

Challenges to Defining and Classifying Suicide and Suicidal Behaviors

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Introduction

After over a century of serious attention to the public health problem of suicide and suicidal behaviors, there have been many significant advances in suicidology; yet challenges remain. We now know a great deal about the epidemiology of suicide and suicidal behaviors. We are beginning to develop a body of knowledge about the biological underpinnings to suicidal behavior through research on the neurobiology and genetics of risk for suicide. However, we still know little about protective factors and what places an individual at acute risk for suicidal behavior. We need to bridge the gap between our expanding knowledge base of the incidence and prevalence of suicidal behaviors in different populations, the etiology, progression, and transmission of suicidal behaviors, and the development of effective clinical and population-based protocols, practices, procedures, and policies.

In order to achieve this goal, we need to translate what we have learned from epidemiological surveillance and research studies into practical clinical and population-based applications. Similarly, what is learned in clinical settings needs to be communicated to researchers and theoreticians so they can better investigate and understand these behaviors. However, the suicide literature remains replete with confusing (and sometimes derogatory or pejorative) terms, definitions, descriptors, and classifications that make it difficult, if not impossible, to compare and contrast different research studies, clinical reports, or epidemiological surveys (Crosby, Ortega, & Melanson, 2011; Jenkins & Singh, 2000; Rudd & Joiner, 1998; Shneidman, 1985; Silverman, 2006), or to make comparisons, generalizations, or extrapolations (Linehan, 1997; Westefeld et al., 2000). Hence, advances in suicidology are hindered by a lack of a standardized nomenclature and classification system. This remains a challenge.

Most individuals who die by suicide are reported to have communicated their intent to others (usually next of kin or friends), and the majority have also visited or been treated by mental health professionals, primary care providers, or other physicians

during the weeks or months preceding their death by suicide (Luoma, Martin, & Pearson, 2002). Why is this so? It may be that family members, significant others, or other supports do not recognize or respond to the conditions, contexts, or communications associated with escalating suicidal risk. A compelling answer is that suicidal behavior is often undiagnosed, undertreated, or mistreated in clinical settings because the signs and symptoms are misunderstood by the clinician, and, for the individual, truthfully answering questions about being suicidal can be influenced by stigma, denial, guilt, anger, and shame (Mann et al., 2005; Malone, Szanto, Corbitt, & Mann, 1995). Determining that a suicide risk assessment has been completed after receiving a negative response to asking a single question (e.g., are you thinking about suicide?) is insufficient, because, in part, the question provides no context, parameters, or time frame.

One of the major difficulties in communicating about suicidal phenomena with our patients and within our disciplines (as well as across disciplines) is that we do not share a precise set of terms or speak the same scientific language. We also do not share the same conceptualizations of what constitutes self-harm and the suicidal process. The terminology we use is often based on our training (Silverman & Berman, 2014b); theoretical, political, social, psychological, biological, and religious perspectives; and the professional responsibilities to identify and count these behaviors in the first place (clinical, epidemiological, public health, research, etc.). Conceptual, methodological, and clinical challenges result from widely varying definitions and classification schemes for such terms as *suicide attempt* (Nock & Kessler, 2006). As a result, epidemiologists cannot consistently and accurately determine the incidence and prevalence of suicide-related phenomena, researchers cannot easily compare their study populations or the effectiveness of their interventions, and clinicians have difficulty in translating research findings into practical applications when working with an individual at risk for suicidal behaviors.

It is a known fact that there is inaccuracy in the reporting of suicidal deaths (Jobes & Berman, 1985; Shneidman, 1980). Estimates of underreporting have ranged from 10% to 50% (Jobes, Berman, & Josselson, 1987; Litman, 1980). Some have noted substantial underreporting and misclassification of childhood and adolescent suicides (Wekstein, 1979). Jobes and Berman reported that the majority (58%) of medical examiners they surveyed in the United States either agreed or strongly agreed that “the actual suicide rate is probably two times the reported rate.” It appears that there may be variations in both the death certification process and the manner of death determination.

Jobes, Berman, and Josselson (1987) have identified over 20 possible sources of variability in the official reporting of suicide data. They suggest that perhaps the single most important source of variability and error in suicide statistics arises from the virtual absence of any standardized classification criteria that coroners and medical examiners might use more uniformly to evaluate cases of equivocal suicide. Although relatively small in number, the category of “undetermined manner of death” may represent a significant number of true suicides (Elnour & Harrison, 2009; O’Carroll, 1989; Rockett, Kapusta, & Coben, 2014; Tollefsen, Hem, & Ekeberg, 2012).

If we cannot even agree upon what defines a suicide, how, then, are we to determine what is an attempt to die by suicide? There is considerable debate about the differential attributes of those who die by suicide, those who attempt suicide, and those who engage in deliberate self-harm (DSH). The resolution of these controversies is hampered

because studies have used dissimilar descriptive methods and definitions for what is a suicide attempt (Linehan, 1986; Maris, 1992). When the suicide attempts are medically serious (e.g., involving admission to an intensive care unit; requiring surgery under general anesthesia; needing extensive, specialized medical care), these two populations overlap considerably (Beautrais, 2001). However, because most epidemiological studies are based on self-report of prior suicidal behavior without defining these terms for the population being surveyed, the profile of those engaging in non-medically serious suicide attempts remains inconsistent and unreliable.

