

Scientizing and Routinizing the Assessment of Suicidality in Outpatient Practice

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Suicidal patients are difficult and challenging clinical problems. Conceptual tools aid the clinician in organizing and evaluating the clinical situation. The authors provide a framework for suicide risk assessment that emphasizes 2 domains—history of past attempt and the nature of current suicidal symptoms—that have emerged in suicide research as crucial variables. These domains, when combined with other categories of risk factors, produce a categorization of risk for the individual patient, leading, in turn, to relatively routinized clinical decision making and activity.

Increasing numbers of patients manifesting acute or chronic suicidal behavior present for outpatient care, as managed care limits access to inpatient care and shortens the length of hospitalizations. For the general outpatient practitioner, then, the need for a consistent and empirically grounded assessment framework for suicidality has become crucial.

In this article we summarize a general assessment framework, and supplement and elaborate it with reference to recent empirical work on the nature and assessment of suicidal symptoms. It is not our purpose to thoroughly restate the details of assessment frame-

works that are currently available or forthcoming (for adults, Rudd, Joiner, & Rajab, in press; for adolescents, Stoelb & Chiraboga, 1998). Rather, we intend to abstract their basic elements to provide practitioners with a concise heuristic for assessment of suicidal symptoms.

A General Assessment Framework

Seven domains of factors relevant to suicide risk can be delineated. These domains are: previous suicidal behavior; the nature of current suicidal symptoms; precipitant stressors; general symptomatic presentation, including the presence of hopelessness; impulsivity and self-control; other predispositions; and protective factors (see Range & Knott, 1997, for a review of 20 assessment instruments that are relevant to assessing these domains).

Previous Suicidal Behavior

The most important domain for risk assessment is previous history of suicide attempt in combination with current suicidal symptoms. There is converging evidence that clinically important differences exist among three groups—suicide ideators, single attempters, and multiple attempters (e.g., Clark & Fawcett, 1992; Rudd, Joiner, & Rajab, 1996). In particular, there appear to be distinct differences in overall baseline risk for multiple attempters, even under the best conditions. In contrast to single attempters or ideators, it appears that the risk rating for multiple attempters is perpetually elevated as a result of the type, chronicity, and severity of psychopathology. Accordingly, risk assessment differs for multiple attempters as compared with ideators and single attempters. For multiple attempters, a significant finding regarding any of the other six domains (to be described next) translates into a designation of at least moderate suicide risk. For ideators and single attempters, by contrast, significant findings regarding the other six domains do not necessarily translate into high risk. This distinction

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will become clearer as we describe the other six domains and as we discuss risk categorization and severity.

It is noted, incidentally, that multiple attempters were once single attempters (indeed, they once had no history of suicidality), and it is thus possible for the clinician to encounter an ideator or a single attempter who is "on the way" to becoming a multiple attempter. We suggest that the clinician not become preoccupied by this issue. Given the type, intensity, and chronicity of symptomatology, as well as other factors (e.g., impulsivity; chaotic environments) that characterize those who may become multiple attempters, our framework (which emphasizes these factors) is likely to produce an appropriate risk designation, even in the event that an eventual multiple attempter is seen before his or her second attempt. This perspective allows the clinician to rely on the relatively objective criterion of past history of suicide attempt and relieves the clinician of the impossible burden of predicting the future trajectory of suicidal behavior.

The Nature of Current Suicidal Symptoms

A large portion of the general population acknowledges suicidal ideation at some point during their lives, and a still higher portion of those presenting in mental health settings note at least some suicidal ideation (Paykel, Myers, Lindenthal, & Tanner, 1974). Accordingly, the mere presence of some suicidal symptomatology is not very discriminating. It would be useful to know which suicidal symptoms are particularly worrisome.

