-orientation may be a risk factor through such avenues as
perceived burdensomeness or thwarted belongingness, or it may serve as a protective factor by allowing the individual to feel an emotional connectedness to loved ones strong enough to prevent suicidal behavior. Conversely, a self-orientation may be so aversive that the individual seeks to escape the misery through suicide, or the self-oriented suicidal individual may ultimately decide to refrain from suicide because of some personally meaningful goals or aspirations that would otherwise go unfulfilled.

**Suicide-Facilitating and Suicide-Protective Factors**

In the suicidology literature there is an extensive history of studying the biological, social, and psychological variables that compel a person to suicidal behaviors. We largely think of these variables as “risk factors” for suicide and the literature is replete with dozens of correlates that are related to why someone would be compelled to take their life (e.g., Maris, Berman, and Silverman, 2000). Juxtaposed against these variables are “protective” factors that otherwise deter, delay, or prevent suicidal behaviors from happening (e.g., Malone et al., 2000). What these lines of research thus create a kind of dialectic between living and dying that has been conceptually examined by various researchers. While a dialectic approach to understanding suicide-facilitating forces vs. suicide preventative influences perhaps creates a useful continuum of possible suicidal behaviors, what is missing in a purely dichotomous approach is the important middle ground between these poles. Clinically, we call this middle ground “ambivalence.” Because of the complexity of suicidal behaviors, more complexity is needed in our collective models. But as Jobes (2010) has pointed out, with some exceptions, ambivalence has been under-studied in the field and there has been too much
of an emphasis on suicidality dichotomies (e.g., acute vs. chronic suicidal risk). Perhaps a more sophisticated approach requires understanding suicidal behaviors as a trichotomy between psychological forces for living, forces for dying, and the conflict in between (O’Connor et al., 2011).

**Internal Struggle Hypothesis**

An important and remarkably overlooked theory on the preceding discussion was first offered by Kovacs and Beck in 1977. Their theory and subsequent research on the “internal struggle hypothesis” showed that many suicidal individuals experience both a wish to live as well as a wish to die simultaneously, rather than experiencing either one exclusively. Using a sample made up entirely of inpatients hospitalized for suicide attempts, a clever but straightforward assessment tool was devised to uncover any internal struggle. Instead of measuring suicidal intent alone, all inpatients were presented with one Likert scale asking for the extent to which they want to live, and another Likert scale asking for the extent to which they want to die. These scores, and the relative disparities between them, showed that an internal struggle over both wanting to live and wanting to die was detectable in many of the suicidal inpatients, the obvious implication of these findings is that many suicidal individuals are highly ambivalent. Kovacs and Beck reported that the full sample consisted of 50% that experienced an internal debate over living or dying, 41% that expressed a clear wish die, and 9% that experienced a clear wish to live.

The only other empirical investigation directly targeting the internal struggle hypothesis was conducted by Brown, Steer, Henriques, and Beck (2005). This study
aimed to expand on the work of Kovacs and Beck (1977) by determining if the wish to live and wish to die ratings could be directly linked to suicidal risk. The two different Likert scales measuring one’s wish to live and wish to die were, again, presented to the respondents. Unlike the original Kovacs and Beck study, Brown et al. formally consolidated these two scores into one “suicide index score”. This new value reflected the difference between the two other ratings with a range from -2 to +2, where -2 represents a strong orientation towards wanting to live and +2 represents a strong orientation towards wanting to die. Using completed suicide as the outcome variable from a sample of over 5,800 psychiatric outpatients, the suicide index score was found to be a significantly viable risk factor in predicting suicide. Analyses showed that there were distinct tiers of risk within the suicide index scores. An index score with a greater orientation towards wanting to live or a balance of wish to live/wish to die (i.e., scores of zero and below) held no predictive value for completed suicides. An index score of +1 or greater was associated with a univariate hazard ratio of 2.68 in predicting deaths by suicide. Index scores of +2 (the highest possible score for an orientation towards wanting to die) were found to have a univariate hazard ratio of 6.58. These results can be interpreted as showing that the distinct tiers of risk yielded by the suicide index score represent a group of individuals with a stronger orientation towards life, a group with a pervasive orientation towards death, and a group in between with a stronger sense of ambivalence over the competing desires to live and to die. These three separate groups closely mimic those found in the original study by Kovacs and Beck, and lend further support to the internal struggle hypothesis.
The idea that suicidal risk can be thought to exist in three separate groups was further supported by O’Connor et al. (2010). Though the study was not directly intended to examine the internal struggle hypothesis, the authors used suicide index scores to separate psychiatric inpatients into three groups: those with a clearer wish to live, those who were ambivalent about living or dying, and those with a clearer wish to die. Scores from self-report measures of suicidal risk were than analyzed to help determine the reliability of the trichotomization. The results showed that self-report scores of risk were significantly able to differentiate the three types of suicidal individuals, and that these distinctions could be made with approximately 77% accuracy. So while there is still only a very small pool of research to draw from that examines the internal debate over suicide, the few empirical studies that do exist support a typological system where suicidality is trichotomized according to the individual’s inclination towards life or death, or their ambivalence over whether or not to end their own life.

**Reasons For Living and Reasons For Dying**

A markedly different approach to the existing theory and research on the continuum of suicidal behavior and ambivalence is reflected in the qualitative research of Jobes and colleagues (e.g., Jobes and Mann, 1999; 2000; Grohmann et al., 2006). In this line of research suicidal patients are asked to write out in their own hand specific reasons for living and reasons for dying. In turn, the investigators were able to create reliable coding categories or themes that capture the content of these written responses. Mann (2002) further refined the coding categories somewhat and found nine common reasons why suicidal individuals still want to live: a) Family, b) Friends, c) Responsibility to
Others, d) Avoid Burdening Others (with suicide), e) Plans and Goals, f) Hopefulness for the Future, g) Enjoyable Things, h) Beliefs, and i) Self. In the qualitative responses provided about reasons for dying, the suicidal sample was again found to have nine highly reliable coding categories: a) Others, b) Unburdening Others, c) Loneliness, d) Hopelessness, e) General Descriptors of Self, f) Escape-General, g) Escape-Past, h) Escape-Pain, and i) Escape-Responsibility. These various rationales for wanting to either shy away from or seek out suicide are interesting for a few important reasons. These coded categories, derived from qualitative open-ended responses taken directly from suicidal samples reflect both theoretically and empirically established risk and protective factors that correspond to the broader literature.

The use of Mann’s (2002) qualitative Reasons for Living vs. Reasons for Dying assessment was further expanded on by Grohmann et al. (2006). This study was able to broaden on the earlier use of this open-ended assessment tool by reporting on the frequency of the competing motivations for wanting to live and die among a higher risk sample of psychiatrically hospitalized adults rather than a sample of lower risk outpatient college students. The individual’s family was the most frequently provided reason for wanting to live, garnering 43% of all such responses. On the other side of the internal debate, the category pertaining to general descriptors of the self (e.g., “I hate myself,” “I’m a failure.”) was the single most frequently mentioned reason for wanting to die, accounting for slightly more than 25% of all such responses. These figures grew even higher when the focus was placed on the portion of the sample deemed to be at the highest suicidal risk. In this sub-sample, roughly 47% of all responses pertaining to
reasons for living were about family members, while 30% of all responses pertaining to reasons for living were general descriptors of the self.

What these findings from Grohmann et al. (2006) seem to suggest is that the pertinent topics at hand have come full circle. The findings suggest that it may be useful to integrate the Self/Relationally-Oriented typology with the Wish To Live/Wish To Die duology in order to better understand the nature of the internal struggle experienced by suicidal people. There may be Relationally-Oriented suicidal people who tend to struggle between relational reasons for living and relational reasons for dying, and Self-Oriented suicidal people who tend to vacillate between self-relevant reasons for living and self-relevant reasons for dying. Or it may be that relational factors were more commonly associated with wanting to live across the sample, and self factors were more commonly associated with wanting to die. When asked directly to respond to open-ended prompts about the internal struggle of suicide, the most common reasons for wanting to live and wanting to die were relationally-oriented and self-oriented.

A study conducted by Harris, McLean, Sheffield, and Jobes (2010) employed a very similar design to the Grohmann et al. study, and yielded comparable results. Obtaining their data from an online-based survey, the authors found common motivations for wanting to live and wanting to die are often distinctly self- and relationally-oriented.

Once again, the most frequently provided reason for living was a person’s family (37% of all responses to the reasons for living prompt) with an additional 8% of responses referring to an individual’s friends. With these two categories combined, relational others directly account for close to 50% of all qualitative responses to prompt asking for a
person’s reasons for living. The portion of the full sample deemed “most suicidal” was fairly consistent with this relationally-orientation in their reasons for living. For this sub-sample, family was still the most common reason for living (25%), and the second most common reason for living was a desire to avoid burdening a loved one with the suicide (16%). On the side of the internal struggle aimed at moving toward suicide, the most frequently cited reason for dying among the full sample was a sense of hopelessness, which accounted for 26% of all reason for dying responses. However, the “most suicidal” group differed from the full sample by responding with general descriptors of the self more often than any other reason for dying (24%).

A final qualitative study of reasons for living vs. reasons for dying was conducted by Jobes et al. (2004). The methods used in this study were unique in that they did not focus on the internal struggle of reasons for living vs. reasons for dying, but instead the goal was directed more towards what was underlying some major contributing factors to suicide. Suicidal outpatients from a college counseling center and a U.S. Air Force clinic were presented with incomplete sentences asking about pain, press, and perturbation which are from Shneidman’s (1987) cubic model of suicide, hopelessness which was taken from the work of Beck and colleagues (Beck, 1986; Beck Brown, Berchick, Stewart, & Steer, 1990), and self-hate, which is one of the key elements of Baumeister’s (1990) theory of suicide. The qualitative coding revealed that nearly all of the most frequent responses provided by both samples were explicitly relationally- or self-oriented (i.e., responses coded as “Relational” such as “I am lonely,” or responses coded as “Internal Descriptors” such as “I am an idiot.”). The only exception was in the Air Force
sample, whose most frequent responses to the prompt regarding perturbation were coded to be “Situation Specific” (i.e., “When I awake,” or “Coming home.”). Looked at on the whole, this would seem to suggest that the top sources of the distress that are contributing to the individual’s suicidality have distinctly relationally- or self-oriented shadings.

The Present Study

In consideration of the preceding discussion, a few key points emerge. Over the last 50 years suicidologists have been keenly interest in the development and elaboration of suicidal typologies for theoretical, empirical, and clinical purposes. Among those typologies, the notions of self-oriented suicides and relationally-oriented suicides have emerged as prominent constructs. A parallel interest in the suicidology literature has been a significant preoccupation with various bio-psycho-social variables that may be thought to facilitate suicidal behaviors. In more recent years an alternative focus in the suicidology literature has examined protective factors, those variables that may deter, delay, or prevent suicidal behaviors. Related to these notions has been an evolving literature on the continuum of suicidal behaviors and a more recent consideration of the ambivalence that many suicidal individuals experience between the psychological push and pull of living versus dying.

What has been missing in the clinical suicidology literature is a quantitative/qualitative integrative methodology for studying the interface of all of these types of components simultaneously to better enable us to understand the nature of the suicidal mind. The present study has endeavored to investigate this very premise. To accomplish this goal, a set of a priori research hypotheses were developed.
Hypotheses

Hypothesis 1: Patients with high self-orientation will be at higher suicidal risk than patients with low self-orientation.

Hypothesis 2: Patients with high relational-orientation will be at lower suicidal risk than patients with low relational-orientation.

Hypothesis 3: Patients with greater self-orientation than relational-orientation will be at higher suicidal risk.

Hypothesis 4: Patients with high facilitative self-orientation will be more strongly associated with suicidal risk than patients with high facilitative relational-orientation.