Currently there is no international surveillance system for the primary purpose of estimating annual national rates of suicide attempts (Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007a). However, the International Association for Suicide Prevention and the International Association for Suicide Research have recently formed a task force to address this issue. Put simply, the absence of a universally accepted nomenclature and set of diagnostic criteria has limited our attempts to accurately quantify the extent of the problem (incidence and prevalence), identify effective interventions, both clinical and preventive, as well as useful markers of vulnerability.

The above problems, among others, make it difficult to

- accurately count the number of suicides and suicide attempts that occur annually;
- accurately differentiate suicide attempts from nonsuicidal self-injuries;
- conduct longitudinal studies of suicide ideators or suicide attempters;
- communicate between and among clinicians, researchers, patients, and patients' families;
- establish suicide and suicide attempts as a major public health problem that warrants investment of resources at the local, regional, national, and international levels;
- determine definitions for levels of risk;
- develop, implement, and evaluate treatment approaches; and
- develop, implement, and evaluate preventive interventions.

Challenges to Developing and Implementing a Standardized Nomenclature and Classification System

Nomenclature for suicidal ideation and behavior has been the subject of considerable international attention and debate (De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006; O'Carroll et al., 1996; Silverman et al., 2007a; Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007b). The need for clear and consistent use of terms to guide research and clinical practice has provided the impetus for efforts to develop standard operational definitions and nomenclature to classify suicide and self-injurious thoughts and behaviors (e.g., Crosby et al., 2011; De Leo et al., 2006; Posner, Oquendo, Gould, Stanley, & Davies, 2007; Silverman et al., 2007a). However, as Heilbron, Compton, Daniel, and Goldston (2010) have noted, implementing a standard nomenclature for clinical and research purposes has long been recognized to be a complex task (Wakefield, 1992; Wilson, 1993).

The ongoing debate concerning nomenclature has perpetuated the use of multiple terms to refer to the same behavior (Bille-Brahe, Kerkhof, De Leo, & Schmidtke, 2004; O'Carroll et al., 1996; Silverman, 2006). For example, the following are

a sampling of terms that have all been used to refer to the act of self-injury with the intent to die (i.e., suicide attempt): parasuicide, failed attempt, failed completion, nonfatal suicide, aborted suicide, self-directed violence, near-lethal attempt, death rehearsal, suicidal episode, courting death, and cry for help. The following are some terms used to describe thoughts with the wish to die (i.e., suicide ideation): suicidal flashes, suicidal preoccupations, morbid ruminations, fleeting thoughts of suicide, and suicidal contemplations. There is also a plethora of terms to describe death caused by a self-injurious behavior with any intent to die as a result of the behavior (i.e., suicide): committed suicide, completed suicide, fatal suicide attempt, self-murder, successful attempt, suicidal execution, lethal suicide attempt, hastened death, intentional self-murder, and rational suicide (Silverman, 2006). Such variability in terminology and definitions not only contributes to imprecise communication, but also limits comparison of prevalence rates nationally and internationally, and hampers clinical and preventive interventions.

There are currently several nomenclatures and/or classification systems that are being developed and tested in the United States (Brenner et al., 2011; Posner et al., 2007; Silverman et al., 2007b), as well as internationally (De Leo et al., 2006). I argue elsewhere that not only must we use the same terminology and definitions, but that these terms must be easily understood, applied, and consistent, and should relate to each other in a way that has utility, meaning, and relevance to the real world of at-risk individuals (Silverman, 2006). We must develop an accurate suicide-related morbidity and mortality database in order to conduct meaningful research, better delineate risk and protective factors as well as mediators and modifiers of suicidal behaviors, develop and implement prevention efforts, and advance the general public health (Jobes, Berman, & Josselson, 1987; O'Carroll, 1989).

Clarifying Terminology

The history of the evolution of terms, definitions, and classification systems can be found in a number of published articles (e.g., De Leo et al., 2004; O'Carroll et al., 1996; Silverman, 2006). Before I review some of the current attempts to develop and implement nomenclature and classification systems, it is pertinent to provide some generally accepted definitions for these constructs.

Nomenclature: A set or system of names or terms, such as those used in a particular science or art; a system of words used technically to name things in a particular discipline. A nomenclature should be commonly understood, widely acceptable, and comprehensive. The terms should define the basic clinical phenomena and be based on a logical set of necessary component elements that can be easily applied. Hence, a nomenclature is simply establishing the words (and definitions) chosen for use in the development of a classification, using taxonomic principles.

Classification: The act of distributing things into classes or categories of the same type; the act or method of distributing into a class or category according to characteristics. A classification system is built upon a nomenclature, a more exhaustive categorization and breakdown of subtypes of related phenomena, and further differentiates among phenomena that appear to be similar by the use of modifiers. A classification

system allows one to add “qualifiers” or subtypes to the main categories in order to further differentiate certain subgroups of individuals who share the same characteristics.