Our own work on this topic converges with that of several other investigators, particularly Beck, Steer, and colleagues (e.g., Steer, Rissmiller, Ranieri, & Beck, 1993; see also Mieczkowski, Sweeney, Haas, & Junker, 1993, Stoelb & Chiriboga, 1998). In a factor-analytic study of the Modified Scale for Suicidal Ideation (Joiner, Rudd, & Rajab, 1997), we argued that two main factors summarize the factor space of suicidal symptomatology. The factors were labeled "resolved plans and preparation" and "suicidal desire and ideation" (Joiner et al., 1997). It is important to note that the resolved plans and preparation factor was more related than the suicidal desire and ideation factor to pernicious suicide indicators such as having recently attempted suicide. We, therefore, concluded that, although suicidal symptomatology of any sort is clinically noteworthy, those symptoms that compose the resolved plans and preparation factor deserve the most emphasis in risk assessment.

The resolved plans and preparation factor was made up of the following symptoms: a sense of courage to make an attempt, a sense of competence to make an attempt, availability of means to and opportunity for attempt, specificity of plan for attempt, preparations for attempt, duration of suicidal ideation, and intensity of suicidal ideation. Our view is that the resolved plans and preparation factor of suicidal symptoms is pernicious; accordingly, anyone who displays its symptoms should be designated as at least a moderate risk for suicide (later in this article, we discuss risk categories and designations).

The suicidal desire and ideation factor comprises the following symptoms: reasons for living, wish to die, frequency of ideation, wish not to live, passive attempt, desire for attempt, expectancy of attempt, lack of deterrents to attempt, and talk of death and/or suicide. Our view is that the suicidal desire and ideation factor of suicidal symptoms is clinically noteworthy, but not as pernicious

as the resolved plans and preparation factor; accordingly, anyone who displays the symptoms of the suicidal desire and ideation factor, in the absence of the symptoms of the resolved plans and preparation factor, should not be designated as a risk for suicide unless they are a multiple attempter or unless other assessment domains (to be discussed later) indicate otherwise. Multiple attempters who display symptoms of the suicidal desire and ideation factor, even in the absence (and certainly in the presence) of the symptoms of the resolved plans and preparation factor, are deemed at least a moderate suicide risk.

We believe this perspective has considerable clinical value. For example, a patient who expresses a wish to die, who talks of suicide, and who reports frequent suicidal ideation is typically quite worrisome to the clinician. In the absence of symptoms from the resolved plans and preparation factor, however (and in the absence of multiple attempt status or complicating factors from other domains), these symptoms do not warrant a high-risk designation. As another example, a patient who expresses little desire for death and relatively infrequent suicidal ideation, but who senses high competence and courage to attempt to suicide, who has means and opportunity, and who reports details of a suicide plan, is at high risk, regardless of other factors.

We would like to comment on two other aspects of this formulation. First, it is interesting to note that features of suicidal ideation load onto both the resolved plans and preparation factor and the suicidal desire and ideation factor. Specifically, intensity and duration of ideation load onto the resolved plans and preparation factor, whereas frequency of ideation loads onto the suicidal desire and ideation factor. Accordingly, we suggest that intensity and duration of suicidal ideation are more pernicious indicators than frequency of ideation. Importantly, our comments here refer not to general negative thoughts or to general morbid ruminations, but refer specifically to ideation about attempting or committing suicide.

Second, items on suicide-related writing (including suicide notes) loaded negatively onto the resolved plans and preparation factor, indicating that the more a patient is writing about suicide, the less he or she is likely to display the other resolved plans and preparation symptoms, such as competence, courage, specificity of plan, and so on (Spirito, Sterling, Donaldson, & Arrigan, 1996, also found that writing was not an especially pernicious suicide indicator; Beck, 1976, made a similar point). This result is interesting in light of the work of Pennebaker and colleagues (e.g., Francis & Pennebaker, 1992), who have argued that writing about personal traumatic experience has long-term beneficial effects on an array of health and functioning indicators, including emotional well-being, immune functioning, reduction of work absences, and successful job searches following job loss. In a similar vein, we suggest that writing has protective functions in that it reduces impulsive and maladaptive problem solving and allows for more effective emotion regulation (both of which skills are key aspects of psychotherapy for suicidal patients; e.g., Rudd et al., 1996).

