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Assessment of Suicidal Intention: The Scale for Suicide Ideation

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This article describes the rationale, development, and validation of the Scale for Suicide Ideation (SSI), a 19-item clinical research instrument designed to quantify and assess suicidal intention. The scale was found to have high internal consistency and moderately high correlations with clinical ratings of suicidal risk and self-administered measures of self-harm. Furthermore, it was sensitive to changes in levels of depression and hopelessness over time. Its construct validity was supported by two studies by different investigators testing the relationship between hopelessness, depression, and suicidal ideation and by a study demonstrating a significant relationship between high level of suicidal ideation and "dichotomous" attitudes about life and related concepts on a semantic differential test. Factor analysis yielded three meaningful factors: active suicidal desire, specific plans for suicide, and passive suicidal desire.

Since suicide continues to be one of the 10 leading causes of death in the United States, the measurement of suicidal risk and the identification of persons likely to make fatal or nonfatal suicide attempts remain high priorities. In recent years, these goals have been pursued primarily through the assessment of psychological, psychiatric, and demographic variables. According to extensive reviews of the literature (Brown & Sheran, 1972; Lester, 1970, 1974), standard psychological tests such as the Rorschach, the TAT, and the MMPI cannot differentiate suicidal from nonsuicidal individuals and have not been found to be useful predictors of suicidal risk. These same reviewers suggest that at the present time, the best predictors of the criterion behavior are specially constructed scales that encompass various attributes of suicidal behaviors.

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In the assessment and prediction of suicidal behaviors, two of the greatest methodological problems concern validation of measurement instruments and definition of the criterion groups. The most desirable validation strategy is the prospective study of high-risk individuals. However, the comparatively rare occurrence of completed suicides in the general population makes prospective studies difficult and costly and requires extremely long follow-up intervals. Furthermore, in many prospective studies, data collected after the suicide attempt or completed suicide actually provide "postdictors" rather than predictors of the target behavior.

Definition of criterion groups has been aided by a tripartite, multiaxial classification of suicidal behaviors proposed by the Task Force for the National Institute of Mental Health's Center for Studies of Suicide Prevention. The three categories are completed suicide, suicide attempt, and suicidal ideas. Each category requires ratings on a number of axes including severity of the intent to die and the medical lethality of the contemplated or actual attempt. The nomenclature was in-

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tended to provide a systematic way of coding, defining, and reporting suicidal behaviors, to aid diagnosis and prognosis, and to delineate fruitful directions for research (Beck et al., 1972; Pokorny, 1974).

In recent years, the bulk of the work in suicidology has been targeted on two of the three populations, namely, attempted suicides and completed suicides. The primary focus of research on nonfatal suicide attempts has been the assessment of current suicidal intent (e.g., Beck, Schuyler, & Herman, 1974; Dorpat & Boswell, 1963; Weissman & Worden, 1972) and the prediction of future fatal suicide attempts (see Beck, Resnik, & Lettieri, 1974; Lester, 1972). The thrust of our own research has also been two-fold: To assess aspects of current suicidal behaviors, and to validate the tripartite, multiaxial classification system and our measurement tools.

We have already constructed an intent scale for "suicide attempters," a section of which is also applicable to "suicide completers." The reliability and validity of the suicide intent scale (for suicide attempters) have been reported elsewhere (Beck, Kovacs, & Weissman, 1975; Beck & Lester, 1976; Beck, Morris, & Beck, 1974; Beck, Schuyler, & Herman, 1974; Beck, Weissman, Lester, & Trexler, 1976). We have also assessed and investigated the role of medical lethality in nonfatal suicide attempts (Beck, Beck, & Kovacs, 1975). We have now extended our investigation to the third category of suicidal behaviors, namely, suicide "ideators."