Taxonomy: The practice and science of classification as well as the laws or principles underlying such a classification; the science dealing with the description, identification, naming, and classification of organisms. Although grounded in a scientific understanding of disease, taxonomies such as The International Statistical Classification of Diseases and Related Health Problems (ICD), must address the needs of the varied and changing public health and health-care delivery communities across the globe. The current practice of updating the ICD nomenclature periodically attempts to balance: (a) the need for a consistent terminology to permit clear communication about diseases that are defined by agreed-upon criteria, with (b) the need to ensure that the classification system (i.e., the taxonomy) properly reflects advances in our understanding of biological pathways and environmental factors that contribute to disease origin and pathology. Hence, a formalized nomenclature is essential for clear communication and understanding.

Currently used disease classifications have properties that limit their information content and usability. “Current disease taxonomies, including ICD-10, are primarily based on symptoms, on microscopic examination of diseased tissues and cells, and on other forms of laboratory and imaging studies, and are not designed optimally to incorporate or exploit rapidly emerging molecular data, incidental patient characteristics, or socio-environmental influences on disease” (Institute of Medicine, 2011, p. 14). Long before we construct a formal taxonomy for suicide and suicidal behaviors, we must first arrive at a set of uniform terms and definitions.

Terminology in Suicide Classification Systems

In relation to suicide and suicidal behaviors, a classification system would help organize subtypes of behaviors, for example, via the use of modifiers that further differentiate subtypes of distinct behaviors. A classification system would categorize behavioral presentations into mutually exclusive “boxes” on the basis of the careful use of terminology and definitions. In the ideal world, no behavioral presentation should “straddle” more than one established “box.” This, of course, is dependent upon gathering enough information about the behavioral presentation in order for it to be classified appropriately by identifying the characteristics that differentiate each classification “box” (Silverman, 2006).

From my perspective, the following are some examples of subtype qualifiers for a suicide classification system:

- **Timing:** Imminent versus Short-Term versus Long-Term
- **Duration:** Acute versus Chronic
- **Frequency:** First Time versus Repetitive versus Chronic
- **Intensity:** Low versus Medium versus High
- **Character:** Unintentional versus Intentional
- **Intent to die:** Present versus Absent
- **Context:** Impulsive versus Planned

- **Quality:** Active versus Passive
- **Dosage:** Nonlethal versus Nearly Lethal versus Lethal
- **Setting:** Public versus Semiprivate versus Private
- **Method:** Firearm versus Hanging versus Jumping versus Overdose
- **Outcome:** Injury versus Noninjury versus Death

In the process of reducing the terminology of suicide to its “essential components,” we first need to agree on what constitutes the “full-range” or continuum of suicide-related thoughts, communications, and actions. And what does “suicide-related” really mean? Are there unique thoughts, communications, and actions that result in self-destructive actions and outcomes? Or do they better identify cognitions, emotions, and actions that may lead to many different actions and outcomes?

Rudd (2000, p. 19) suggested that what is needed is “an inclusive conceptual framework that allows for direct clinical application of empirical findings across specific areas of functioning (i.e., cognitive, emotional, biological, behavioral, and interpersonal domains).” Such a model would address the broad range of factors empirically validated as relevant, incorporating the diagnostic components of DSM-5 and the forthcoming ICD-11. Rudd suggested that cognitive theory and therapy offer a unique foundation for such integrative efforts (e.g., Alford & Beck, 1997).

Although one can argue about the degree of specificity for describing suicidal behaviors, there is a set of commonly used terms that generally describes suicidal thoughts and behaviors. These suicide-related generic terms are *ideation* (with or without a plan); *intent*; *motivation*; *preparatory acts* (toward imminent self-harm); *self-harm or self-injurious behaviors* (with or without injury, or fatal); *undetermined suicide-related or self-injurious behaviors* (with or without injury, or fatal); *suicide attempt* (with or without injury); and *suicide* (Brenner et al., 2011; Matarazzo, Clemans, Silverman, & Brenner, 2013).

The definitions of terms such as *suicide attempt* or *self-harm* are predicated on the definition of *suicide*. After all, a true suicide attempt is an action, the goal of which is to die by suicide. However, as noted elsewhere (Silverman, 2006), there are at least 15 definitions of suicide in our scientific literature, and at least 10 definitions of suicide attempt or *nonfatal self-injury*. Until we establish a standardized nomenclature, we will continue to have differences between and among official reporting sources (e.g., police, coroner, medical examiner death certificates), research studies, clinical population reports (e.g., hospital discharge summaries, emergency department reports, first-responder reports), and epidemiological surveys (which are often dependent upon self-report).

A brief list of the challenges to resolving these conundrums is presented below:

- 1 Agreeing on which terms should be used and defining them as mutually exclusive. There remains confusion about when to apply and what exactly constitutes terms such as suicidality, intentional or deliberate self-harm, suicide-related behavior, parasuicide, and nonsuicidal self-injury.
- 2 Developing a nomenclature that is free of bias—philosophical, theoretical, biological, sociological, political, religious, cultural, and so on. The current state of our knowledge suggests that suicidal thoughts and behaviors express themselves differently in different cultures, different age groups, different genders, and different ethno-racial groups.