In summary, with regard to the assessment of current suicidal symptoms, some symptoms are more worrisome than others. This knowledge is not only useful to clinical decision making (e.g., risk categorization), but may also prove reassuring to the clinician (who would be overwhelmed by a perceived need to respond to every mention of any suicidal symptom as if it represented severe suicide risk). Although we believe this formulation to be useful, it

is not to be viewed or utilized in isolation; rather, it leads to thorough and efficient suicide assessment only in context of evaluation of other factors (especially previous attempt status), the remainder of which is discussed in the next section. Having said that, however, at this stage of evaluation, one already knows two extremely important pieces of information: whether or not someone has a history of multiple attempts and whether or not someone displays pernicious symptoms (i.e., from the resolved plans and preparation factor) of current suicidality. The remaining five domains of assessment provide a context in which to interpret these two important sources of clinical data.

Precipitant Stressors

Paykel, Prusoff, and Myers (1975) noted that suicide attempters reported four times as many stressful life events in the 6 months before the attempt, as compared with matched general population controls. In a retrospective study, Cohen-Sandler, Berman, and King (1982) studied life events in three groups of hospitalized psychiatric children and young adolescents (aged from 5 to 14 years old), diagnosed as suicidal, depressed (nonsuicidal), and psychiatric controls (neither suicidal nor depressed), respectively. They found that suicidal participants had experienced higher levels of stress during the year prior to admission, as well as over the life span, than either depressed or psychiatric controls. De Wilde, Kienhorst, Diekstra, and Wolters (1992) reported a similar result among adolescents, noting that "they had experienced more turmoil in their families, starting in childhood and not stabilizing during adolescence" (p. 45). Recent psychological autopsy studies have reported that distinct life events seem to be significantly associated with an increased risk of completed suicide, including specific stressors such as interpersonal losses (e.g., recent separation of parents among adolescents, disruption of a relationship), interpersonal discord, legal troubles, and physical or emotional abuse (Brent, Perper, Mortiz, & Allman, 1993; Marttunen, Aro, & Lonnqvist, 1993).

In the assessment process, then, the occurrence of relatively recent life stressors, perhaps particularly those involving interpersonal loss and disruption, should be evaluated. For any patient, the existence of notable stress combined with suicidal symptoms from the resolved plans and preparation factor is sufficient to warrant the designation of at least moderate suicide risk. For a multiple attempter, even in the absence of suicidal symptoms from the resolved plans and preparation factor, the occurrence of stress calls for a designation of at least moderate risk. For a nonmultiple attempter, the occurrence of recent stress, combined with suicidal symptoms from the suicidal desire and ideation factor (but not from the resolved plans and preparation factor), probably warrants a designation of low-to-moderate risk, depending on assessment of remaining domains—if other domains are unremarkable, low risk is probably the best designation; the more notable findings in other domains, the more the risk increases (we return to decision making regarding risk severity in a later section). Of course, the nonmultiple attempter who has not experienced recent stress and who displays no suicidal symptoms is, in general, a low risk.

It is interesting that recent data from our research program indicate that negative life stress predicts the duration but not the severity of a suicidal crisis among multiple attempters. That is, even in the absence of precipitant life stress, a person with a

multiple attempt history may develop a relatively acute suicidal crisis, but one that should resolve relatively rapidly. When stress is present, the crises of multiple attempters tend to be of longer duration. Given that many of the pernicious symptoms from the resolved plans and preparation factor involve enduring processes (e.g., duration of ideation, planning), a stress-dependent suicidal crisis in a multiple attempter is reason for particularly serious concern and a designation of serious risk.