Suicide ideators are individuals who currently have plans and wishes to commit suicide but have not made any recent overt suicide attempt (Beck et al., 1972). Since suicide ideation logically precedes a suicide attempt or completed suicide, it seems appropriate to focus on the intensity, pervasiveness, and characteristics of the ideation and wish in order to assess current suicidal intention and potentially to predict later suicidal risk. Thus, we constructed a scale to quantify relevant facets of suicidal intent applicable to suicide ideators. At present, our scale is primarily a research tool to be employed in the investigation of suicidal ideation and its correlates. However, we are conducting long-term prospective studies that may eventually establish its usefulness as a clinical predictor of suicidal risk.

In the development of our scale, the major emphasis was on relevant psychological variables (e.g., nature of the suicidal wish) as opposed to demographic variables (e.g., age, sex, race). Although demographic variables are useful to demarcate *groups* of individuals at high risk for suicide, they have little practical utility in the assessment of a *specific* individual. Moreover, demographic variables may be of little specificity in clinical research that aims to investigate meaningful psychological correlates of suicidal intention or changes in the target behavior as a function of time or treatment intervention.

A crucial conceptual and semantic problem has to be addressed in considering the utility of any instrument purporting to measure suicidal behaviors: the distinction between "suicidal intent" and "suicidal risk." The concept of suicidal intention encompasses such factors as the intensity, pervasiveness, and duration of the individual's wish to die, the degree to which the wish to die outweighs the wish to live (Kovacs & Beck, 1977), and the degree to which the individual has transformed a "free-floating" wish to die into a concrete formulation or plan to kill him- or herself. Moreover, the end result of the suicidal ideation reflects the degree to which the individual has been able to overcome inner deterrents to suicidal wishes (fears of the unknown, of "botching" the attempt; guilty feeling in relation to survivors; religious and moral objections).

Whereas suicidal intent may be regarded as a psychological phenomenon subject to exploration and measurement, suicidal risk is a predictive statement of the probability of the occurrence of a fatal suicide attempt and can be conceived in terms of a complex (although not fully formulated) equation. Suicidal intention would represent one important variable in this formula. Other essential components of the suicidal risk formula are factors such as the lethality of the method contemplated by the suicidal individual: his or her knowledge of lethal dosages of drugs

or skill and familiarity with other forms of self-destruction, and his or her access to the contemplated lethal method (such as an adequate number of sleeping pills or firearms and ammunition). Another variable to be factored into the equation is the presence of environmental resources that would facilitate the detection of suicidal intent and intervention by another individual and would provide assistance in obtaining immediate and adequate medical help following a suicide attempt. Of course the presence of a viable social support system that may defuse the intensity of a suicidal wish is also an important intangible factor.

Description of the Scale for Suicide Ideation

To avoid confusion with the Suicide Intent Scale (SIS), which we employ with individuals who have attempted suicide (Beck, Schuyler, & Herman, 1974), the present scale was named the Scale for Suicide Ideation (SSI). The SSI was designed to quantify the intensity of current conscious suicidal intent by scaling various dimensions of self-destructive thoughts or wishes. Suicidal ideation also encompasses "suicidal threats" that have been expressed in overt behavior or verbalized to others.

The items on the SSI were partly clinically derived and partly rationally derived. Systematic observations and interviews of suicidal patients yielded a list of salient preoccupations, concerns and wishes, and thinking and behavior patterns. Those areas were then selected which seemed to reflect the spectrum of suicidal preoccupations most frequently observed in the patients' verbalizations and behaviors. Previously reported research studies yielded additional content areas. We initially devised a 30-item scale, which we administered to 35 suicidal patients. We then eliminated those items that were found to overlap other items, that were unwieldy, or that were difficult to score. On the basis of this selection process, we improved the clarity and wording of the remaining items and constructed a 19-item scale. Each item consists of three alternative statements graded in intensity from 0 to 2.