Additionally, various post hoc analyses were originally anticipated in order to study the possible *additive or interaction* effects of facilitative self-orientation and relational-orientation and preventive self-orientation and relational orientation.

While the preceding hypotheses guided the investigation, the constraints of the dataset required a modification of the research methodology which will be discussed more fully in Chapter 2.
CHAPTER 2

Method

The present study was developed to specifically test the overarching theoretical constructs of self- vs. relational-orientations, and suicide facilitating- vs. preventative-orientations. This makes the current study an extension of similar studies – such as the previously described work of Grohmann et al. (2006) – which have shown that suicidal individuals' reasons for living and reasons for dying are heavily influenced by directly inter- and intrapersonal factors. The Grohmann et al. study was conducted using a sub-sample of the dataset first explored by Conrad et al. (2009). As such, the current study will likewise use the archival data from the Conrad et al. study, but will use the full number of suicidal participants from the original sample.

Setting

The data for the Conrad et al. (2009) study were collected at the Mayo Psychiatry and Psychology Treatment Center, St. Mary’s Hospital, in Rochester, Minnesota. This facility is among the largest psychiatric treatment centers in the country, with over 60 psychiatrists and psychologists and over 100 licensed beds. While the center treats both children and adults, this study was conducted with two particular adult units: the acute care unit, which specializes in the treatment of psychiatric emergencies, and the mood disorders unit which specializes in the treatment of major depressive and bipolar disorders. On average, these two units serve 1,500 patients per year.
Participants

Participants from the original Conrad et al. (2009) cohort were 149 adult psychiatric inpatients admitted to one of the two units. Of these consecutively admitted inpatients, 108 were research participants – admitted to the inpatient unit between November of 2004 and May of 2006 – who had attempted suicide or had serious suicidal ideation within 48 hours prior to admission. In addition, there were 41 control inpatients who had not had suicidal ideation within 48 hours of admission. While there were no specific inclusion criteria to the patients in this study other than presenting with serious suicidal risk, pregnant women and acutely psychotic patients unable to complete the assessment tools (as determined by the psychiatric nurses) were excluded from the study. For the current study, only the 108 suicidal participants were included in analyses due to the strict focus on suicide facilitating- vs. suicide preventative-orientations. Thus the ultimate research sample consisted of 32 men and 76 women, aged 18 – 67 ($M = 36.31$, $SD = 11.59$). With regards to racial composition, 90% of the sample was Caucasian, 2% was American Indian, 2% Latino, 1% Asian, and the remaining 5% of the sample did not specify their racial background. While no specific data were taken on socioeconomic status, the population of the Rochester area is generally regarded as well-educated and has a middle-class economic background.

Measures

Suicide Status Form-II (SSF-II). The SSF-II (Jobes, 2006) is a revised version of the SSF (Jobes et al., 1997) and is a theoretically derived suicide assessment instrument used to assess, document, and track suicidality. The SSF-II is unique in that it uses both
quantitative and qualitative assessments to reveal several aspects of a patient’s experience of suicidality. The “Core SSF Assessment” consists of five theoretical constructs that have been empirically shown to underlie suicidality (pain, stress, agitation, hopelessness, and self-hate) along with a final assessment of overall behavioral risk of suicide. Each construct in the Core SSF Assessment is rated on a five-point rating scale that is followed by a qualitative sentence prompt to elicit the patient’s personal written description of each construct (e.g., “What I find most painful is ____.”; “I am most hopeless about ____.”). The Core SSF Assessment is followed by ratings of internal vs. relational aspects of suicide risk, which are then followed by a qualitative assessment about Reasons For Living vs. Reasons for Dying. Based on the work of Linehan et al. (1983), Jobes and Mann (1999), and Mann (2002), this assessment prompts the patient to list up to five reasons for wanting to live and five reasons for wanting to die which are then rank ordered. The SSF-II also includes two 7-point rating scales on which participants rate their wish to live and their wish to die. This section is based on Kovacs and Beck’s (1977) work asserting that suicidal people engage in an “internal struggle” between the two competing wishes. The last section of the SSF-II pertains to the “One Thing Response”. As the name implies, this section consists of only one item – a qualitative sentence stem that prompts the patient to write out the one thing that would help him or her no longer feel suicidal.

Previous research with a suicidal outpatient college sample has demonstrated that the SSF has good convergent and criterion-prediction validity as well as moderate to good test-retest reliability (Jobes et al., 1997). These data were further replicated in the
previously mentioned Conrad et al. (2009) study with suicidal inpatients. While the psychometrics for the Core SSF were solid for outpatient suicidal college students, the validity and reliability of the assessment was even more robust with the high-risk inpatient sample (Conrad et al., 2009).

For the present study, the quantitative ratings from the wish to live and wish to die assessment were used to derive a “Suicide Index Score” for each patient, following the approach used by Brown et al., 2005. This composite score of risk is created by subtracting an individual’s wish to live rating from his or her wish to die rating to achieve a new score that exists along a continuum – an interval scale – ranging from a complete wish to live (-6) to a complete wish to die (+6); it follows that mid-range scores (e.g., -1, 0, +1) reflect internal conflict and ambivalence about life and suicide. Use of these ratings and the Suicide Index Scores has been shown to have a meaningful relationship to actual suicidal intent and behaviors (Kovacs & Beck, 1977; Brown, Steer, Henriques, & Beck, 2005).

Beck Hopelessness Scale (BHS). The BHS (Beck, Weissman, Lester, & Trexler, 1974) is a 20-item true/false self-report measure that assesses three aspects of hopelessness: feelings about the future, loss of motivation, and expectations. These three subscales can be merged together to yield a total hopelessness score. Each item pertains to the respondent’s experiences of hopelessness during the past week. The subscale and total scale scores are obtained by adding together the number of “pessimistic” responses. The BHS has high internal consistency (as indexed by Kuder-Richardson coefficients in the .90’s), test-retest reliability in the high .60’s, and concurrent validity with clinicians’
ratings of hopelessness ($r = .74$; Beck, Steer, & Ranieri, 1988).

*Reasons for Living Inventory (RFL).* The RFL (Linehan et al., 1983) is a self-report measure in which the individual responds to 48 reasons for not attempting suicide on a six-point scale that assesses how important each reason is to that respondent. The RFL has high internal reliability ($\alpha = .74$ to $\alpha = .94$; Linehan et al., 1983) and strong three-week test-retest reliability ($r = .83$; Osman, Jones, & Osman, 1991). Studies have found that people with a history of suicide attempts report fewer reasons for living on the RFL (Oquendo et al., 2004).

*Suicide Assessment – Surveyor Form.* The Suicide Assessment – Surveyor form served as an investigation into several key aspects of each patient’s suicidality and was developed specifically for administration in the present study. The assessment focused on such clinically pertinent details as the frequency of an individual’s recent suicidal ideation, the presence of any suicidal plan and/or intent, the access to any means for a possible suicide attempt, and whether an individual has made any specific preparations for a suicide attempt. All items were clinician-administered. Of particular relevance to the present study was the assessment’s inquiry into the patient’s past suicide attempts. This is because the empirical research shows that greater numbers of past attempts at suicide are highly indicative of a heightened level of current suicidal risk, even after controlling for the contributions of strong covariates like hopelessness and psychopathology (Joiner et al., 2005).
Administration Procedures

Nine nurses on staff in the treatment center identified eligible participants from among the new admissions. The nurses, two staff psychiatrists and two resident psychiatrists served as surveyors. Each surveyor explained the study and the informed consent form to each patient and asked the patient to complete the form. No nurse conducted an informed consent with any patient under that nurse’s care, but instead would ask another clinician to do so to avoid any appearance of coercion. Each patient-participant was given a packet of assessment measures to complete within 24 hours of admission.

Statistical Analyses

*Creation of coded independent variables.*

To create the quasi-independent variables at the heart of this study, patients’ written responses to all of the qualitative assessment sections of the SSF (i.e., incomplete sentence prompts, reasons for living vs. dying, and the one thing response) were categorically coded by two trained coders (a Master’s level graduate student in clinical psychology and a licensed clinical psychologist). Each individual SSF qualitative response was coded twice:

1. “Self-Oriented” vs. “Relationally-Oriented”.

2. “Suicide-Facilitating Orientation” vs. “Suicide-Preventative Orientation”.

This coding strategy approach was based, in part, on previous coding manuals used in early SSF qualitative studies that demonstrated high levels of inter-rater reliability (Fratto et al., 2005; Grohmann et al., 2006; Jobes, 2004; Mann, 2002). A new qualitative coding
manual was developed to help define these factors and guide the distinctions made between them (see Appendix F).

Once inter-rater reliability was achieved for the coding of these respective constructs (using conventions established by Landis & Koch, 1977), all the coded responses were used to calculate overall indices of the two main constructs for each patient in the study: Self- vs. Relational-Orientation and Suicide-Facilitative vs. Preventative Orientation. For the Self/Relational-Orientation construct, this was done by creating a proportion score where the number of Self-Oriented responses for each patient was divided by that patient’s total number of responses (e.g., 14 Self-Oriented responses / 16 total responses = a proportion score of 0.875). Thus, the Self/Relational-Orientation proportion represents a continuum with lower scores indicative of a greater focus on relationships and higher scores indicative of a greater focus on the self.

The Suicide-Facilitative/Preventative Orientation variable was computed in the same way, but with one key difference. Instead of using every response a participant provided across every qualitative prompt on the SSF-II, only responses from the Reasons For Living/Dying assessment were used to create the Suicide Facilitative/Preventative-Orientation construct. This was done because the remaining qualitative prompts from the SSF-II tend to have a naturally suicide-facilitating bias (e.g., “I am most hopeless about ____.”) or a naturally suicide-preventative bias (e.g., “The one thing that would help me no longer feel suicidal would be ____.”), which has the potential to skew these responses. In contrast, the Reasons For Living/Dying section is completely neutral; it gives the individual an equal opportunity to provide suicide-facilitative or suicide-
preventative responses with no a priori bias for responses. Thus, the Suicide-Facilitative/Preventative Orientation variable was computed by creating a proportion score where the number of Suicide-Facilitative responses provided just in the Reasons For Living/Dying section was divided by the total number of responses provided in that section. This proportion represents a continuum with lower scores indicative of a more suicide-preventative orientation, and higher scores indicative of a more suicide-facilitative orientation.

At this point, an important methodological point must be made. Over the course of the qualitative coding process, it became apparent that the optimal method of creating the coded independent variables was impractical in the current dataset. Specifically, the dichotomous nature of the coding (i.e., qualitative responses could be coded as only as having either a Self-Oriented or a Relational-Oriented) resulted in the two levels of each of the two coded variables being inversions of each other. In the calculated proportion scores, for instance, a patient’s Self-Oriented score of 0.875 automatically means that his/her Relational-Oriented score would be 0.125. Consequently, the two different sets of coded variables could no longer be truly examined independent of one another.

In order to help address this methodological obstacle, the sample itself was dichotomized so that the more Self-Oriented patients and the more Relationally-Oriented patients could be clearly distinguished. A median-split was performed along the continuum of Self/Relation-Oriented proportion scores with 54 patients being placed
in the group considered to be predominantly Relationally-Oriented and the remaining 54 patients placed in the group considered to be predominantly Self-Oriented.