General Symptomatic Presentation, Including the Presence of Hopelessness

The presence of Axis I and II symptomatology should be screened, particularly major depressive disorder, anxiety disorders, alcohol and substance disorders, and any personality disorder (Stoelb & Chiraboga, 1998). Diagnostic comorbidity (e.g., the co-occurrence of a mood and anxiety disorder) should be especially noted. Cornelius, Salloum, Mezzich, & Cornelius (1995), for example, reported that alcohol use significantly heightened suicidality among patients with major depression (see also Windle & Windle, 1997). We (Joiner et al., 1997) reported that patients with a comorbid anxiety and mood disorder were especially likely to display elevated levels of symptoms from the resolved plans and preparation factor emphasized earlier. Hopelessness, too, is a strong predictor of suicidal symptoms, even more so than depressive symptoms and mood disorder diagnosis (Beck, Steer, Beck, & Newman, 1993; Chance, Kaslow, & Baldwin, 1994; but see Cole, 1989, who found that hopelessness was not a strong predictor of suicidal symptoms among adolescents).

As with precipitant stressors, the implications of general symptomatology for risk assessment differs depending on attempt history and the nature of current suicidal symptoms. For a multiple attempter, even in the absence of suicidal symptoms from the resolved plans and preparation factor, the presence of general symptomatology indicates a designation of at least moderate risk. For any patient, the existence of notable general symptomatology combined with suicidal symptoms from the resolved plans and preparation factor is sufficient to warrant a designation of at least moderate suicide risk. For a nonmultiple attempter, the presence of general symptomatology, combined with suicidal symptoms from the suicidal desire and ideation factor (but not from the resolved plans and preparation factor), probably warrants a designation of low-to-moderate risk, depending on assessment of remaining domains. If other domains are unremarkable, low risk is probably the best designation; the more notable findings in other domains, the more the risk increases (again, decision making regarding risk severity is summarized in a later section).

Other Predispositions to Suicidal Behavior

Numerous person-centered and background factors have demonstrated associations with suicidality. The most important, history of prior suicide attempt, was discussed earlier, as were certain person-centered factors, such as past and current psychiatric history (e.g., personality disorders, mood disorders).

Two other environmental factors the clinician should consider are chaotic family history and history of physical or sexual abuse. More specifically, de Wilde et al. (1992) reported that suicide attempters were more likely to have suffered events including

separation or divorce of parents, sexual abuse, physical abuse, change in caretaker, mental health event of family member, change in living situation, and change in residence. Some studies have specifically examined relationships between particular traumatic life events (e.g., sexual and physical abuse) and suicide attempt, and many have found that in comparison with other clinical or normal control participants, suicide attempters were more likely to have been abused (Wagner, 1997; Yang & Clum, 1996). Also, Martin (1996) investigated associations between adolescents' reported sexual abuse and suicide attempts, and found that: 51% of sexually abused women had attempted suicide; lifetime suicide attempts were five times more frequent in sexually abused than in nonabused respondents. These findings agree with the conclusions of some recent reviews (Kendall-Tackett, Williams, & Finkelhor, 1993; Wagner, 1997; Yang & Clum, 1996) and suggest that sexual abuse is a relatively prevalent negative life event that may lead to a number of serious psychological problems, including suicide attempt.

By now, the logic of our framework should be clear: For a multiple attempter, even in the absence of suicidal symptoms from the resolved plans and preparation factor, the presence of predispositions such as abuse history indicates a designation of at least moderate risk. For any patient, these predispositions, combined with suicidal symptoms from the resolved plans and preparation factor, are sufficient to warrant a designation of at least moderate risk. For a nonmultiple attempter, the presence of these predispositions, combined with suicidal symptoms from the suicidal desire and ideation factor (but not from the resolved plans and preparation factor), probably warrants a designation of low-to-moderate risk, depending on assessment of remaining domains.

Impulsivity

An impulsive behavioral style deserves evaluation in the risk assessment process. Pfeffer, Hurt, Peskin, and Siefker (1995) reported a significant relation between suicide attempts and impulse control among youth, as have others (e.g., Apter, Plutchik, & van Praag, 1993). There is an interesting possibility that dysregulation (i.e., low output or low stability) of the 5-hydroxytryptamine serotonergic system in the central nervous system increases impulsivity and is related to a host of impulsive behaviors, including but not limited to suicidal behaviors (e.g., arson, violence; e.g., Bourgeois, 1991).