Table 1
Demographic Information for 90 Hospitalized Suicide Ideators

Variable	Male (n = 41)	Female (n = 49)
Race (%)		
Caucasian	53.7	65.3
Negro	39.0	30.6
Other	7.3	4.1
Age (in years)		
M	35.7	32.7
SD	14.1	10.5
Last school grade completed		
M	10.7	10.9
SD	2.8	2.5
Civil status (%)		
Single	39.0	28.6
Married	22.0	36.7
Cohabiting	7.3	2.0
Widowed, separated, divorced	31.7	32.7
Employment status (%)		
Unemployed/retired/ housewife	61.0	75.5
Employed	31.7	20.4
Student	7.3	4.1
Psychiatric diagnosis (%)		
Depressive disorders	51.2	67.3
Schizophrenias	22.0	20.4
Other	26.8	12.3

The total score is computed by adding the individual item scores. Thus, the possible range of scores is 0–38.

The items assess the extent of suicidal thoughts and their characteristics as well as the patient's attitude towards them; the extent of the wish to die, the desire to make an actual suicide attempt, and details of plans, if any; internal deterrents to an active attempt; and subjective feelings of control and/or "courage" regarding a proposed attempt.

The SSI is completed by a clinician based on the patient's answers in a semistructured interview. Depending on the psychiatric status of the patient as well as the degree to which he or she is articulate, the clinician has the option to follow different lines of inquiry. By employing this format, the clinician can elicit specific information needed to complete each item of the scale.

Table 2
Internal Consistency of the Scale for Suicide Ideation

Item and rating	Item-total score correlation
1. Wish to live	.51**
0. Moderate to strong	
1. Weak	
2. None	
2. Wish to die	.61**
0. None	
1. Weak	
2. Moderate to strong	
3. Reasons for living/dying	.59**
0. For living outweigh for dying	
1. About equal	
2. For dying outweigh for living	
4. Desire to make active suicide attempt	.72**
0. None	
1. Weak	
2. Moderate to strong	
5. Passive suicidal desire	.63**
0. Would take precautions to save life	
1. Would leave life/death to chance	
2. Would avoid steps necessary to save or maintain life	
6. Time dimension: Duration of suicide ideation/wish	.58**
0. Brief, fleeting periods	
1. Longer periods	
2. Continuous (chronic) or almost continuous	
7. Time dimension: Frequency of suicide	.63**
0. Rare, occasional	
1. Intermittent	
2. Persistent or continuous	
8. Attitude toward ideation/wish	.67**
0. Rejecting	
1. Ambivalent; indifferent	
2. Accepting	
9. Control over suicidal action/acting-out wish	.49**
0. Has sense of control	
1. Unsure of control	
2. Has no sense of control	
10. Deterrents to active attempt (e.g., family, religion, irreversibility)	.66**
0. Would not attempt because of a deterrent	
1. Some concern about deterrents	
2. Minimal or no concern about deterrents	
11. Reason for contemplated attempt	.50**
0. To manipulate the environment; get attention, revenge	
1. Combination of 0 and 2	
2. Escape, surcease, solve problems	
12. Method: Specificity/planning of contemplated attempt	.47**
0. Not considered	
1. Considered, but details not worked out	
2. Details worked out/well formulated	
13. Method: Availability/opportunity for contemplated attempt	.22*
0. Method not available; no opportunity	
1. Method would take time/effort; opportunity not readily available	
2a. Method and opportunity available	
2b. Future opportunity or availability of method anticipated	

Table 2 (*continued*)

Item and rating	Item-total score correlation
14. Sense of "capability" to carry out attempt	.39**
0. No courage, too weak, afraid, incompetent	
1. Unsure of courage, competence	
2. Sure of competence, courage	
15. Expectancy/anticipation of actual attempt	.56**
0. No	
1. Uncertain, not sure	
2. Yes	
16. Actual preparation for contemplated attempt	.46**
0. None	
1. Partial (e.g., starting to collect pills)	
2. Complete (e.g., had pills, loaded gun)	
17. Suicide note	†
0. None	
1. Started but not completed; only thought about	
2. Completed	
18. Final acts in anticipation of death (e.g., insurance, will)	.15
0. None	
1. Thought about or made some arrangements	
2. Made definite plans or completed arrangements	
19. Deception/concealment of contemplated suicide	.04
0. Revealed ideas openly	
1. Held back on revealing	
2. Attempted to deceive, conceal, lie	

Note. $N = 90$.
† Item-total correlation could not be computed, since all subjects had a 0 coding.
* $p < .05$.
** $p < .01$.