In contrast, the Suicide Facilitating/Preventative-Orientation was trichotomized into three distinct levels in accordance with Beck and Kovacs’ (1977) Internal Struggle Hypothesis, which empirically supported the recognition of three distinct groups: those with an intense desire to die, those with an intense desire to live, and those who were experiencing an internal conflict over living or dying. Given this approach, the current study fashioned a trichotomization intended to mimic a spectrum previously established by the Beck and Kovacs methodology by dividing the sample into three distinct groups: the 36 patients whose proportion score reflected a majority of suicide-preventative responses, the 36 patients whose proportion score reflected a majority of suicide-facilitative responses, and the 36 patients whose proportion score reflected a perfect ambivalence (i.e., an equal number of both suicide-preventative and suicide-facilitative responses). More specific information on the numbers of patients who fit each group and sub-group can be found in Table 1. The parenthetical numbers in Table 1 indicate the numbers of female patients in each group and sub-group.
Table 1

*Numbers of Patients in Each Group and Sub-Group*

<table>
<thead>
<tr>
<th></th>
<th>Self-Orientation</th>
<th>Relational-Orientation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide-Preventative</td>
<td>14 (8)</td>
<td>22 (12)</td>
<td>36 (20)</td>
</tr>
<tr>
<td>Orientation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambivalent Orientation</td>
<td>19 (13)</td>
<td>17 (15)</td>
<td>36 (28)</td>
</tr>
<tr>
<td>Suicide-Facilitative</td>
<td>21 (17)</td>
<td>15 (11)</td>
<td>36 (28)</td>
</tr>
<tr>
<td>Orientation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>54 (38)</td>
<td>54 (38)</td>
<td>108</td>
</tr>
</tbody>
</table>

*Hypotheses.*

Once it became apparent that the two levels of each qualitatively coded independent variable were no longer explicitly independent of one another, many of the study’s originally proposed hypotheses became redundant. For example, Hypothesis 1 and Hypothesis 2 outlined in the Introduction section become effectively the same hypothesis in that the testing of the sample’s Self-Orientation would automatically be a de facto test of the sample’s Relational-Orientation. Thus, all of the originally proposed hypotheses had to be practically revised for final analysis. Therefore the reformulated hypotheses for the current investigation are as follows:

**Hypothesis 1:** Patients who are predominantly Self-Oriented will be at higher suicidal risk than the patients who are predominantly Relationally-Oriented.

**Hypothesis 2:** A significant main effect would be detected for suicidal risk across the Suicide-Facilitating/Preventative Orientation factor.
Hypothesis 3: Within the Suicide-Facilitating/Preventative Orientation factor, patients with a predominantly Suicide-Facilitating Orientation will be at a higher suicidal risk than the patients with a predominantly Suicide-Preventative Orientation. Additionally, within the Suicide-Facilitating/Preventative Orientation factor, patients with a predominantly Suicide-Facilitating Orientation will be at a higher suicidal risk than the patients with an Ambivalent Orientation.

What follows from the analyses of the main effect hypotheses is a series of analyses examining the interactions of the research constructs. While the investigator originally anticipated the analysis of possible interactions, specific a priori hypotheses of these interactions were not specifically proposed. In addition, as originally proposed, various post hoc analyses were performed to shed further light on our primary results.

Statistical testing.

Kappa statistics were first computed to ensure adequate levels of inter-rater reliability for the coding of the qualitative responses as either Self-Oriented or Relationally-Oriented, and Suicide-Facilitating or Suicide-Preventative. To examine how these various orientations are uniquely and collaboratively associated with suicidal risk, 2 X 3 X 2 ANOVAs were used to detect differences in the total score from the Beck Hopelessness Scale, the total score from Linehan’s RFL Inventory, and the Suicide Index Score from the SSF-II. The factors of these ANOVAs consisted of dichotomized Self/Relational-Orientation, trichotomized Suicide Facilitating/Preventative-Orientation, as well as gender, which was included as a covariate due to its own well-established role in suicidality (e.g., Andriolo, 1998; Canetto, 1997; Canetto & Sakinofsky, 1998;
Shneidman, 1985). In the tests of the main effect for the Suicide-Facilitating/Preventative Orientation, planned comparisons were conducted – regardless of the significance of the initial $F$ value – in order to better understand the relationships of the three levels within this one factor. These comparisons focused on possible differences between the Suicide-Preventative group and the Suicide-Facilitative group, and differences between the Ambivalent group and the Suicide-Facilitative group. Also, log linear analyses were used to examine participants’ suicide attempt history. These log linear analyses consisted of a saturated model that simultaneously included Self/Relational-Onteration, Suicide-Facilitative/Preventative Orientation, and gender. In these tests, suicide attempt history was categorized into the groups of participants who had made no or one prior suicide attempt, and those who had made two or more past suicide attempts. This was done in order to help make the most clinically useful distinction between those with only mild to moderate risk of future suicide attempts, and those who are at a more severely elevated risk of future suicide attempts for the duration of their lifetime.
CHAPTER 3

Results

The results of the study are presented in what is essentially a sequential format, moving from the more straightforward research questions and subsequent findings to more complex findings obtained from multi-way interactions and post-hoc analyses. The initial focus of the presented results is on the qualitative coding itself and the utility of the two coding schemes, followed by the findings pertaining to the relationships between suicidal risk and each of the three main independent variables taken individually. After the main effects are outlined, the relevant two- and three-way interactions are presented, along with post-hoc testing that was deemed necessary during the course of the analyses. This approach of moving from the less complex results to the more complex results will allow for a better comprehension of the intricate overall picture of findings.

Aside from the inter-rater agreement of the two coded variables, and the specific analyses aimed at hypotheses testing, more general information on the independent and dependent variables is presented in Tables 1 and 2. Mean scores and standard deviations are included in Table 1, and the intercorrelations between these variables are listed in Table 2. As a reminder, the proportion scores for the Self/Relational-Orientation and the Suicide-Preventative/Facilitative Orientation factor represent points on a continuum. In the Self/Relational-Orientation factor, a score of 0.00 would equate to a complete Relational-Orientation, and a score of 1.00 would equate to a complete Self-Orientation. In the Suicide-Preventative/Facilitative Orientation, a score of 0.00 would equate to a complete Suicide-Preventative Orientation, and a score of 1.00 would equate to a complete Suicide-Facilitative Orientation. The variable pertaining to patients’ suicide
attempt history was omitted from both Tables 2 and 3 due to its use in this study as a categorical variable. However, as a continuous variable, the mean number of suicide attempts in the current sample was 3.18, with a standard deviation of 6.84.

Table 2

*Means and Standard Deviations for Key Variables of Interest*

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self/Relational-Orientatio</td>
<td>0.57</td>
<td>0.18</td>
</tr>
<tr>
<td>n Proportion Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide-Preventative/Facilitative</td>
<td>0.49</td>
<td>0.20</td>
</tr>
<tr>
<td>Orientation Proportion Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beck Hopelessness Scale Score</td>
<td>12.66</td>
<td>5.66</td>
</tr>
<tr>
<td>Reasons For Living Inventory Score</td>
<td>159.77</td>
<td>44.92</td>
</tr>
<tr>
<td>Suicide Index Score</td>
<td>0.56</td>
<td>4.19</td>
</tr>
</tbody>
</table>

Table 3

*Intercorrelations Among the Key Variables of Interest*

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self/Relational-Orientatio</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Suicide-Preventative/Facilitative</td>
<td>.25*</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orientation Proportion Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Beck Hopelessness Scale Score</td>
<td>-.22*</td>
<td>.34***</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Reasons For Living Inventory Score</td>
<td>-.11</td>
<td>-.39***</td>
<td>-.51***</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>5. Suicide Index Score</td>
<td>.31**</td>
<td>.59***</td>
<td>.66***</td>
<td>-.43***</td>
<td>--</td>
</tr>
</tbody>
</table>

* p < .05, ** p < .01, *** p < .001
Inter-Rater Reliability of Qualitative Coding

Kappa coefficients were computed for the coding of all responses as either Self- or Relationally-Oriented, and then again for the coding of responses as either Suicide-Facilitating or Suicide-Preventative. The kappa for the coding of Self/Relational-Orientation was .98, \( p < .001 \), and the kappa for the coding of Suicide-Facilitating/Preventative Orientation was .99, \( p < .001 \). Both values are indicative of exceptionally high levels of inter-rater reliability between the two raters on each respective coding scheme. The two coders reconciled the few discrepancies in coded responses prior to any subsequent analyses.

**Hypothesis 1**

As noted in the Method section, the reformulated Hypothesis 1 addresses the nature of the patients’ Self/Relational-Orientation and suicidal risk. The coding of all of the qualitative responses as either Self-Oriented or Relationally-Oriented allowed for a median-split of the data in which each patient was categorized as either Self- or Relationally-Oriented. This dichotomized Self/Relational-Orientation coding was found to be related to the indicators of suicidal risk in a fairly limited way. The Self-Oriented patients did not obtain Beck Hopelessness Scale scores that were significantly different from the Relationally-Oriented patients, \( F(1, 90) = 1.61, p = .21 \). No significant main effect was found for Self/Relational-Orientation with respect to scores on the Reasons for Living Inventory, \( F(1, 88) = .02, p = .89 \). There was no significant difference found between Self-Orientation, Relational-Orientation, and a patient’s number of past suicide attempts, partial \( \chi^2(1) = .05, p = .83 \). However, there was a significant difference found
between the two groups in their Suicide Index Scores, \( F(1, 95) = 9.84, p < .01 \). Those in the Self-Oriented group had an average Suicide Index Score of .14, and thus expressed a wish to live and a wish to die that were approximately of the same strength, while the Relationally-Oriented group’s average score of -2.34 shows a desire to live that is noticeably stronger than the desire to die. In other words, a Relational-Orientation has a significantly stronger protective value against suicide risk, at least in terms of the Suicide Index Score as an operational definition of this risk.

**Hypothesis 2**

As noted in the Method section, the reformulated Hypothesis 2 pertains to the Suicide-Preventative/Facilitative Orientation and its role in suicidal risk. The Suicide-Preventative/Facilitative Orientation coding variable proved to be the most robust single factor examined. The distribution of the qualitative coding scores resulted in patients being trichotomized into the Suicide-Preventative, Ambivalent, and Suicide-Facilitative groups. The main effect was found to be significant for each of the four dependent measures of suicidal risk. There was a significant difference between the three groups with respect to their scores on the Beck Hopelessness Scale. Figure 1 shows that the Preventative group had a mean Beck Hopelessness Score of 10.17, the Ambivalent group had a mean score of 12.62, while the Suicide-Facilitative group had a mean score of 15.01, \( F(2, 90) = 5.22, p < .01 \).
The main effect for Suicide-Preventative/Facilitation Orientation on the Reasons for Living Inventory was also found to be significant, $F(2, 88) = 5.14, p < .01$. In this case, higher scores indicate a protective value against suicide because they show a greater endorsement of the collective list of reasons for living. Figure 2 shows that the Preventative group scored the highest with a mean of 177.00, while the Ambivalent group had the lowest mean score of 141.88, and the Facilitative group endorsed the reasons for living at a slightly greater level than the Ambivalent group with a mean of 148.53.
Figure 2
Scores on the Reasons For Living Inventory for Suicide-Preventative/Facilitative Orientation

Qualitative coding, and the resulting trichotomization of patients into the Suicide-Preventive, Ambivalent, and Suicide-Facilitating groups also revealed significant differences in Suicide Index Scores. The main effect of the mean Suicide Index Scores across all three groups was $F(2, 95) = 18.24, p < .001$. As can be seen in Figure 3, the Preventative group had a mean Suicide Index Score of -3.49, meaning that their wish to live strongly outweighed their wish to die. The Ambivalent group had a mean score of -1.83, showing a stronger wish to live, though not to the same degree as the Preventative group. The Facilitative group showed an average Suicide Index Score of 2.03, clearly showing a greater intensity in the wish to die over the wish to live.
There were also large disparities in the numbers of patients in each group who had multiple past suicide attempts as opposed to one or none, partial $\chi^2(1) = 7.83$, $p = .02$. As can be seen in Figure 4, the Preventative group had five out of 20 individuals with a history of two or more suicide attempts. The Ambivalent group was almost evenly divided with 11 of 21 patients with two or more past suicide attempts. The Facilitative group showed a strong inclination towards past suicide attempts with 15 of 21 individuals with a multiple attempt history. Table 3 briefly summarizes these collective results.
Table 4