Our framework indicates that impulsive multiple attempters receive a designation of at least moderate risk, regardless of other variables. For any patient, an impulsive behavioral style, in combination with suicidal symptoms from the resolved plans and preparation factor, brings a designation of at least moderate risk. For the nonmultiple attempter, impulsivity, either taken alone or combined with suicidal symptoms from the suicidal desire and ideation factor (but not from the resolved plans and preparation factor), probably warrants a designation of low-to-moderate risk, depending on assessment of remaining domains.

One upshot of our assessment approach is that an impulsive multiple attempter's designation as a suicide risk is likely to be relatively long-standing, because multiple attempt status endures, and impulsivity is a relatively stable trait. In our view, this is an appropriate designation and is likely to change only in the context of relatively long-term psychotherapy aimed at (among other

things) modifying the impulsive behavioral style. Although the risk status of an impulsive multiple attempter is unlikely to dramatically decrease, it can dramatically increase in the event that other factors (e.g., precipitant stressors) exacerbate risk.

Protective Factors

We noted in an earlier section, that, consistent with the work of Pennebaker and colleagues (e.g., Francis & Pennebaker, 1992), suicide-related writing can be viewed as a protective factor. However, two additional points should be considered. First, our view is not that suicide-related writing is desirable among general clinical populations. Of course, it is best if patients do not consider suicide at all, whether in writing or whatever form. Rather, our point is that given suicidal symptoms, writing appears to be a protective factor regarding pernicious outcome. Second, it is certainly possible for a patient to write about his or her courage and competence to make an attempt, the intensity of suicidal ideation, the specific details of a plan, and so on. That is, suicide-related writing is unlikely to serve a protective function if it merely is the mode of communication for the pernicious symptoms of the resolved plans and preparation factor.

Social support is another potential protective factor. In a 5-year follow-up of patients who had attempted suicide, Fridell, Johnsson, and Traskman-Bendz (1996) found that low quality of social network significantly predicted reattempt. In Finland, Heikkinen, Isometsa, Marttunen, and Aro (1995) compared suicide completers with the general population and reported that people who committed suicide were more commonly never married, divorced, or widowed, and were more frequently living alone, as compared with the general population.

Person-centered variables, such as self-control and problem-solving ability, may also serve as protective factors (indeed, certain types of suicide-related writing can be viewed as constructive self-control processes). In our research program (e.g., Rudd et al., 1996), we have emphasized the therapeutic and protective value of a routinized and considered approach to solving interpersonal and other problems; indeed, accessing this and other protective resources is one reason that the outpatient treatment of suicidal treatment is possible, even among multiple attempters. One example of good self-control and problem solving is the propensity to seek and maintain treatment when needed. Indeed, we have shown that some of those most at risk for suicidality (e.g., those with personality disorders) show a tendency toward help negation (e.g., voluntary withdrawal from recommended treatment after resolution of the immediate crisis; Rudd, Joiner, & Rajab, 1995). In this context, it is ironic to note that some clinics' screening policies rule out those at high risk for suicidality, which may encourage help negation tendencies (e.g., patient not following through on referrals).

Unlike previous domains, the logic of our framework differs somewhat regarding protective factors. In our view, protective factors do not gainsay a confident risk assessment based on the factors described earlier in this article. For example, any patient who clearly is experiencing symptoms from the resolved plans and preparation factor and clearly possesses at least one more risk factor should be designated as at least a moderate risk, even if protective factors are present. However, protective factors may tip the balance in cases where confident categorization is not made.

For example, a nonmultiple attempter who experiences mild symptoms from the resolved plans and preparation factor, has no other risk factors, but completely lacks protective factors could be viewed as a moderate risk, whereas the same patient with several protective factors could be viewed as a low risk.