- 3 Being sensitive to different needs. For example, the epidemiologist, medical examiner/coroner, public health officer, first responder, researcher, clinician, and emergency room physician often focus on different aspects of the suicidal continuum, and use different measures and sources in order to record their findings and observations. Furthermore, they require different standards of evidence, levels of certainty for such evidence, and they place different emphases on different aspects of evidence.
- 4 Defining those terms that are related to the act of *death by suicide*, such as *suicide ideation*, *suicide intent*, and *suicide attempt*, when there is not a clear or consistent definition of the term *suicide*. The nomenclature must be internally consistent, and all the terms must be based on, and relate to, a culturally sensitive, and consistent definition of suicide.
- 5 Deciding which terms are pejorative or dismissive. The use of certain terms to label self-injurious behaviors may bias decisions about the level of clinical care needed, or color the perceptions of the urgency with which follow-up care is needed after a crisis (Heilbron et al., 2010). Such terms include *completed suicide*, *successful suicide*, *committed suicide*, *suicide gesture*, *failed attempt*, *suicide victim*, *nonfatal suicide*, and *nonfatal suicide attempt* (Crosby et al., 2011; Silverman, 2006). For example, the terms completed suicide and successful suicide imply achieving a desired outcome, whereas those involved in the mission of preventing deaths by suicide would view this event as undesirable. Furthermore, death by suicide is a final state, so the use of the adjective “completed” or “successful” is unnecessary and connotes a judgment. The term failed attempt gives a negative impression of the person’s action, implying an unsuccessful effort aimed at achieving death. The term nonfatal suicide portrays a contradiction in terms. A “suicide” indicates a death, while “nonfatal” indicates that no death occurred. Furthermore, “failed” or “nonfatal” suggests that the person somehow was not capable of accomplishing their apparent intent to die. The use of the adjective “committed” (e.g., committed suicide) suggests a legal connotation. The term *gesture* (e.g., suicide gesture) connotes a value judgment with a pejorative or negative impression of the person’s intent.
- 6 Remaining consistent with the terminologies and approaches used by public health agencies and by scientific fields that study other forms of violence (e.g., homicides and sexual assault) and unintentional injuries (e.g., motor vehicle crashes).
- 7 Resolving the distinctions between what we label a suicide attempt, deliberate (intentional or instrumental) self-harm, or nonsuicidal self-injury.
- 8 Developing a standardized nomenclature that is sufficiently adaptable to allow some alterations for specific uses within certain specialties or professions. However, there must be a clear crossover table to demonstrate equivalencies between and among terms currently used in existing nomenclatures, so that clinical, research, and epidemiological studies can be compared (Matarazzo, Clemans, Silverman, & Brenner, 2013).
- 9 Examining as many factors as possible that are involved in the behavior. To best assess these factors in a comprehensive manner, clinicians and researchers need an instrument or protocol that allows for reliable data collection across a wide range of settings, and one that can clearly distinguish between suicidal behaviors and nonsuicidal self-injurious behaviors.

- 10 Overcoming the factors that might affect the reliable self-reporting of self-destructive behaviors, for example, fear of reprisal (involuntary hospitalization), or being judged by the researcher, care provider, or first responder as “crazy” or “mentally ill.” Until we destigmatize suicide and suicidal behaviors, and redefine them as self-inflicted injuries that are mediated by biology or other external sociocultural factors, we will never be able to accurately count or acquire the data we need to improve our understanding of the suicidal process and the suicidal patient, develop interventions to address these components, and ultimately develop effective preventive interventions. Of note, a new term has entered our lexicon—*lived experience*—that has been created to self-identify those individuals who have engaged in nonfatal self-injurious behavior with the intent to die.

We remain dependent upon other scientific fields to educate us about how aspects of cognition, brain development (acquisition of reasoning, cognitive skills, executive functioning), social behavior, and risk-taking behaviors impact the development of suicidal thinking and the unfolding of suicidal actions. For example, when does ideation become clinically significant? And under what conditions? What are the essential elements that must contribute to an individual’s risk appraisal? At what age and under what contexts can an individual develop and access executive functioning, such as understanding the consequences of certain actions?

We must go beyond our reliance on self-report surveillance instruments for understanding such important components of the suicidal process as suicidal thoughts, intent, motivation, planning, significance of prior life events, appraisal of current stressors, history of prior self-destructive behaviors, and so on. If we are to continue to be dependent upon self-reports in our surveillance, research, and clinical studies, then we must provide the respondents with clear terms, definitions, and examples of what we are seeking to measure.

Examples of Definitional Obfuscation

There remains confusion about what exactly constitutes suicidal behavior, deliberate self-harm, *suicidality*, or suicide-related behavior, and how to define suicide and suicide attempt (Silverman, 2006; Silverman et al., 2007a). Linehan, Comtois, Brown, Heard, and Wagner (2006) critiqued prior research studies using different definitions and terms, and determined that the following characteristics were assessed in varying degrees: whether or not a suicide attempt or self-injury has occurred; whether the participant has injured himself or herself once or repeatedly; the exact number of suicidal or otherwise self-injurious acts during a stated time period; the first and most recent act; existence of intent at the time of a self-injurious act; instrumental intent or motivation for an act, other than suicide intent; method used and its lethality or medical severity; degree of impulsivity (resisting urges, degree of planning, warning others, drinking); likelihood of “rescue” from an act; and behavior or consequences after the suicidal act.

The following terms and definitions illustrate the overlap or lack of clarity when describing suicide and suicidal behaviors.