*Relationships Between Suicide-Preventative/Facilitative Orientation and Indices of Suicidal Risk*

<table>
<thead>
<tr>
<th></th>
<th>Preventative Group</th>
<th>Ambivalent Group</th>
<th>Facilitative Group</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Hopelessness Scale Score</td>
<td>10.17</td>
<td>12.62</td>
<td>15.01</td>
<td>5.23 *</td>
</tr>
<tr>
<td>Reasons For Living Inventory Score</td>
<td>179.00</td>
<td>141.88</td>
<td>148.53</td>
<td>5.14 **</td>
</tr>
<tr>
<td>Suicide Index Score</td>
<td>-3.49</td>
<td>-1.83</td>
<td>2.03</td>
<td>18.24 ***</td>
</tr>
<tr>
<td>Past Suicide Attempts Patients with 0 or 1 Attempt</td>
<td>15</td>
<td>10</td>
<td>6</td>
<td>partial $\chi^2 = 7.83$ *</td>
</tr>
<tr>
<td>Patients with 2 or more Attempts</td>
<td>5</td>
<td>11</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

* $p < .05$, ** $p < .01$, *** $p < .001$
Hypothesis 3

The main effect findings within the multi-way ANOVAs for the trichotomized Suicide-Preventative/Facilitative Orientation variable were further explored with planned comparisons to delve into what pairwise differences may be driving the significant F values. Specific focus was devoted to the Facilitative group in these comparisons considering that this group poses the greatest clinical concern of the three. Within the significant main effects for each of these ANOVAs, raw t tests were used to compare the mean scores from the Facilitative group against the Preventative group, and the Facilitative group against the Ambivalent group respectively. Where the degrees of freedom noted are not integers, the adjusted t value is being reported to account for unequal variances between the two groups.
The mean Beck Hopelessness Scale scores of the Facilitative and Preventative groups were found to be significantly different, where \( t(57.85) = 3.48, p < .001 \), indicating that the Facilitative group was experiencing a greater sense of hopelessness than the Preventative group. Though, when compared to the Ambivalent group, the Facilitative group was not found to be feeling significantly more hopeless, \( t(68) = 1.44, p = .16 \). A significant difference was also found between the Facilitative group and the Preventative group with respect to their group scores on the Reasons For Living Inventory, \( t(63) = 2.59, p = .01 \). But, as was the case from the Beck Hopelessness Scale, when the Facilitative and Ambivalent groups’ scores from the Reasons For Living Inventory were directly compared, no significant difference was found between the two, \( t(66) = .46, p = .65 \).

In keeping with the pattern, a significant difference was found between the Facilitative group and the Preventative group with regard to their Suicide Index Scores, where the Facilitative group was found to be much more inclined to want to die and the Preventative group had a more overpowering wish to live, \( t(69) = 7.22, p < .001 \). Unlike what the follow-up comparisons revealed about group scores from the Beck Hopelessness Scale and the Reasons for Living Inventory, the Suicide Index Scores of the Ambivalent group and the Facilitative group were also found to be significantly different from each other, \( t(69) = 3.48, p < .001 \). Table 3 has been adapted in Table 4 to summarize the findings of these comparisons within the Suicide-Preventative/Facilitative Orientation factor. No analogous planned comparison tests were used to investigate group differences within the Suicide-Preventative/Facilitation Orientation factor for patients’ suicide
attempt history. This was because the log linear test performed was not conducive to follow-up comparisons, and because these possible group differences for this particular variable were deemed to be beyond the scope of the current project.
Table 5
Within Factor Comparisons of the Suicide-Preventative/Facilitative Orientation

<table>
<thead>
<tr>
<th>Measure</th>
<th>Preventive Group</th>
<th>Ambivalent Group</th>
<th>Facilitative Group</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Hopelessness Scale Score</td>
<td>10.17</td>
<td>12.62</td>
<td>15.01</td>
<td>3.48***</td>
</tr>
<tr>
<td>Reasons For Living Inventory Score</td>
<td>179.00</td>
<td>141.88</td>
<td>148.53</td>
<td>2.59**</td>
</tr>
<tr>
<td>Suicide Index Score</td>
<td>-3.49</td>
<td>-1.83</td>
<td>2.03</td>
<td>7.22***</td>
</tr>
</tbody>
</table>

* p < .05, ** p < .01, *** p < .001
The Association of Gender with Suicidal Risk Measures

As originally proposed, the current study took into consideration the possible meaningful impact of Gender as a covariate. In the analyses, Gender, taken by itself as a covariate, was not found to have a very strong connection to the available indicators of suicidal risk in this study. There was no significant difference between males and females on the Beck Hopelessness Scale, $F(1, 90) = .19, p = .67$. Nor was there any difference between males and females on the Reasons for Living Inventory, $F(1, 88) = .19, p = .66$. Within the saturated log linear model examining suicide attempt history, Gender was not found to be significantly associated with past suicide attempts, partial $\chi^2(1) = .22, p = 64$. However, the one significant difference between males and females was found among their Suicide Index Scores. Of the range from -6 to +6, the average Suicide Index Score for males was -2.02 while the average score for females was -0.17, with $F(1, 95) = 5.47, p = .02$. This shows that the women of the present study expressed roughly the same intensity in both their wish to live and their wish to die, while the men had expressed a wish to live that outweighed their wish to die.

Interactions of All Factors in Relation to Suicidal Risk Measures

Interaction effects between Gender, Self/Relational-Orientaion, and Suicide-Preventative/Facilitative Orientation tended to be non-significant for each of the major suicidal risk indices examined, but with a few noteworthy exceptions. For the Reasons For Living Inventory, two of the two-way interactions were not significantly related to patients’ total score, but the remaining two-way interaction was significant. Neither the Gender X Self/Relational-Orientaion interaction was related to the Reasons For Living
Inventory’s total score, \( F(1, 88) = 1.28, p = .26 \), nor was the interaction of Gender and Suicide-Preventative/Facilitative Orientation, \( F(2, 88) = 1.10, p = .34 \). The two-way interaction that was significantly related to scores from the Reasons For Living Inventory was the Self/Relational-Orientation X Suicide-Preventative/Facilitative Orientation, \( F(2, 88) = 8.94, p < .001 \). As Figure 5 shows, scores on the Reasons For Living Inventory varied heavily depending on the sub-groups within the interaction. For those individuals classified as Relationally-Oriented, the Preventative group had a mean score of 190.84, the Ambivalent group scored at 110.05, and the Facilitative group had a score of 164.43; conversely, for those who were more Self-Oriented, the Preventative group had a Reasons For Living Inventory score of 163.15, the Ambivalent group scored at 173.71, and the Facilitative group had a score of 132.64. The three-way interaction of Gender X Self/Relational-Orientation X Suicide-Preventative/Facilitative Orientation was not strong enough to clearly be influencing scores on the Reasons For Living Inventory, \( F(2, 88) = 2.89, p = .07 \).
Figure 5
Interaction of Self/Relational-Orientation and Suicide-Preventative/Facilitative Orientation for Reasons For Living Inventory

For Suicide Index Scores, only the Gender X Self/Relational-Orientation two-way interaction was found to be significant, $F(1, 95) = 4.51, p = .04$. The Gender X Suicide-Preventative/Facilitative interaction had no notable influence of Suicide Index Scores, $F(2, 95) = 1.93, p = .15$, which was also the case with the Self/Relational-Orientation X Suicide-Preventative/Facilitative Orientation interaction, $F(2, 95) = .17, p = .84$. Figure 6 illustrates how, in the Gender X Self/Relational-Orientation interaction, one’s Self/Relational-Orientation was associated with a sizable disparity in Suicide Index Scores for males (the Self-Oriented males’ $M = .58$, while Relationally-Oriented males’ $M = -4.10$), but the females scored almost identically regardless of Self-Orientation ($M = ...$)
.06) or Relational-Orientation (M = .23). The three-way interaction was not found to be linked to patients’ Suicide Index Scores, $F(2, 95) = .95, p = .39$.

**Figure 6** (Interaction of Gender and Self/Relational-Orientation for Suicide Index Scores)**

With regard to patients’ suicide attempt history, the log linear modeling rejected the simultaneous inclusion of Gender, Self/Relational-Orientation, and Suicide-Facilitative/Preventative Orientation in a collective relationship to past suicide attempts, $\chi^2(2) = .14, p = .94$. Instead, the model that best fit the data was the one that included all two-way and one-way effects of the independent variables in association with suicide attempt history, likelihood ratio $\chi^2(9) = 22.22, p = .008$. Within the saturated model, the interplay between Self/Relational-Orientation and Suicide-Facilitative/Preventative Orientation was shown to be strongly linked to numbers of past suicide attempts, partial $\chi^2(2) = 11.58, p = .003$. The contrasting graphs in Figure 7 show that the distribution of patients into the different categories was quite different for the Relationally-Oriented and
Self-Oriented groups. The lowest risk group of all appeared to be the Relationally-Oriented Preventative group which consisted of 10 people with one or no past suicide attempts; while the highest risk group appeared to be the Self-Oriented Facilitative group which included 11 individuals with a history of multiple suicide attempts. A similar finding was revealed in the interaction between Gender and Suicide-Facilitative/Preventative Orientation as it pertained to suicide attempt history, partial $\chi^2(2) = 11.89, p = .003$ (see Figure 8). In this case, the group that seemed to exhibit the lowest risk were the Preventative-Oriented males who had no multiple attempters and eight individuals with one or no past suicide attempts. Conversely, the group that appeared to be of greatest concern in this context was the group of females who were Facilitative-Oriented. This group consisted of six patients who had made zero or one past suicide attempt, and 12 patients with multiple past suicide attempts.
Figure 7
Interaction of Self/Relational-Orientation and Suicide-Preventative/Facilitative Orientation linked to Suicide Attempt History

Self-Oriented Group

Relationally-Oriented Group
Figure 8
*Patients’ Suicide Attempt History for Interaction of Gender X Suicide-Preventative/Facilitative Orientation*
The total score from the Beck Hopelessness Scale was the only index of suicidal risk for which none of the interactions were significantly related. The Gender X Self/Relational-Orientation interaction was unrelated to Beck Hopelessness Scale score, $F(1, 90) = .02, p = .89$. The interaction of Gender and Suicide Preventative/Facilitative-Orientation was also found to be not significantly related to hopelessness scores, $F(2, 90) = 1.03, p = .36$. Likewise, there was no significant interaction of Self/Relational-Orientation and Suicide Preventative/Facilitative-Orientation, $F(2, 90) = 1.62, p = .20$. And, finally, the interaction of all three variables of interest was also not significantly related to hopelessness scores, $F(2, 90) = .10, p = .90$.