A Note on Self-Reports Versus Clinicians' Judgments

Ideally, there would be concordance between patients' self-reports and clinicians' judgments. However, discrepancies occur. In a recent study of this issue (Joiner, Rudd, & Rajab, 1999), we found that such discrepancies mostly occurred because clinicians took a (probably advisable) better-safe-than-sorry approach, and viewed patients as more suicidal than patients viewed themselves. However, patients' self-reports were better than clinicians' views at predicting suicidality several months later, suggesting that patient self-report has considerable probative value, even compared with clinician-ratings. It is important to note that two sources may account for clinicians' overestimates of suicidality. First, clinicians may treat a past history of a single suicide attempt in the same way as a history of multiple attempt, whereas we argue that only the latter group deserves special categorization. Second, clinicians may be particularly sensitive to patients' personality traits, particularly those of a histrionic nature, which may serve to somewhat artificially inflate actual risk estimates.

What to Decide and What to Do?

Rating Risk Severity: A Continuum of Suicidality

The following continuum of suicidality is recommended for severity ratings: (a) *nonexistent*—no identifiable suicidal symptoms, no past history of suicide attempt, and no or few other risk factors; (b) *mild*—a multiple attempter with no other risk factors or, a nonmultiple attempter with suicidal ideation of limited intensity and duration, no or mild symptoms of the resolved plans and preparation factor, and no or few other risk factors; (c) *moderate*—a multiple attempter with any other notable finding, a nonmultiple attempter with moderate-to-severe symptoms of the resolved plans and preparation factor, or a nonmultiple attempter with no or mild symptoms of the resolved plans and preparation factor, but moderate-to-severe symptoms of the suicidal desire and ideation factor and at least two other notable risk factors; (d) *severe*—a multiple attempter with any two or more other notable findings or a nonmultiple attempter with moderate-to-severe symptoms of the resolved plans and preparation factor and at least one other risk factor; and (e) *extreme*—a multiple attempter with severe symptoms of the resolved plans and preparation factor, or a nonmultiple attempter with severe symptoms of the resolved plans and preparation factor and two or more other risk factors. Figure 1 provides an abstracted schematic of our general approach.

What to Do?

For those in the nonexistent and mild risk categories, we suggest that some variant of the following statement be regularly made:

In the event that you begin to develop suicidal feelings, here's what I want you to do: First, use the strategies for self-control that we will discuss, including seeking social support. Then, if suicidal feelings

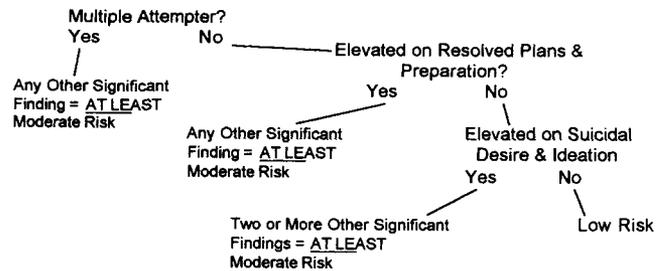


Figure 1. A decision-tree summary of procedure for outpatient assessment of suicidality.

remain, seek me out or whoever is covering for me. If, for whatever reason, you are unable to access help, or, if you feel that things just won't wait, call or go to the ER—here is the phone number.

That some variant of this statement was made should be clearly documented in progress notes. We recommend continued risk assessment activities for patients in the nonexistent and mild risk categories, because suicidality can suddenly increase for an array of unpredictable reasons.

For those in the moderate risk category, we recommend the following: Consideration of increase in the frequency or duration of outpatient visits to address specific, identified stressors, and facilitate symptom resolution; active involvement of the family and supportive others if possible; frequent reevaluation of treatment goals (e.g., symptom remission, reduction in the frequency, intensity, or specificity of suicidal ideation, reduced hopelessness, improved problem-solving, adaptive coping, improved hopefulness, improved self-control, establishing or mobilizing an available or accessible support system), 24-hr availability or emergency of crisis services for the patient, frequent reevaluation of suicide risk, noting the specific changes that elevate or reduce risk (e.g., no further suicidal ideation), consideration of medication for symptom relief if not already in use; consideration of use of telephone contacts for monitoring purposes, professional consultation as indicated or needed for risk assessment and treatment planning, and consideration of input from family members with respect to risk indicators (e.g., instituting a suicide watch at home). Regarding availability of emergency or crisis services, we recommend that the details of an emergency plan (e.g., what to do, step-by-step; phone numbers) be put on a card and provided to patients (e.g., on the back of one's business card). This simple step significantly reduced subsequent attempts (for single attempters) and also reduced service demand (counter to many clinicians' worries; Morgan, Jones, & Owen, 1993). Once established, risk designation and the attendant clinical decisions and activities should be regularly documented in progress notes.