Reliability

Internal Consistency

The internal consistency of the SSI was determined on a sample of 90 patients who were hospitalized for self-destructive ruminations. The 90 patients were consecutive admissions who were asked to participate in a psychiatric research interview shortly after their admission. The SSI was filled out by the research clinician. Demographic characteristics of the 90 patients are presented in Table 1. At the time of admission, the majority of the patients received a primary diagnosis of depression.

The internal consistency of the SSI was evaluated through two methods. First, an item analysis showed that each item had a positive correlation with the total scale score and that 16 of the 19 coefficients were significant. The SSI items and the item-total correlation coefficients are presented in Table 2.

The second method of evaluating internal consistency was the determination of coefficient alpha, KR-20 (Cronbach, 1951). For the 90 cases, a reliability coefficient of .89 was obtained.

Interrater Reliability

Twenty-five of the 90 consecutively admitted patients were seen concurrently by two clinicians who alternated in interviewing successive patients. Following the interview, each clinician independently completed the SSI. The interrater reliability coefficient was .83 ($p < .001$).

Validity

Concurrent Validity

Concurrent validity of the SSI was evaluated by determining how well the scale scores correlated with other measures of

suicidal ideation or suicidal risk, such as clinical evaluations and psychological inventory scores.

The SSI scores were also compared to the "self-harm" items of the Beck Depression Inventory (BDI; Beck, 1972), independently obtained by a research assistant. The correlation between ideation scores and the BDI item was .41 ($p < .001$). The relatively low correlation may reflect the limited range (0–3) on the BDI item.

Discriminative Validity

Since the SSI was partly designed as a research screening instrument, it may be expected to discriminate between groups who, on an a priori basis, can be assumed to differ in degree of suicidal intent. Comparisons of the SSI scores of the 90 patients hospitalized for suicidal ideation ($M = 9.43$, $SD = 8.44$) and 50 outpatients who sought psychiatric treatment for their depression ($M = 4.42$, $SD = 5.77$) yielded a significant between-groups difference, $t = 4.14$, $p < .001$. The two groups were similar in degree of depression as measured by the Beck Depression Inventory, $t = .67$, *ns*. This finding is consistent with the fact that upon hospital admission, the majority of the ideators were diagnosed as having depressive disorders (see Table 1).

Construct Validity

The SSI scores from the previously described 90 patients were also used to test a number of hypotheses relevant to the construct under investigation.

The major hypothesis tested was that hopelessness is more closely related than depression to the extent of suicidal ideation. This hypothesis was based on previous findings that among suicide attempters the statistical association between suicidal intent and depression is an artifact resulting from their joint attachment to a third variable, namely, hopelessness (Beck, Kovacs, & Weissman, 1975; Minkoff, Bergman, Beck, & Beck, 1973).

Table 3
Mean Suicide Ideation Scores by Levels of Hopelessness and Depression in Hospitalized Suicide Ideators

	Hopelessness scale score			
	Low (0–8)		High (9–20)	
Variable	Score	*n*	Score	*n*
Beck (1972) Depression Inventory score				
Low (0–25)	6.85	35	8.91	21
High (26–63)	8.27	12	13.67	31

Note. $N = 90$.

Each patient completed the Hopelessness Scale (HS) and the Beck Depression Inventory (BDI), which were administered and scored by a research assistant independently of the SSI. The HS is a relatively new instrument that was developed by our research team as an objective measure of hopelessness or negative expectations. Its reliability and validity have been previously reported (Beck, Weissman, Lester, & Trexler, 1974). The BDI, our psychometric measure of depression, assesses affective, cognitive, motivational, and vegetative symptoms of depression. The reliability and validity of this instrument have been repeatedly confirmed (Beck, 1972; Beck & Beamesderfer, 1974).