**Post-Hoc Comparisons**

The decision was made to conduct a post-hoc Tukey HSD test in the case of one anomalous finding. In the interaction of Self/Relational-Orientation X Suicide Preventative/Facilitative-Orientation for Reasons For Living Scores, the mean score of the Relationally-Oriented Ambivalent group was so noticeably lower than the mean scores of all other groups that it warranted closer scrutiny (see Figure 5). The Tukey HSD test was selected as it is best suited for the pairwise comparisons desired here where the Relationally-Oriented Preventative group would be compared to the Self-Oriented Preventative group, the Relationally-Oriented Ambivalent group would be compared to the Self-Oriented Ambivalent group, and the Relationally-Oriented Facilitative group would be compared to the Self-Oriented Facilitative group. These comparisons would help to uncover notable mean differences contributing to the interaction’s significant F value and, in the relationship of these comparisons to each other, show if the Ambivalent
group is prone to the opposite phenomenon that is influencing the Preventative and Facilitative groups. Of these three Tukey HSD tests, only the difference between the Self-Oriented Ambivalent group ($M = 173.71$), and Relationally-Oriented Ambivalent group ($M = 110.05$) was found to be significant, $p < .001$. The Relationally-Oriented Preventative group ($M = 190.84$) was not significantly different from the Self-Oriented Preventative group ($M = 163.15$), $p = .45$; and the difference between the Relationally-Oriented Facilitative group ($M = 164.43$) and the Self-Oriented Facilitative group ($M = 132.64$) was also not significant, $p = .21$. 
CHAPTER 4

Discussion

The current study was designed to investigate how an individual’s self-orientation and relational-orientation are linked to increased suicidal risk, with a complimentary focus on the relationship between suicidal risk and an individual’s apparent inclination towards a suicide-preventative orientation, a state of ambivalence, or a suicide-facilitating orientation. The present study was unique in that its focus on self- vs. relational-orientation was explicit and a priori, unlike other studies where self- and relational-orientations are often underlying elements of other constructs and are part of post hoc interpretations of findings. Another noteworthy feature of this study is that the pertinent orientations were assessed exclusively through qualitative coding of patient responses provided to open-ended prompts. Such qualitative data have been used with increasing prominence in recent years, but the current study appears to be one of the few where a patient’s own words are the sole source of the data used to create major constructs reflecting their mindset about their own potential suicide.

Inter-Rater Reliability of Qualitative Coding

The actual coding of the qualitative data itself proved to be one of the strongest elements of the study’s design. The inter-rater agreement for both the Self/Relational-Orientation coding and Suicide-Preventative/Facilitating Orientation coding was close to perfect, with kappa coefficients of .98 and .99 respectively. This high level of reliability exceeds that of previous studies that also used the Suicide Status Form to obtain qualitative data from suicidal populations (Jobes, 2004; Jobes & Mann, 1999). Such high levels of agreement suggest that these constructs are very easily discernable and could be
applied in future research with considerable confidence that the qualitative coding of these two factors.

**The Association of Gender with Measures of Suicidal Risk**

In the case of Gender, only the Suicide Index Scores revealed a significant difference between males and females, with females being more inclined towards “wishing to die” than males. This is a somewhat surprising finding given that an overwhelming amount of research has consistently shown that males account for far more suicides than do females. It is possible that this finding is a function of the clinical sample that was used for the present study. Some research has shown that suicidal women are up to twice as likely as suicidal men to seek out mental health services (Pirkis, Burgess, Meadows, & Dunt, 2001; Luoma, Martin, & Pearson, 2002; Souminem, Isometsä, Ostamo, & Lönqvist, 2002). Thus, it may be that the males who are most severely suicidal “succeed” in taking their own lives before they find their way into a psychiatric inpatient unit like the one used for this study. Furthermore, prior research found that the female portion of the current sample was engaging in a noticeable exaggeration of their symptom distress (Kahn-Greene, 2009). This may help to account for the significantly elevated desire to die that was obtained from the female patients in the current study.

**Hypothesis 1**

Hypothesis 1 proposed that patients who are predominantly Self-Oriented will be at higher suicidal risk than the patients who are predominantly Relationally-Oriented. The Self/Relational-Orientation factor was found to be linked to relative suicidal risk in that
the Self-Oriented patients had significantly higher Suicide Index Scores, and so Hypothesis 1 was partially confirmed. This reaffirms the general principle that a person’s focus on the positive and meaningful relationships in their life serves as a powerful protective buffer against suicide. This buffer is strong enough on average to protect against heightened suicidal risk in spite of the influences of other interpersonal variables, such as perceived burdensomeness and thwarted belongingness, that have been shown to function as significant risk-factors for suicide (Joiner et al., 2002; Van Orden et al., 2006; Conner et al., 2007).

**Hypothesis 2**

Hypothesis 2 posited that a significant main effect would be detected for increased suicidal risk across the Suicide-Facilitating/Preventative Orientation factor. This hypothesis was roundly confirmed to be true with the Suicide-Facilitative/Preventative Orientation proving to be the one factor most consistently linked to a person’s risk level for suicide. For three of the four dependent variables tested, those patients who were determined to have a Suicide-Preventative Orientation were found to be at the lowest risk, the patients determined to have a Suicide-Facilitative Orientation were found to be at the highest risk, and the patients determined to be in the Ambivalent group had risk scores in between the other two groups. In the one instance where this was not the case – scores on the Reasons For Living Inventory – those patients with a Suicide-Preventative Orientation were still found to be at the lowest risk, while the Ambivalent
and Suicide-Facilitative Oriented patients were statistically at an equally high risk for possible suicide.

Thought of strictly in straightforward terms, this pattern may seem somewhat unremarkable: The group deemed to be more mentally geared towards wanting to live had scores indicative of a low risk of suicide, while the group deemed to be geared towards wanting to die had scores indicative of a high risk of suicide. But this would be an oversimplification that ignores the underlying meaning of this pattern of findings. Specifically, since the three groups were created using the qualitative data from the Reasons For Living/Dying prompts, this means that relative suicidal risk level may be correlated with fairly remarkable accuracy using only the patient’s own written words. In essence, if a clinician wants to know the potential relative risk of the patient, using the SSF-II to assess their reasons for wanting to live and die may meaningfully reveal three important typologies for relative risk.

Hypothesis 3

Hypothesis 3 was created as a more focused follow-up to Hypothesis 2 so that specific group differences could be tested within the Suicide-Facilitating/Preventative Orientation factor. This hypothesis consisted of two parts. The first part said that, within the Suicide-Facilitating/Preventative Orientation factor, patients with a predominantly Suicide-Facilitating Orientation will be at a higher relative suicidal risk than the patients with a predominantly Suicide-Preventative Orientation. The results showed that those with a Suicide-Facilitating Orientation were at significantly greater risk for suicide as
measured by Beck Hopelessness Scale scores, the Reasons For Living Inventory scores, and Suicide Index Scores. Therefore, the first half of Hypothesis 3 was definitively proven to be true. The second half of Hypothesis 3 proposed that, within the Suicide-Facilitating/Preventative Orientation factor, patients with a predominantly Suicide-Facilitating Orientation will be at a higher relative suicidal risk than the patients with an Ambivalent Orientation. This portion of the hypothesis was partially confirmed to be true, as the Suicide Index Score was the only measure in which a significantly difference could be detected between these two groups.

Clinically, an important interpretation can be drawn from these findings. It is not surprising that the group with a Suicide-Facilitating Orientation was at significantly greater risk than the group with the Suicide-Preventative Orientation. However, the finding that the Ambivalent group would be at a lower risk-level than the Suicide-Facilitative group on only an inconsistent basis suggests that a suicidal person who is ambivalent about life and death may actually be just as clinically worrisome as someone who is already inclined towards wanting to die.

On a more theoretical level, these results also help contribute to an overall understanding of the subgroups originally proposed and investigated by the Internal Struggle Hypothesis (Kovacs and Beck, 1977; Brown, Steer, Henriques, & Beck, 2005). Even now – 30 years after its introduction – there has been very little empirical research on the Internal Struggle Hypothesis, and virtually no research that specifically examines the relative risk of suicidal individuals with an ambivalent mindset. The current study
helps to clarify our understanding of both of these areas by showing that trichotomized subgroups of suicidality do appear to have their own unique patterns of relative suicidal risk in relation to one another.

**Interactions of All Constructs in Relation to Suicidal Risk Measures**

Statistical interactions of the key constructs investigated were similar to the group differences examined through Hypotheses 1 and 3 in the sense that the interactions were somewhat inconsistent across the suicidal risk measures investigated but could still be detected. For example, an interaction of Gender and Self/Relational-Orientation was found only for patients’ Suicide Index Scores. Though such an interaction was not found to be significant for the other risk indices, this particular finding showed that a Relational-Orientation offered a sizable protective buffer against relative suicide risk for males but made virtually no difference in the Suicide Index Scores for females. There is something unique about the Relationally-Oriented males that helps make their Suicide Index Scores significantly lower than all other patients. This may relate back to the differences in sex roles already described. With the communion construct widely considered to be one of the fundamental components of femininity (Bem, 1974, 1975, & 1976; Spence, 1984), it could be that a Relational-Orientation is the more novel perspective for males, and thus a Relational-Orientation becomes all the more protective in its novelty.

Another interaction that was found to be significant involved Gender and the Suicide-Facilitative/Preventative Orientation factor. Of the four dependent variables
measuring suicidal risk, this interaction was found to only be significant for patients’ suicide attempt history. As can be seen in Figure 8, the impact of Suicide-Facilitative/Preventative Orientation on suicide attempt history varies greatly depending on if the patient is male or female. The protective value of having a Suicide-Preventative Orientation was quite strong for the males but fairly negligible for females, while on the other hand the self-destructive value of having a Suicide-Facilitative Orientation was quite strong for females but fairly negligible for males. Put simply, the raw numbers show that males with a Suicide-Preventative Orientation have the most clinically favorable suicide attempt history, and females with a Suicide-Facilitative Orientation have the most clinically worrisome suicide attempt history. The precise explanation for this is a little difficult to determine but it would seem that this finding is generally in line with the well known gender differences in suicidality. One of the most widely accepted gender differences in the field is sometimes called the gender paradox of suicide and refers to the phenomenon where men complete suicide in much greater numbers than women, but women attempt suicide in much greater numbers than men (Canetto, 1997; Canetto & Sakinofsky, 1998). The numbers shown in Figure 8 could actually be a depiction of how this plays out in clinical populations. For women who are more focused on suicide, as measured by their Suicide-Facilitative/Preventative Orientation, there is a connection to histories with more and more suicide attempts. In contrast, as men focus more on suicide, they hit something of a ceiling on attempt history and are probably
“succeeding” in their attempts more, making them undetectable in the kinds of analyses that have been performed here.

The final two interactions that were found to be significant both involved the two, key independent variables of interest – Self/Relational-Orientation and Suicide-Facilitative/Preventative Orientation. The interactions of these two constructs were found to be significant in predicting both suicide attempt history and scores from the Reasons For Living Inventory. As these findings are examined closely, some particular interpretations begin to stand out. To begin with, Figures 5 and 7 both show that the patients with a Relational-Orientation who also had a Suicide-Preventative Orientation were the one group, on average, that demonstrated the lowest overall risk for suicide. These patients constituted the one group that had the highest scores on the Reasons For Living Inventory as well as suicide attempt histories that were the least indicative of possible attempts in the future. In contrast, the Self-Oriented patients who also had a Suicide-Facilitative Orientation constituted the one group that generally demonstrated the greatest overall risk for suicide. This group had the second lowest scores on the Reasons For Living Inventory as well as the suicide attempt history most indicative of possible attempts in the future. When these findings are looked at in concert with one another, the significant interactions help to show the cumulative effect of these two factors. A patient’s Suicide-Preventative Orientation may offer a protective buffer against a possible suicide, but this buffer is increased by the presence of a Relational-Orientation. Conversely, an individual’s Suicide-Facilitative Orientation may be an important risk.
factor for suicide, but this risk is further exacerbated by the presence of a Self-Orientation.