Parasuicide

The World Health Organization (WHO)/EURO Multicentre Study on Parasuicide was a multinational, European study that covered two broad areas of research: monitoring trends in the epidemiology of parasuicide (epidemiological monitoring study); and follow-up investigations of parasuicide populations, with a view to identifying the social and personal characteristics predictive of future suicidal behavior (repetition prediction project). Aitken, Buglass, and Kreitman (1969) combined all nonfatal suicidal behaviors into one category called “parasuicide,” without assessing the true motivation of the behavior, and at the same time preserving the link to completed suicide. As Linehan et al. (2006, p. 303) have pointed out, “Although parasuicide as a term has been widely accepted among researchers and was the definition selected for the WHO/EURO multinational study, the definition has not gained popularity both because the term is often interpreted as indicating no suicide intent (i.e., as mutually exclusive of suicide attempts instead of the intended larger category including suicide attempts) and because it does not translate well in other languages. The term deliberate self-harm avoids this problem but fails to capture the relationship of the behaviour to suicide.” As a result, the WHO/EURO investigators revised their nomenclature to replace “parasuicide” with “fatal or nonfatal suicidal behaviour with or without injuries” and also required that the behavior be “nonhabitual” to distinguish nonfatal suicidal behavior from the other repetitive self-injurious behaviors (De Leo et al., 2004; Schmidtke, Bille-Brahe, De Leo, Kerkhof, & Wasserman, 2004).

Suicidality

There is no definition of suicidality other than that it is the state of being suicidal. But what does that mean? Does it mean having the full constellation of suicidal ideations, intent, motivations, and plans? Does it mean having made a suicide attempt, or having been exposed to others who have been suicidal or rehearsed a suicidal act? Is it the equivalent of being in a “suicidal condition” or “suicidal state of mind” (Litman, 1980)? The term suicidality has been used as a “catch-all” term to represent a broad range of suicide-related cognitions, emotions, and behaviors (Silverman, 2006). For the most part it has been used to categorize individuals who have expressed a combination or permutation of cognitions (ideation, intent, motivation, and planning), as well as behavior (“threats”, “gestures”, rehearsals, and attempts). It has also been used to categorize patients who are manifesting active mental illness and report thinking about or feeling suicidal, or even having engaged in recent self-injurious behaviors. Hence, it becomes nearly impossible to compare populations who are deemed to be expressing suicidality.

Despite efforts to remove the term suicidality from the nomenclature, it remains a very common term in the clinical discourse and in the scientific literature. A leading group of international experts in suicide prevention, psychometrics, pharmacoepidemiology, and genetics, as well as research psychiatrists involved in studies of psychiatric disorders associated with elevated suicide risk across the life cycle, concluded that the term suicidality is not as clinically useful as more specific terminology, such as ideation, attempts, and suicide (Meyer et al., 2010). I would argue strongly, along with others (Crosby et al., 2011; Meyer et al., 2010; Posner et al., 2007) that such

a term be removed from the lexicon because it has no real utility other than to identify a situation or state where an individual expresses some ill-defined form of suicide-related cognition, emotion, or behavior.

Suicide Ideation

Besides thinking about dying by self-injury, some clinicians and researchers include planning, motivation, and intent under the rubric of suicidal ideation. Some do not make the distinction between what is suicidal thinking and what are morbid thoughts (Rudd, 2006). Some believe that there is a clear distinction between fleeting, persistent, and chronic suicidal thinking. Others make distinctions between active and passive suicide ideation (Borges, Angst, Nock, Ruscio, & Kessler, 2008; Silverman & Berman, 2014a).

Valtonen et al. (2009) explored whether the ways of defining and measuring suicidal ideation markedly influence which patients with bipolar disorder are classified as suicidal. They also explored the extent to which the correlates for suicidal ideation differ as a consequence of different definitions, and investigated the predictive value of different measures of suicidal ideation for suicide attempts during a 6-month follow-up. They compared the predictive value of three different scales of suicidal ideation: Scale for Suicidal Ideation, Hamilton Depression Scale item 3, and Beck Depression Inventory item 9. Altogether 74% of patients had suicidal ideation as defined in at least one of the aforementioned ways, only 29% met the criteria for all three ways; agreement between definitions ranged from low to moderate. They concluded that who is classified as having suicidal ideation depends strongly on the definition and means of measurement among patients with bipolar disorder. Hence, different measures for ideation have the potential to cause inconsistency when correlates of suicidal ideation are investigated.

Intent to Die

The presence or absence of intent to die, whether determined as subjective or objective, has generally been seen as a key factor in differentiating nonsuicidal from suicidal self-harm behaviors (Beck, Beck, & Kovacs, 1975; Hjelmeland & Knizek, 1999; Silverman, 2006; Silverman et al. 2007a). Most would agree that engaging in a suicidal behavior (e.g., attempt) involves some degree of determination, desire, wish, and goal-oriented planning. But is this “intent to die” a cognition, emotion, or behavior? And is it essential, or a defining element, for a thought/ideation or a self-injury to be labeled as “suicidal”? Many patients who self-harm, when asked by clinicians at the time of the injury, will deny that they had an intent to die, despite the evidence to the contrary (e.g., high lethality of the act, prior history of near-lethal suicide attempts, corroborating information from family, friends, or support network). Difficulties in diagnosis can arise when the assessment of the intent to die is denied by the patient yet some ambivalence is present. As Rosenberg et al. (1988, p. 1446) stated, “with respect to intent, absence of evidence is not evidence of absence.”