Using the SSI as the criterion measure, we found that both hopelessness and depression positively correlated with the extent of current suicidal ideation ($r = .47$, $p < .001$, and $r = .39$, $p < .001$, respectively). When BDI scores were partialed out, the correlation between hopelessness and suicide ideation was still significant ($r = .32$, $p < .002$). On the other hand, when HS scores were removed statistically, the correlation between the BDI and ideation scores was nonsignificant.

To obtain a further estimate of the power of the BDI and HS to predict suicidal ideation, the sample of 90 patients was divided into two roughly equal-sized groups based on the median scores for both hopelessness and depression. The mean SSI scores for the four paired groups were computed. The data indicate that irrespective of whether the BDI

scores were high or low, the groups with high hopelessness had higher mean ideation scores (see Table 3).

The construct validity of the SSI has been also confirmed by an independent investigator. Wetzel (1975) studied suicidal patients and nonsuicidal controls from three psychiatric hospitals. Based on their SSI scores, the ideators were ranked from zero to high intent. The data indicated that with increased severity of suicidal intention, patients had significantly less favorable ratings of the concept of "life." Moreover, suicide ideators ranked by SSI levels also differ on ratings of the concepts of "myself" and "suicide," low SSI scores being associated with more favorable semantic ratings (Wetzel, 1976b).

Wetzel (1976a) also reported that high-intent suicide ideators, defined by levels of SSI scores, were significantly more hopeless than either low-intent ideators or nonsuicidal psychiatric controls. As assessed by the Zung (1965) Depression Inventory, high-intent ideators were significantly more depressed than either the low-intent ideator group or the controls. In line with the findings of the present study, Wetzel (1976a) also found that in his sample of 56 suicide ideators interviewed in hospital and community mental health settings, hopelessness (HS) was a better correlate of suicidal ideation than depression.

Sensitivity Over Time

Data from a sample of 19 psychiatric outpatients who sought treatment for depression were used to examine the sensitivity of the SSI to changes over time. We found that SSI scores 1 week prior to outpatient treatment ($M = 4.74$) correlated .51 ($p < .05$, Spearman's rho) with scores at the end of treatment ($M = 3.53$). Changes in levels of BDI-assessed depression correlated .65 ($p < .004$) with changes in SSI scores; changes in hopelessness from pretreatment to posttreatment correlated .57 ($p < .01$) with changes in suicidal intent. The direction of change in hopelessness correctly identified the direction of change in suicide ideation in 17 of the 19 subjects, while direction of change in depression identified 16 subjects. Similar results were reported by Wetzel (1976a).

Factor Analysis

The data obtained from the 90 suicide ideators (described in Table 1) were subjected to a factor analysis. Product-moment correlation coefficients were computed, and the resulting correlation matrix was subjected to a principal-components analysis with varimax rotation.

The analysis yielded five components; three of these were psychologically meaningful, whereas the two additional components involved few items, and the communality among them was difficult to interpret. For this reason, another analysis was performed, forcing the data into three components.

Table 4 presents the item loadings on each of the three components. Only loadings $\geq .50$ were considered salient. Factor I has been labeled "Active Suicidal Desire" and is represented by 10 items. Items loading high on this factor encompass attitude toward living and dying and specific formal characteristics of suicidal ideation. Factor II, labeled "Preparation," is represented by 3 items that deal with actual formulation of the contemplated attempt. Factor III, labeled "Passive Suicidal Desire," is made up of 3 items that encompass passive avoidance of steps to save life, courage to carry out the attempt, and concealment of suicidal ideas/plans.

Discussion

The development of the Scale for Suicide Ideation was prompted by the need for a valid research instrument to identify suicidal individuals and to investigate meaningful correlates of suicidal ideation. The assessment and quantification of suicidal intention is also suggested by the tripartite, multiaxial classification of suicidal behaviors, which seeks to eliminate semantic obscurities that have plagued this field.