The second noteworthy aspect of these interactions can be seen in the results obtained for the Ambivalent patients. For both suicide attempt history and Reasons For Living Inventory scores, the general picture presented by Figures 5 and 7 is that the Relationally-Oriented patients posed a smaller suicidal risk than the Self-Oriented patients except in the case of the Ambivalent group. The more Suicide-Preventative and Suicide-Facilitative groups of Relationally-Oriented patients had higher scores on the Reasons For Living Inventory (albeit not significantly higher according to the post-hoc analyses) and less severe suicide attempt histories than their Self-Oriented counterparts. But the complete reverse was true of the patients categorized as Ambivalent. Those who were both Self-Oriented and Ambivalent had fewer multiple suicide attempters, more individuals who had either never attempted suicide or attempted only once, and significantly higher scores on the Reasons For Living Inventory than their Relationally-Oriented counterparts. Simply put, if a person is particularly ambivalent about suicide, then there is a noticeable protective value in being Self-Oriented, but if a person has much inclination either way about suicide then there is modest protective benefit in being Relationally-Oriented. This pattern was unanticipated and cannot be decisively explained here, but the individual components seem to mimic a state of poor ego strength which has been shown to be a risk factor for suicide in its own right (Plutchik, Botsis, & Van Praag, 1995; Leenaars, 1999). The construct of ego strength has been conceptualized in a variety
of ways, but particularly pertinent aspects of an individual with poor ego strength include an inability to effectively cope with life’s problems, an intense feeling of being torn between the competing desires of the id and the superego, and a difficulty maintaining a sense of self during psychic distress (Symonds, 1951; Brown & Pedder, 1979). So it may be that the qualitative codings designed to detect Relationally-Oriented, Ambivalent patients had coalesced to identify the individuals with the lowest ego strength, who have their own distinct levels of suicidality.

**Clinical Implications**

Considering the challenges that must be faced in working with suicidal patients, the study’s resulting clinical implications may be considered the true crux of the entire investigation. What may be uniquely helpful about the particular points discussed here is that they are all aimed at assisting a clinician’s direct efforts to either assess or make therapeutic interventions with a suicidal patient. These one-on-one strategies to assist the clinician serve as a strong compliment to the Suicide Status Form-II itself which was designed to help foster collaboration between the clinician and the patient (Jobes, 2006).

The two qualitatively coded factors at the heart of the current study provide several opportunities for clinical interpretation and intervention, and these opportunities can be taken advantage of immediately after the suicidal individual has provided the qualitative data. For instance, the Suicide-Facilitating/Preventative Orientation factor offers the chance for a clinician to make an informed judgment regarding a person’s relative risk-level for suicide. With as little as a critical glance at the balance of a
person’s responses within the Reasons For Living/Dying section of the Suicide Status Form-II, a clinician can make a simple yet empirically-backed appraisal of the individual’s relative level of risk for a possible suicide. Following this, a person’s Self/Relational-Orientation can be obtained fairly quickly by a clinician and incorporated into the therapeutic/assessment process however the clinician best sees fit. The results of this study suggest that this factor could be used most effectively when understood in conjunction with the patient’s Suicide-Facilitating/Preventative Orientation. Specifically, a Relationally-Oriented person with a Suicide-Preventative attitude can be characterized as having a significantly reduced level of relative risk compared with a Self-Oriented person with a Suicide-Facilitative attitude. These group distinctions have obvious clinical implications for essentially all aspects of the therapeutic process, and the nature of the qualitative coding for these factors means that a clinician can make such distinctions in a data-driven format in little more than one or two minutes.

The clinical utility of these two coded factors is further augmented by the qualitative responses themselves. The underlying content that yield the two coded factors – and the specific prompts that they were provided for – offer the clinician the perfect source of data to help tease out the individual nuances that contribute to the two different orientations. A person could be both Ambivalent and Self-Orientated overall, but a discerning clinician may see that Relationally-Oriented responses dominate the patient’s Reasons For Living, while Self-Oriented responses dominate the Reasons For Dying. These important details about what kinds of qualitative responses are being provided (i.e.,
specific content), where they are being provided (i.e., to which prompts), and to what degree they are being provided (i.e., Self-Orientation, Suicide-Facilitative Orientation), collectively make for influential implications regarding how the clinician decides to work with the patient.

**Limitations of the Current Study**

As is the case with any scientific investigation, the current study has certain limitations. The more straightforward of these limitations center around the study’s sample size and lack of ethnic diversity. One hundred and eight inpatients hospitalized for suicidal behavior and/or ideation does constitute a respectable sample size for studying suicidality, but is still small enough to cast some doubt on the statistical power of any analyses. Ethnic diversity was also extremely limited in that the racial make-up of the sample is skewed disproportionately towards Caucasians with virtually no representation of Latino, Asian-American, or African-American individuals. Despite these limitations, the study was able to yield a number of significant and meaningful findings, even for analyses focused on suicide attempt history which permitted testing only on a sub-sample of the full number of patients available (N = 62). Also, even though the ethnic homogeneity of the sample makes it difficult to generalize the results to the broader population, the sample of the current study does have a broader age range than many other studies of suicidality. The age range of the sample used (patients aged 18 – 67) means there is representation of all major age groups except for the elderly, and thus
generalizability is improved in this regard. Nonetheless, any follow-up research will want to improve on these methodological limitations.

Another methodological point that could easily be interpreted as a limitation is the very typological design itself. Categorizing patients into Self-Oriented vs. Relationally-Oriented, and Suicide-Preventative, Ambivalent, and Suicide-Facilitative groups can create a serious restriction of statistical variance that may inhibit detection of significant findings. Many researchers and statisticians recommend the alternative approach of using regression analyses to test the continuous data, as opposed to what was done in the current study – using ANOVAs to test categorical groups (MacCallum, Zhang, Preacher, & Rucker, 2002; Irwin & McClelland, 2003). It must be noted at this point that the regression approach was explored and subsequently rejected for the present study for two key reasons. Firstly, the pattern of results remained largely the same regardless of which statistical method was used. And secondly, in the one key instance where the pattern of results was not the same, the regression analyses did not find a significant finding but this was ultimately believed to be a false negative. The regression found no significant interaction of the Self/Relational-Orientation factor X the Suicide-Facilitating/Preventative Orientation factor in predicting scores from the Reasons For Living Inventory. This non-finding was believed to have been a result of the best-fit regression lines being mapped onto the data in a way that essentially ignored the drastic swings in scores from the two Ambivalent groups, and thus cannot be considered an accurate reflection of the true state of the data. Even so, the use of the less preferable
method of testing dichotomized and trichotomized data can be seen as a limitation of the current study, and follow-up research may want to investigate the Self/Relational-Orientation, and Suicide-Facilitating/Preventative Orientation factors in their continuous forms in order to satisfy the need for the more customary style of analyses.

Another important consideration that must be made when interpreting this study is the extent to which a person will remain within any distinct typology over time. For the two critical independent variables of interest, it must be made perfectly clear that these are cross-sectional data, and so they do not offer much value in understanding how an individual might move fluidly from one typology to another. The Suicide-Facilitating/Preventative Orientation factor is most applicable when making this point because, while it is presented here as three distinct typologies, it would also be very easy for the reader to think in terms of a progression from a Suicide-Preventative Orientation, to a state of Ambivalence, to a Suicide-Facilitative Orientation. The current study is, thus, limited in that it cannot offer any insight into any longitudinal progression across such a spectrum. In fact, there have been no longitudinal studies investigating how a person’s location on the spectrum of suicidal ambivalence changes across time. This is an unfortunate gap on the overall literature and should be an important area of further research in the future.

One last limitation worth addressing has less to do with any statistical analyses and more to do with the content of the qualitative coding. In the creation of the Self/Relational-Orientation factor, all relational-others are treated equally with no
accounting for any differences that might exist in the level of emotional connectedness that the patient has in the different relationships mentioned. This is a limitation of the current study because such differences in emotional connectedness play a huge rule in how we relate to others. Abele and Wojciszke (2007) conducted a study that showed that agentic traits are considered more important in a close friend than in an unrelated peer. The authors aptly summarized this by saying that “the specific other matters” (p. 761). It is impossible to know just how much the specific other matters in the present study because wanting to live “for Puck, my dog” was coded as being effectively the same as wanting to live “to be a servant to God”. Future investigations into Self/Relational-Orientations in suicidal individuals may want to examine just how meaningful the “specific other” is when it comes to making life or death decisions.

**Summary and Future Directions**

There are a number of ways that the current study can influence future study of, and work with, suicidal populations. Beyond the possibilities for follow-up research described above, there are a few other areas of potential investigation that would likely bring beneficial results. The results of this study showed that distinct sub-groups of suicidal individuals often present with different profiles of risk, and that these different profiles suggest unique typologies which come with their own special challenges for both assessment and treatment. Based on the results that have been presented, targeted therapeutic interventions should be developed to help address the suicidal risks posed by the different orientations (and the various combinations thereof). These kinds of targeted
interventions have been explored by several authors, including Stellrecht et al. (2006) who described various assessment/treatment techniques aimed specifically at the individual elements of Joiner’s Interpersonal-Psychological theory of suicide (2005). The field should continue to pursue such tailored interventions wherever feasible.

This point about using new research to pursue better assessment/treatment techniques is especially poignant for the concept of ambivalence. Beyond more innovative and effective assessment/treatment techniques, further research is needed on the state of ambivalence generally. Other than the investigations conducted by Beck and his colleagues described above, virtually nothing exists in the extant literature devoted to how these suicidal individuals with decidedly mixed emotions think about the value of their own lives. The current study shows that the people who are particularly ambivalent about life and death can yield surprising and unpredictable results. While there is an obvious motivation to understand the suicidal person who has all but given up on life entirely, the ambivalent group is still woefully misunderstood and requires further study.

The current study and its findings also have the capacity to yield important new avenues in the specific area of suicide risk assessment. The qualitative/quantitative hybrid coding system used to generate the main independent variables can help serve as a unique yet straightforward way of gauging degree of risk. The Suicide-Preventative/Facilitative Orientation, by itself, is an extremely viable part of this system, and should be a key focal point of future research. The Suicide-Preventative/Facilitative Orientation factor was originally devised – in part – to help specify the underlying nature of the patient’s Self- or
Relational-Orientation. However, as the results have demonstrated, this one factor can be extremely useful in its own right. It is created from qualitative data that are easily obtained from the individual, it is coded in a format that is extraordinarily reliable, it is calculated using a simple proportion score, and it is highly predictive of every risk factor that it has been tested against. A risk assessment variable this robust could be very valuable in clinical settings at all levels. It is conceivable that, for the sake of pragmatism, replication studies could help to produce an algorithm capable of using the Suicide-Preventative/Facilitative Orientation factor to estimate scores for other suicidal risk variables as a way of streamlining an Intake procedure. This orientation could have similar value on the opposite end of the process as an outcome variable measuring how much a person’s reasons for wanting to live or die may have changed over the course of treatment. Through these kinds of efforts and implementations in the future, it is hoped that our overall understanding of suicide will be advanced and that pain and suffering can be alleviated for thousands of suicidal people and their loved ones.
Appendix A

Informed Consent Form
Consent Form for Participation in a Research Study

TITLE: “Psychometric Study of the Suicide Status Form (SSF)”

IRB #: 2181-04 00

RESEARCHERS: Dr. T. W. Lineberry and colleagues

PROTOCOL LAST APPROVED BY INSTITUTIONAL REVIEW BOARD: October 21, 2004

THIS FORM APPROVED: October 21, 2004

This is an important form. Please read it carefully. It tells you what you need to know about this research study. If you agree to take part in this study, you need to sign this form. Your signature means that you have been told about the study and what the risks are. Your signature on this form also means that you want to take part in this study.

Why is this research study being done?

This study is being done to establish the usefulness of a form that is used to assess patients who are suicidal. Mental health professionals develop forms to assess and appropriately treat mental and emotional problems. Clinical assessment forms are particularly important in the treatment of patients who are suicidal.

How many people will take part in this research study?

The plan is to have 350 people take part in this study at the Mayo Clinic in Rochester. Up to 500 people may be screened to find enough eligible people to begin the study.

What will happen in this research study?