For those in the severe and extreme risk categories, we recommend immediate evaluation for psychiatric hospitalization (including involuntary hospitalization, depending on the circumstances, especially for those in the extreme risk group). Patients in this group should be accompanied and monitored at all times, with active involvement of family members or police as warranted by the situation. Many of the activities recommended for the moderate category (e.g., professional consultation) also apply here. As before, clear documentation of risk category and attendant decisions

and actions is necessary. It is important for patients in the moderate, severe, and extreme risk categories that the variable and time limited nature of risk must be noted (even for those making multiple attempts), and modifications in risk ratings across sessions must be considered. In other words, subsequent progress note entries will eventually need to indicate resolution of risk, or at least clinical activity aimed at such.

Summary and Conclusion

The clinician is faced with the daunting burden of predicting the future trajectory of suicidal behavior. Our perspective allows the clinician to rely on relatively objective criteria, allaying this burden somewhat. With regard to the assessment of risk, some factors are more worrisome and telling than others. This knowledge is not only useful to clinical decision making (e.g., risk categorization) but may also prove reassuring to the clinician (who would be overwhelmed by a perceived need to respond to every mention of any suicidal symptom as if it represented severe suicide risk).

It should also be noted that our approach, as outlined above and in Figure 1, does not specifically include every possible risk factor (e.g., homosexual orientation in adolescents; Stoelb & Chiraboga, 1998). However, any additional risk factor can be incorporated within our scheme by treating it as a "significant finding" (see Figure 1). With these considerations in mind, we believe that our guidelines will prove instrumental in assessing suicide risk.

Assessment of suicide risk has always been quite an important clinical enterprise; it is even more so in a health care climate that shifts the care of high risk patients from inpatient to outpatient settings. Assessment of two domains—history of past attempt and the nature of current suicidal symptoms—when combined with evaluation of other relevant risk factors, produces a relatively objective categorization scheme.

Our framework can be summarized as follows (see Figure 1): For multiple attempters, any noteworthy finding from the domains of current suicidal symptoms, precipitant stressors, general symptoms or hopelessness, predispositions, and impulsivity translates into at least moderate suicide risk. For nonmultiple attempters, the combination of notable suicidal symptoms from the resolved plans and preparation factor and at least one noteworthy finding from the other domains translates into at least moderate suicide risk. For nonmultiple attempters who display no suicidal symptoms from the resolved plans and preparation factor but who do display symptoms from the suicidal desire and ideation factor, the presence of two or more noteworthy findings from the other domains translates into at least moderate suicide risk. On this basis, once categorization is established, clinical decision making and activities are clarified.

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Call for Nominations

The Publications and Communications Board has opened nominations for the editorships of *Behavioral Neuroscience*, *JEP: Applied*, *JEP: General*, *Psychological Methods*, and *Neuropsychology* for the years 2002-2007. Michela Gallagher, PhD; Raymond S. Nickerson, PhD; Nora S. Newcombe, PhD; Mark I. Appelbaum, PhD; and Laird S. Cermak, PhD, respectively, are the incumbent editors.

Candidates should be members of APA and should be available to start receiving manuscripts in early 2001 to prepare for issues published in 2002. Please note that the P&C Board encourages participation by members of underrepresented groups in the publication process and would particularly welcome such nominees. Self-nominations are also encouraged.

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- Lyle E. Bourne, Jr., PhD, for *Psychological Methods*
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