Nevertheless, it has long been recognized and debated that suicide intention is a multidimensional variable, characterized by different degrees of intensity/severity, and influenced by all possible aspects of human experiences (cultural, existential, spiritual, etc.). Reducing it to a dichotomic (yes/no) category may be pragmatic, but also a dangerous generalization, with potentially misleading implications, including the lowering of clinical attention and concern.

There remain a number of important unanswered and under-researched questions relating to the relationship between intent and suicidal thoughts and behaviors, of which the following are the most salient:

- 1 Is intent a component of suicide ideation?
- 2 Is planning a component/essential ingredient of intent versus ideation?
- 3 Is intent needed to classify a self-injurious behavior as being “suicidal”?
- 4 What role does the presence of intent have in determining level of risk?
- 5 How do the motivations (rationales) for engaging in self-injurious behaviors differ from the intent? Are motivations another component of suicide ideation?
- 6 How do we measure intent? What are its defining characteristics?
- 7 How explicit or implicit does the ideation or emotion need to be in order to label it as “suicide intent”? Are there defining degrees of implicitness or explicitness?
- 8 Should the presence of intent be the defining characteristic that separates nonsuicidal self-injury from suicidal self-injury?
- 9 If we know that a significant percentage of individuals labeled as expressing non-suicidal self-injury do later engage in suicide attempts and/or eventually die by suicide, then does that negate the importance of including intent in our definitions of suicide-related ideations and behaviors?
- 10 By defining deliberate self-harm as being self-injurious actions with or without the intent to die, are we lumping together different populations whose self-harm behaviors may have different underlying etiologies and goals?

Suicide Gesture

In a review of the history of the use of the term *suicide gesture*, Heilbron et al. (2010, p. 222) state: “Building on an earlier collaborative effort sponsored by the National Institute of Mental Health, the Center for Mental Health Services, and the American Association of Suicidology (O’Carroll et al., 1996), Silverman et al. (2007a) referred to the term suicide gesture as akin to a behavioral form of suicide threat, and they did not include the term in their recommended nomenclatures because of its imprecision and arguably dismissive connotations. Posner et al. (2007) cited similar reasons for deciding against use of the term ‘suicide gesture’ in the Columbia-Classification Algorithm for Suicide Assessment (C-CASA).” In a recent publication of the Centers for Disease Control and Prevention (CDC) (Crosby et al., 2011), describing uniform definitions to be used in suicide surveillance, the term suicide gesture similarly is not recommended because of the subjective and often negative nature of the term.

As Heilbron et al. (2010, p. 222) indicate, the term suicide gesture has been used inconsistently and may negatively impact the quality of care provided to patients. Furthermore, “Despite the fact that many current or proposed systems for describing self-harm behaviours do not recommend the use of suicide gesture as a label, the term has continued to be used widely in clinical practice and in research, as well as in training settings.”

Suicide Attempt

Two lines of evidence suggest that suicidal behaviors are repetitive: many of those who die by suicide have made a previous suicide attempt; and many of those who have engaged in a suicide attempt will make subsequent attempts (Beautrais, 2004; Conner,

Langley, Tomaszewski, & Conwell, 2003). In a 5-year follow-up study of a consecutive series of 302 individuals admitted to hospital for medically serious suicide attempts, Beautrais found that 37% made at least one further attempt and 6.7% died by suicide. In a larger study of all patients admitted for any degree of attempted suicide during the 10-year period, 1993–2002, Gibb, Beautrais, and Fergusson (2005) found that within 10 years, 28.1% of those who had been admitted for an index suicide attempt were readmitted for a further suicide attempt, and 4.6% died by suicide. We know that approximately 25% of those who engage in medically serious suicide attempts do so within 5 min of deciding to end their lives, and are often labeled as “impulsive” suicidal individuals (Simon et al., 2001). Furthermore, approximately 50% engaged in near-lethal suicide attempts within 1 hour of the thought entering their awareness.

It is important to recognize that intent and lethality are not unitary or even necessarily highly correlated constructs, for it has been observed that most suicidal behavior is associated with mixed motives and varying degrees of ambivalence about life and death (Shneidman, 1996), making it difficult to neatly categorize self-injurious behaviors on the basis of the presence or absence of intent and degree of lethality. Furthermore, there is no simple relationship between intention, preparation, lethality, and outcome.

It follows that concerted efforts need to be made to identify those at most risk of an index suicide attempt, as well as providing services to those who have engaged in an index suicide attempt, irrespective of its level of lethality. A prior suicide attempt is statistically the best predictor of future suicide attempts and death by suicide, and a history of repeated attempts further increases the risk of death by suicide. To that end, it is imperative to have a clear and consistent definition of what is a suicide attempt. Such a standardized definition does not presently exist.

Deliberate Self-Harm and Nonsuicidal Self-Injury

The concept of deliberate self-harm arose out of Kreitman’s original creation of the term *parasuicide* to label all suicide-related self-injury that did not result in death by suicide (Kreitman, 1977). As a result, the term gained much favor in Europe broadly, but not so in the United States. In fact, as mentioned above, the WHO used the term to describe a number of large-scale epidemiological studies that were undertaken in multiple sites in Europe (Schmidtke et al., 1996, 2004).