In this study, the researchers are interested in comparing a new clinical assessment form to other, established forms that measure similar concepts. You will fill out forms that ask about your feelings. The researchers will compare your responses on the new form to your responses on the established forms. That will help the researchers determine the usefulness of the new form. Your participation in this study is greatly appreciated, and will benefit future patients and the mental health professionals who treat them.
You will be given a group of 12 short questionnaires to fill out after a brief interview, including the K-10+, the Outcome Questionnaire 45.2, the Stages of Change Ladder (inpatient), the Suicide Status Form, the Behavioral Health Questionnaire, the Pressure Inventory III, the Hopelessness Scale, the Reasons for Living Scale, the Orbach & Mikulincer Mental Pain Scale, the Beck Self-Concept Test, the Barratt Impulsivity Scale, and the State-Trait Inventory for Cognitive and Somatic Anxiety. It may take between 60 and 90 minutes to fill out the questionnaires.

How long will I be in this research study?

You will be in this study for 2 days. When you enter the study, you will fill out forms that will take about an hour to complete. Two days later, you will fill out one or two forms that will take about five minutes to complete.

Are there reasons I might leave this research study early?

Taking part in this research study is your decision. You may decide to stop at any time. You should tell the researcher or the nurse, who gave you the research forms, if you decide to stop.

In addition, the researchers or Mayo may stop you from taking part in this study at any time if it is not in your best interest, if you do not follow the study rules, or if the study is stopped.

What are the risks of this research study?

The risks of participating in this study include some discomfort you may experience due to thinking about psychological issues, emotions, and beliefs. You probably will not experience more discomfort than you had before being in the study. If a question on the forms upsets you, you should discuss that with your mental health professional.

A pregnancy test will not be necessary as part of this study because there is no risk to an unborn child in this study.

Are there benefits to taking part in this research study?

This study will not directly make your health better.
What other choices do I have if I don’t take part in this research study?

Participation in this study is voluntary and you may choose not to participate. This study is only being done to gather information.

Will I need to pay for the tests and procedures?

You will not need to pay for any tests and procedures that are done just for this research study. However, you and/or your health plan will need to pay for all other tests and procedures that you would normally have as part of your regular medical care.

What happens if I am injured because I took part in this research study?

If you have side effects from the study treatment, you need to report them to the researcher and your regular physician, and you will be treated as needed. Mayo will give medical services for treatment for any bad side effects from taking part in this study. Such services will be free if not covered by a health plan or insurance. No additional money will be offered.

What are my rights if I take part in this research study?

Taking part in this research study does not take away any other rights or benefits you might have if you did not take part in the study. Taking part in this study does not give you any special privileges. You will not be penalized in any way if you decide not to take part or if you stop after you start the study. Specifically, you do not have to be in this study to receive or continue to receive medical care from Mayo Clinic. If you stop the study you will still receive medical care for your condition.

You will be told of important new findings or any changes in the study or procedures that may affect you or your willingness to continue in the study.

Who can answer my questions?

You may talk to Dr. Timothy W. Lineberry at any time about any questions or concerns you have about this study. You may contact Dr. Lineberry (or an associate) by calling the Mayo operator at telephone (507) 284-2511.

You can get more information about Mayo policies, the conduct of this study, or the rights of research participants from Cindy L. Boyer, Administrator of the Mayo Foundation Office for Human Research Protection, telephone (507) 284-2329 or toll free (866) 273-4681.
Authorization To Use And Disclose Protected Health Information

Your privacy is important to us, and we want to protect it as much as possible. By signing this form, you authorize Mayo Clinic at Rochester and the investigators to use and disclose any information created or collected in the course of your participation in this research protocol. This information might be in different places, including your original medical record, but we will only disclose information that is related to this research protocol for the purposes listed below.

This information will be given out for the proper monitoring of the study, checking the accuracy of study data, analyzing the study data, and other purposes necessary for the proper conduct and reporting of this study. If some of the information is reported in published medical journals or scientific discussions, it will be done in a way that does not directly identify you.

This information may be given to other researchers in this study including collaborators at Catholic University, or private, state or federal government parties or regulatory authorities (U.S. and other countries) responsible for overseeing this research. These may include the Office for Human Research Protections, or other offices within the Department of Health and Human Services, and the Mayo Foundation Office for Human Research Protections or other Mayo groups involved in protecting research subjects.

If this information is given out to anyone outside of Mayo, the information may no longer be protected by federal privacy regulations and may be given out by the person or entity that receives the information. However, Mayo will take steps to help other parties understand the need to keep this information confidential.

This authorization lasts until the end of the study.

You may stop this authorization at any time by writing to the following address:

Mayo Foundation
Office for Human Research Protection
ATTN: Notice of Revocation of Authorization
200 1st Street SW
Rochester, MN 55905

If you stop authorization, Mayo may continue to use your information already collected as part of this study, but will not collect any new information.

A copy of this form will be placed in your medical record.
I have had an opportunity to have my questions answered. I have been given a copy of this form. I agree to take part in this research study.

(Date / Time)  
(Printed Name of Participant)  
(Clinic Number)

(Signature of Participant)

(Date / Time)  
(Printed Name of Individual Obtaining Consent)

(Signature of Individual Obtaining Consent)
Appendix B

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

Patient: ___________________________  Clinician: ___________________________  Date: ___________________________  Time: ___________________________

Section A (Patient):
I have thoughts of ending my life: 0 1 2 3 4
(0=Never; 1=Rarely; 2=Sometimes; 3=Frequently; 4=Always)

Rate and fill out each item according to how you feel right now.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Then rank in order of importance 1 to 5 (1=most important to 5=least important).</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind; not stress, not physical pain):</td>
</tr>
<tr>
<td></td>
<td>Low pain: 1 2 3 4 5 :High pain</td>
</tr>
<tr>
<td></td>
<td>What I find most painful is:</td>
</tr>
<tr>
<td>2)</td>
<td>RATE STRESS (your general feeling of being pressured or overwhelmed):</td>
</tr>
<tr>
<td></td>
<td>Low stress: 1 2 3 4 5 :High stress</td>
</tr>
<tr>
<td></td>
<td>What I find most stressful is:</td>
</tr>
<tr>
<td>3)</td>
<td>RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance):</td>
</tr>
<tr>
<td></td>
<td>Low agitation: 1 2 3 4 5 :High agitation</td>
</tr>
<tr>
<td></td>
<td>I most need to take action when:</td>
</tr>
<tr>
<td>4)</td>
<td>RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):</td>
</tr>
<tr>
<td></td>
<td>Low hopelessness: 1 2 3 4 5 :High hopelessness</td>
</tr>
<tr>
<td></td>
<td>I am most hopeless about:</td>
</tr>
<tr>
<td>5)</td>
<td>RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):</td>
</tr>
<tr>
<td></td>
<td>Low self-hate: 1 2 3 4 5 :High self-hate</td>
</tr>
<tr>
<td></td>
<td>What I hate most about myself is:</td>
</tr>
</tbody>
</table>

N/A

6) RATE OVERALL RISK OF SUICIDE:
Extremely low risk: 1 2 3 4 5 :Extremely high risk
(will not kill self) (will kill self)

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

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

<table>
<thead>
<tr>
<th>Rank</th>
<th>REASONS FOR LIVING</th>
<th>Rank</th>
<th>REASONS FOR DYING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

The one thing that would help me no longer feel suicidal would be: ___________________________
Appendix C

Beck Hopelessness Scale
BECK HOPELESSNESS SCALE

This questionnaire consists of a list of twenty statements (sentences). Please read the statements carefully one by one. If the statement describes your attitude for the past week, including today, write down TRUE next to it. If the statement is false for you, write FALSE next to it. You may simply write T for TRUE and F for FALSE. Please be sure to read each sentence.

___ A. I look forward to the future with hope and enthusiasm.

___ B. I might as well give up because there is nothing I can do about making things better for myself.

___ C. When things are going badly, I am helped by knowing that they can’t stay that way forever.

___ D. I can’t imagine what my life would be like in ten years.

___ E. I have enough time to accomplish the things I most want to do.

___ F. In the future I expect to succeed in what concerns me most.

___ G. My future seems dark to me.

___ H. I happen to be particularly lucky and I expect to get more of the good things in life than the average person.

___ I. I just don’t get the breaks, and there’s no reason to believe I will in the future.

___ J. My past experiences have prepared me well for my future.

___ K. All I see ahead of me is unpleasantness rather than pleasantness.

___ L. I don’t expect to get what I really want.

___ M. When I look ahead to the future I expect I will be happier than I am now.

___ N. Things just won’t work out the way I want them to.

___ O. I have great faith in the future.

___ P. I never get what I want so it’s foolish to want anything.

___ Q. It is very unlikely that I will get any real satisfaction in the future.

___ R. The future seems vague and uncertain to me.

___ S. I can look forward to more good times than bad times.

___ T. There’s no use in really trying to get something I want because I probably won’t get it.
Appendix D

Reasons For Living Inventory
INSTRUCTIONS: Many people have thought of suicide at least once. Others have never considered it. Whether you have considered it or not, we are interested in the reasons you would have for not committing suicide if the thought were to occur to you or if someone were to suggest it to you.

On the following pages are reasons people sometimes give for not committing suicide. We would like to know how important each of these possible reasons would be to you at this time in your life as a reason to not kill yourself. Please rate this in the space at the left on each question.

Each reason can be rated from 1 (Not At All Important) to 6 (Extremely Important). If a reason does not apply to you or if you do not believe the statement is true, then it is not likely important and you should put a 1. Please use the whole range of choices so as not to rate only at the middle (2, 3, 4, 5) or only at the extremes (1, 6).

In each space put a number to indicate the importance to you of each reason for not killing yourself.

1. Not At All Important (as a reason for not killing myself, or, does not apply to me, I don't believe this at all).
2. Quite Unimportant
3. Somewhat Unimportant
4. Somewhat Important
5. Quite Important
6. Extremely Important (as a reason for not killing myself, I believe this very much and it is very important).

Even if you never have or firmly believe you never would seriously consider killing yourself, it is still important that you rate each reason. In this case, rate on the basis of why killing yourself is not or would never be an alternative for you.

In each space put a number to indicate the importance to you of each for not killing yourself.