The valid identification of suicidal ideators is also important, given recent studies that suggest a relationship between self-destructive ruminations and other forms of suicidal

Table 4
Varimax Rotated Principal-Components-Analysis of the Scale for Suicide Ideation

Item	Component			Communality (h^2)
	Factor I	Factor II	Factor III	
Wish to live	*.77*	.09	−.19	.64
Wish to die	*.69*	.10	.13	.50
Reasons for living/dying	*.75*	.23	−.06	.62
Desire to make active suicide attempt	*.79*	−.04	.20	.67
Passive suicidal desire	.48	−.09	*.71*	.74
Time dimension: Duration	*.71*	.08	−.13	.53
Time dimension: Frequency	*.82*	.12	−.10	.70
Attitude toward ideation/wish	*.83*	.15	.03	.70
Control over suicidal action	.42	.38	−.04	.33
Deterrents to active attempt	*.51*	.48	.04	.49
Reason for contemplated attempt	*.64*	−.06	.32	.51
Method: Specificity/planning	.19	*.83*	−.12	.73
Method: Availability/opportunity	−.06	*.52*	.25	.34
Sense of "capability" to carry out attempt	.07	.19	*.73*	.57
Expectancy/anticipation of actual attempt	*.68*	.42	.08	.65
Actual preparation	.06	*.75*	.05	.56
Final acts	.36	.04	−.28	.21
Deception/concealment of contemplated attempt	−.22	.04	*.73*	.59
% of variance	35.3	10.9	9.8	

Note. $N = 90$. Factor I = active suicidal desire; Factor II = preparation; Factor III = passive suicidal desire. Numbers in italics identify the meaning of each factor.

behavior. For example, a study by Cantor (1976) reported that frequency of self-reported suicidal thoughts was higher in a sample of college students who had made past suicide attempts than among students with no history of self-destructive behavior. Wetzel's (1975, 1976a, 1976b) studies seem to indicate a continuity between suicide ideators and suicide attempters on a number of attitudes. The present study and the work of Wetzel support the assumption that underlays construction of the scale, namely, that self-destructive tendencies are manifest in identifiable and quantifiable thoughts, wishes, and attitudes about suicide.

An aspect of the psychometric properties of the SSI, namely the analysis of its internal consistency, warrants further consideration. As the data in Table 2 indicate, the item-total score correlations range from .04 to .72; the coefficient for "suicide note" could not be computed, since all subjects had a 0 coding on that item. The three items that have low correlations with the total SSI score highlight a problem area in clinical research, namely, whether to include items that are clinically important but do not meet accepted psychometric standards.

Given the data in Table 2, a psychometric perspective would argue in favor of eliminating Items 17, 18, and 19. However, from a clinical standpoint, the relevant phenomena, which have a low rate of occurrence in this sample, have important prognostic value. Suicide notes, deception, and "final acts in preparation for death" are *clinically* meaningful indicators of the severity of suicidal intent. The research literature on suicidal behaviors has consistently demonstrated the predictive value of suicide notes (Beck, Morris, & Lester, 1974) and "final acts" in assessing suicide intent (Dorpat & Boswell, 1963; Resnik & Hathorne, 1972; Tuckman & Youngman, 1968).

Thus, eliminating items relevant to these behaviors would result in the exclusion of information that could be decisive in assessing suicidal intention. For this reason and because of the finding of an acceptable alpha coefficient, these items have been retained.

Data on the construct and discriminative validity of the scale (as a component of suicidal risk) are being currently tested in a 10-year longitudinal study of suicidal ideators. Although the predictive validity of the SSI will not be determined for several years, it provides an ideal tool as an independent variable in the investigation of psychological and clinical correlates of suicidal ideation. It may also be employed as a dependent variable measure in studies that assess the efficacy of treatment intervention with suicidal individuals. At the present time, the SSI appears to have real potential as a research instrument. It may be used not only as an independent variable to discriminate among individuals varying in degree of suicidal ideation but also as a dependent measure to quantify change resulting from treatment interventions. Moreover, the scale may also be of help to the clinician in the systematic gathering and quantification of data relevant to patients' or clients' thoughts, plans, and wishes about suicide.

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