Over time, the term deliberate self-harm replaced *parasuicide*, but this term may have a potentially pejorative connotation, depending upon whether the word “deliberate” is understood to mean the intent to die, or whether it refers to the self-harm itself (i.e., the person harmed themselves of their own volition). Hence, the current term being used in Europe to describe self-injury that does not lead to death is *self-harm* (with or without intent). In the United States, the term *nonsuicidal self-injury* is becoming popular to describe similar behaviors. However, nonsuicidal self-injury excludes those individuals who overdose (self-poisoning), even when as many as 25%–50% of those who self-poison may report no suicidal intent (O’Connor et al., 2007). Another criticism of nonsuicidal self-injury as a diagnostic term is that the prefix “nonsuicidal” is misleading, because many studies have reported nonsuicidal behaviors, such as self-cutting, as being associated with greater risk for subsequent suicide attempts and/or death by suicide (Kapur, Cooper, O’Connor, & Hawton, 2013). A related complication is that the term suicide

gesture remains in the lexicon in the United States, despite well-developed reasons to replace it with more precise descriptions of suicidal behaviors and the functional assessment of suicide-related behaviors (Heilbron et al., 2010).

The original definition of deliberate self-harm included all self-injurious behaviors, regardless of whether the individual had intended to die. Deliberate self-harm has been identified as a behavior that carries considerable risk of subsequent self-harm, including suicide attempt and death by suicide, and may be a more accurate description of these behaviors than nonsuicidal self-injury (Kapur, Cooper, O'Connor, & Hawton, 2013). An early study by Hawton and Fagg (1988) found that at least 1% of patients referred to general hospitals in the United Kingdom for deliberate self-harm died by suicide within a year of an episode of deliberate self-harm, and 3%–5% within 5–10 years. Other studies found that 1%–2% of patients die by suicide in the year following being seen in a hospital emergency department or being admitted for treatment (Owens, Horrocks, & House, 2002), with an estimated 7%–10% of individuals eventually dying by suicide (Nordentoft et al., 1993). Of note is that, until recently, researchers have almost totally ignored studying nonhospital-treated self-harm. As a result, we are only now learning about the incidence and prevalence of deliberate self-harm that occurs in the community (Klonsky & Olino, 2008).

The deliberate self-harm literature as well as the suicide attempt literature rarely distinguishes the populations by method (self-poisoning, cutting, etc.), location of the injury (wrists, arms, legs, head, etc.), physical location at the time of self-injury, time of day, day of week, and so on. Without such a classification system, it is more difficult to differentiate between the nonsuicidal deliberate self-harm and suicide attempt behaviors. Deliberate self-harm is more common among females (upward of 2/3 of patients in some studies). Similarly, in the United States, suicide attempts occur at a ratio of about 3–4:1 for females versus males. In both populations, the largest percentage of cases is among adolescents and young adults. In the hospital-treated deliberate self-harm literature, the large majority of the patients have self-poisoned (Hawton, 1997).

Despite the foregoing definitional and classification issues inherent in differentiating these populations, some recent studies suggest that deliberate self-harm differs from suicide attempts in clinically important ways (Brown, Henriques, Sosdjan, & Beck, 2004; Chapman & Dixon-Gordon, 2007; Chapman, Gratz, & Brown, 2006). Reasons for suicide attempts are more likely to involve “making others better off” (reducing burdensomeness), whereas reasons for deliberate self-harm include “anger expression” and “distraction” (Brown et al., 2004). Other studies highlight the differing emotional experiences associated with these behaviors, although emotional relief is a key motivation for both deliberate self-harm and suicide attempts (Brown et al., 2004). Individuals who engage in deliberate self-harm report that the behavior relieves unendurable anxiety or tension; temporarily reduces anger, anxiety, sadness, depression, and shame; or as a form of self-punishment, relieves anger directed inward, self-blame, and self-loathing for perceived social transgressions (Chapman & Dixon-Gordon, 2007; Kemperman, Russ, & Shearin, 1997; Krasser, Rossmann, & Zapotoczky, 2003).

Chapman and Dixon-Gordon (2007) found that relief was the most common consequence of deliberate self-harm, whereas anger was the most common consequence of a suicide attempt. They suggest that deliberate self-harm serves an emotion regulatory function. However, a significant proportion of individuals reported that their predominant emotional experience following deliberate self-harm was negative, most notably including sadness. How these characteristics differ from those who

engage in suicide attempts is yet to be well delineated. Linehan (1997) has suggested that the presence or absence of the intent to die during self-harm is a critical factor that can differentiate the two behaviors. However, it is important to note that multiple motives often underpin both suicide attempts and deliberate self-harm (Hjelmeland & Knizek, 1999).

Recent research has suggested that all forms of deliberate self-harm (self-cutting and overdose; regardless of the intent) may be a precursor to suicidal behaviors. The long-term results of the multicentre study of self-harm in the United Kingdom demonstrated that those who self-cut are actually at higher risk of suicide than those who overdose with medication, although both groups were found to be at increased risk (Hawton et al., 2015).