1. Not At All Important
2. Quite Unimportant
3. Somewhat Unimportant
4. Somewhat Important
5. Quite Important
6. Extremely Important

____ 1. I have a responsibility and commitment to my family.
____ 2. I believe I can learn to adjust or cope with my problems.
____ 3. I believe I have control over my life and destiny
____ 4. I have a desire to live.
____ 5. I believe only God has the right to end a life.
____ 6. I am afraid of death
<table>
<thead>
<tr>
<th></th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not At All Important</td>
</tr>
<tr>
<td>2</td>
<td>Quite Unimportant</td>
</tr>
<tr>
<td>3</td>
<td>Somewhat Unimportant</td>
</tr>
<tr>
<td>4</td>
<td>Somewhat Important</td>
</tr>
<tr>
<td>5</td>
<td>Quite Important</td>
</tr>
<tr>
<td>6</td>
<td>Extremely Important</td>
</tr>
<tr>
<td>7</td>
<td>My family might believe I did not love them</td>
</tr>
<tr>
<td>8</td>
<td>I do not believe that things get miserable or hopeless enough that I would rather be dead</td>
</tr>
<tr>
<td>9</td>
<td>My family depends upon me and needs me</td>
</tr>
<tr>
<td>10</td>
<td>I do not want to die</td>
</tr>
<tr>
<td>11</td>
<td>I want to watch my children as they grow</td>
</tr>
<tr>
<td>12</td>
<td>Life is all we have and is better than nothing</td>
</tr>
<tr>
<td>13</td>
<td>I have future plans I am looking forward to carrying out</td>
</tr>
<tr>
<td>14</td>
<td>No matter how badly I feel, I know that it will not last</td>
</tr>
<tr>
<td>15</td>
<td>I am afraid of the unknown</td>
</tr>
<tr>
<td>16</td>
<td>I love and enjoy my family too much and could not leave them</td>
</tr>
<tr>
<td>17</td>
<td>I want to experience all that life has to offer and there are many experiences I haven't had yet which I want to have</td>
</tr>
<tr>
<td>18</td>
<td>I am afraid that my method of killing myself would fail</td>
</tr>
<tr>
<td>19</td>
<td>I care enough about myself to live</td>
</tr>
<tr>
<td>20</td>
<td>Life is too beautiful and precious to end it</td>
</tr>
<tr>
<td>21</td>
<td>It would not be fair to leave the children for others to take care of</td>
</tr>
<tr>
<td>22</td>
<td>I believe I can find other solutions to my problems</td>
</tr>
<tr>
<td>23</td>
<td>I am afraid of going to hell</td>
</tr>
<tr>
<td>24</td>
<td>I have a love of life</td>
</tr>
<tr>
<td>25</td>
<td>I am too stable to kill myself</td>
</tr>
<tr>
<td>26</td>
<td>I am a coward and do not have the guts to do it</td>
</tr>
<tr>
<td>27</td>
<td>My religious beliefs forbid it</td>
</tr>
<tr>
<td>28</td>
<td>The effect on my children could be harmful</td>
</tr>
<tr>
<td>29</td>
<td>I am curious about what will happen in the future</td>
</tr>
<tr>
<td>30</td>
<td>It would hurt my family too much and I would not want them to suffer</td>
</tr>
<tr>
<td>31</td>
<td>I am concerned about what others would think of me</td>
</tr>
<tr>
<td>32</td>
<td>I believe everything has a way of working out for the best</td>
</tr>
<tr>
<td>33</td>
<td>I could not decide where, when, and how to do it</td>
</tr>
<tr>
<td>34</td>
<td>I consider it morally wrong</td>
</tr>
<tr>
<td>35</td>
<td>I still have many things left to do</td>
</tr>
<tr>
<td>36</td>
<td>I have the courage to face life</td>
</tr>
<tr>
<td>37</td>
<td>I am happy and content with my life</td>
</tr>
<tr>
<td>38</td>
<td>I am afraid of the actual &quot;act&quot; of killing myself (the pain, blood, violence</td>
</tr>
<tr>
<td>39</td>
<td>I believe killing myself would not really accomplish or solve anything</td>
</tr>
<tr>
<td>40</td>
<td>I have hope that things will improve and the future will be happier</td>
</tr>
<tr>
<td>41</td>
<td>Other people would think I am weak and selfish.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1.</td>
<td>Not At All Important</td>
</tr>
<tr>
<td>2.</td>
<td>Quite Unimportant</td>
</tr>
<tr>
<td>3.</td>
<td>Somewhat <strong>Unimportant</strong></td>
</tr>
</tbody>
</table>

___ 42. I have an inner drive to survive
___ 43. I would not want people to think I did not have control over my life
___ 44. I believe I can find a purpose in life, a reason to live
___ 45. I see no reason to hurry death along
___ 46. I am so inept that my method would not work
___ 47. I would not want my family to feel guilty afterwards
___ 48. I would not want my family to think I was selfish or a coward
Appendix E

Suicide Assessment – Surveyor Form
Suicide Assessment – Surveyor

Suicidal Ideation within past 48 hours?  ☐ Yes  ☐ No (Control – go to Question # ___)

Currently Suicidal (at time of assessment) ☐

Currently Suicidal With Plan or Intent ☐

Currently Suicidal and Attempted Suicide (within 48 hours) ☐

Not currently suicidal but suicidal within past 48 hours ☐

Not currently suicidal and attempted suicide (within 48 hours) ☐

Not currently suicidal but parasuicidal behavior (within 48 hours) ☐

*Alert patient’s treatment team and Dr. Lineberry/Cathy Shea if any items in this box are present for safety reasons. Document who was notified, notification date and time on last package sheet.

Y  N  Current Intent

Suicide plan (if present):

When: _____________________________________________________________

Where: ___________________________________________________________

How: ____________________________________________________________

Describe: _________________________________________________________

Access to means  Y  N

Y  N  Suicide Preparation

Describe: _________________________________________________________

Y  N  Suicide Rehearsal

Describe: _________________________________________________________
### History of Suicidality

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

- **Ideation**
  - Describe: ____________________________
  - Frequency: _____ per day, _____ per week, _____ per month
  - Duration: _____ seconds, _____ minutes, _____ hours

- **Single Attempt**
  - Describe: ____________________________

- **Multiple Attempts**
  - Describe: ____________________________

---

Not suicidal within past 48 hours

- Ever had thoughts of suicide? [ ]
- Never had thoughts of suicide? [ ]
- Ever felt better off dead? [ ]
- Never felt better off dead? [ ]
- Ever attempted suicide? [ ]

*If yes to ever attempted suicide question or ever had thoughts of suicide, go to history of suicidality boxes above.*
For the following questions, ask if the patient would describe himself or herself as having problems with each of the categories and describe if present.

Y  N  Impulsivity
Describe: ______________________________________

Y  N  Substance abuse
Describe: ______________________________________

Y  N  Significant loss
Describe: ______________________________________

Y  N  Interpersonal isolation
Describe: ______________________________________

Y  N  Relationship problems
Describe: ______________________________________

Y  N  Health problems
Describe: ______________________________________

Y  N  Legal problems
Describe: ______________________________________
Appendix F

Qualitative Coding Manual
The SSF Qualitative Coding Manual for Self vs. Relationally Oriented Statements and Suicide Facilitative vs. Preventative Statements

I. Overview

The Suicide Status Form (SSF) (Jobes et al., 1997) is a suicide risk assessment instrument that attempts to measure a client’s suicidality from both a quantitative and qualitative standpoint. This coding manual will be used to analyze qualitative data derived from the four main open-ended response prompts. These four response prompts consist of the five Incomplete Sentences (“What I find most painful is _____”; “What I find most stressful is _____”; “I most need to take action when _____”; “I am most hopeless about _____”; and “What I hate most about myself is _____”), Reasons for Living (a prompt that allows the suicidal respondent to provide his/her top five reasons for wanting to live), Reasons for Dying (a prompt that allows the suicidal respondent to provide his/her top five reasons for wanting to die), and the “One Thing” response (where the suicidal respondent answers the question “The one thing that will help me no longer feel suicidal is _____”). This manual employs two conceptual coding dimensions for each statement yielded within each of these four assessment constructs (Self-Oriented vs. Relationally-Oriented statements, and Suicide Facilitative vs. Suicide Preventative statements). These two dimensions will be used in an attempt to reliably understand a respondent’s overall level of focus for each of these two areas both independent of each other, as well as in conjunction with each other.

II. Coding Guidelines for Self-Oriented vs. Relationally-Oriented Statements

Each individual qualitative response obtained across the four open-ended assessment prompts should be coded as either Self-Oriented or Relationally-Oriented. In coding, each response should be coded – by default – as Self-Oriented unless it meets one of the following conditions:

A. If a response includes an explicit mention of another individual, it should be coded as Relationally-Oriented.
   Examples:
   “Working with my father.”
   “When my husband doesn’t call.”

B. If a response includes an explicit mention of another group of individuals, it should be coded as Relationally-Oriented.
   Examples:
   “Expectations of me from family members.”
   “I won’t have to be scared anymore when my boys yell at each other.”

C. If a response includes an explicit mention of a particular animal, it should be coded as Relationally-Oriented.
Examples:
“I have to take care of my dog.”
“I want to live for Rose, my horse.”

D. If a response includes an explicit mention of an external entity (regardless of whether or not the respondent has any direct relationship with this entity), the response should be coded as Relationally-Oriented.
Examples:
“I want to live for my future children.”
“I want to live my life until God takes me.”

E. If a response does not include any explicit mention of another relational entity but does include an explicit mention of feelings of loneliness or isolation, it should be coded as Relationally-Oriented. The reason for this is that the concepts of loneliness and isolations – by definition – include external relational entities.
Examples:
“I feel so lonely.”
“I’ve never been accepted.”

F. If a response does not include any explicit mention of another relational entity but does include an explicit mention of a relational state, it should be coded as Relationally-Oriented. As with Guideline E above, the reason for this is that specific relational states – by definition – include external relational entities.
Examples:
“I am a bad mother.”
 “[I want to die because of my] failed marriage.”
 “[I want to die because I’m] not a good mentor.”

G. If a response includes an explicit mention of an external organization or agency made up of individuals it should be coded as Relationally-Oriented only if it specifically mentions those individuals. Otherwise, it should be coded as Self-Oriented.
Examples:
“I want to live to finish school and get a job.” = Self-Oriented
 “[I’m stressed about] my job and trying to balance work and home.” = Self-Oriented
 “[I’m afraid nobody at work would miss me.”] = Relationally-Oriented
 “[I want to die so they] would be able to find someone better at work.” = Relationally-Oriented

III. Coding Guidelines for Suicide-Facilitative vs. Suicide Preventative Statements

Just as each individual qualitative response obtained from all four open-ended assessment prompts should be coded as either Self- or Relationally-Oriented, so to should every response be coded as either Suicide-Facilitative or Suicide Preventative. Unlike
Self- vs. Relational-Oriented, though, coding guidelines for Facilitative vs. Preventative are specific to each of the four main response prompts.

A. Incomplete Sentences
By default, all responses to the Incomplete Sentences should be coded as Facilitative with the exception of responses that deny the premise of the prompt. Such responses should be coded as Preventative.

**Examples of Exceptions:**
“I don’t hate myself.” = Preventative
“No, I am not hopeless.” = Preventative

B. Reasons For Living
By default, all responses to RFL should be coded as Preventative unless the response makes an explicit denial of any reasons for living, or if the response expresses clear ambivalence that offers no decisively preventative value against suicide. In such cases, the responses should be coded as Facilitative.

**Examples of Exceptions:**
“I can’t think of any reasons why I’d want to live.” = Facilitative.
“I really don’t know.” = Facilitative.

C. Reasons For Dying
By default, all responses to RFD should be coded as Facilitative unless the response makes an explicit denial of any reasons for dying, or if the response expresses clear ambivalence that offers no decisively facilitative value for suicide. In such cases, the responses should be coded as Preventative.

**Examples of Exceptions:**
“Right now I want to get better and live so I guess there are no reasons for to want to die right now.” = Preventative.
“I guess I can’t really think of anything in particular.” = Preventative.

D. One Thing
Responses given for the One Thing should, by default, be coded as Preventative, unless the response meets one or more of the following criteria:

1. If the respondent’s One Thing is inherently unrealistic, it should be coded as Facilitative.

**Examples:**
“Hitting the big lotto and having my health back.” = Facilitative.
“If this would all go away and be normal again.” = Facilitative.
2. If the respondent’s One Thing is clearly unattainable, it should be coded as Facilitative.
   Examples:
   “To be able to start my life over and make different decisions.” = Facilitative.
   “If everything in my life would be perfect.” = Facilitative.

3. If the respondent’s One Thing is noticeably flippant or not in keeping with the clinical spirit of the task, it should be coded as Facilitative.
   Examples:
   “To get this class over with.” = Facilitative.
   “To die.” = Facilitative.
References


Harris, K., & McLean, J. (2007, August). The internal suicide debate: Reasons for living vs. reasons for dying. Poster session presented at the annual meeting of the International Association for Suicide Prevention, Killarney, Ireland.


Jobes, D.A. (2004, October). *The psychology of suicide: Research on what suicidal patients have to say.* Keynote address of the 3rd Annual Military Suicide Prevention Conference, Crystal City, VA.


115