Relevance to the General Population's Understanding and use of Terminology

Concerns about correct labeling for purposes of clinical decision making are not unique to suicidology. There is a current controversy in the field of cancer regarding the labeling of certain pathological conditions that do not lead to death. For example, Esserman, Thompson, and Reid (2013) suggest reserving the term *cancer* for conditions with natural histories ending in metastasis and death, in order to reduce screening and decrease rates of overtreatment for less aggressive forms of disease. They acknowledge that the term cancer has taken on a broad meaning within the cultural lexicon. The general public has adopted many medical terms and concepts that often represent a wide spectrum of illness and disease states. It has been pointed out that “for better or worse, cancer is no longer just a diagnosis, it is an identity” (Capurso, 2014).

For example, the general public applies the term *depression* to intermittent, occasional sadness and despair as well as to chronic, debilitating disease that can result in death. However, depression may not begin with sadness or a low mood. In an analogous manner, being labeled “suicidal” or with “suicidality” is not a specific descriptor of suicide thoughts, symptoms, or behaviors, but rather an identity. What is meant by “He/she is no longer suicidal?” Does this mean he/she no longer has current ideation, current intent, or access to lethal means? What about the motivations to end a life? Can they remain present and still label an individual as not being “suicidal”?

The use of more precise descriptors is consistent with the overarching goals of performing more competent suicide risk assessments and more clearly communicating the results to inform treatment planning, which are critical components of effective and ethical care for suicidal individuals (e.g., Jobes, Rudd, Overholser, & Joiner, 2008; Heilbron et al., 2010).

The Need for Sensitivity and Consistency

The measurement needs of epidemiologists differ from those of clinicians or researchers. Epidemiologists are interested in counting discrete outcomes (e.g., deaths). Primary care physicians do not need to know subtypes of self-destructive behaviors or the nuances of suicidal intentions or plans. They do need to know the

few screening questions to ask that will elicit an answer that broadly identifies the patient as requiring a referral to a mental health professional. The emergency department physician needs to know the criteria to determine whether the behavior being assessed will lead to further self-injury.

The clinical researcher needs to differentiate accurately among the population of persons who are engaged in self-destructive behaviors, and to be able to compare populations across research sites. Given the multidimensional aspects of suicidal thoughts and behaviors, the researcher needs to have valid and reliable criteria for allocating the study samples into discrete groups. The mental health clinician needs to know the specifics of the current ideation, intent, plans and actions, as well as the history of prior self-destructive behaviors (e.g., who, where, when, why, how much, how often) in order to determine which treatment approach has the best likelihood of succeeding. The mental health clinician also needs to determine what contribution a current mental disorder may add to the expression of self-destructive behaviors.

The Role of Nomenclature in Screening

One method of assessing the extent/degree of an individual's suicidal state is by using screening instruments to elicit signs and symptoms found to be associated with suicidal thoughts and actions. How the question is worded can determine the response, because the wording is a reflection of our understanding of the parameters, and cultural expression of the underlying construct that we are trying to measure. Take, for example, the commonly used question, "Have you seriously thought of killing yourself recently?" For this question, what does "seriously" mean? Does it matter to know whether the time frame is "recently," "last 2 weeks," "last month," "last 6 months," "last year," or "lifetime"? Without a specific definition and context of the construct being screened for, it becomes very difficult to interpret the response. Rarely are definitions of "suicide ideation/thoughts" and "suicide attempt" provided on screening instruments.

There are many assessment instruments to identify the presence of suicidal ideations and/or suicidal behaviors. However, they differ in terms of standard measures of validity, reliability, and clinical utility. They often lack clear definitions or assess for mutually exclusive behaviors. One striking limitation is that they do not all ask about all the multiple factors or characteristics that are considered to be suicide-related behaviors (Linehan et al., 2006; Meyer et al., 2010).

Recent Efforts to Clarify Suicidal Behaviors

The intent of this overview is not to present an exhaustive review of all the attempts to develop nomenclatures and classification systems for the study of suicide and suicide-related thoughts and behaviors, but to highlight some recent examples.

WHO/EURO Parasuicide Multicentre Study (1996–2001)

In the 1990s, the WHO embarked on the EURO/WHO Parasuicide Multicentre Study, which required a nomenclature to differentiate various suicidal behaviors (with a specific emphasis on the identification of parasuicidal behaviors) (De Leo et al.,

2004, 2006; Schmidtke et al., 2006). The use of the term *parasuicide* was based on Kreitman's definition of parasuicide as "a nonfatal act in which an individual deliberately causes self-injury or ingests a substance in excess of any prescribed or generally recognised therapeutic dosage" (Kreitman, 1977). As is evident, Kreitman's term avoids any reference to intent or motivation (Kreitman, 1977). In 1999, the study changed its original name ("Study on Parasuicide") into "Suicidal Behaviour." The study ended in 2001, after having involved 35 centers.

The study methodology included a list of 14 possible "intentions" and was able to reliably demonstrate the simultaneous presence of multiple motivations in suicidal individuals (Hjelmeland et al., 2002). Thus, the degree of lethality depends upon intention, preparation, planning, knowledge of the lethality of the method, and, in some cases, upon purely coincidental factors. One of the main outcomes of the study was a strong push toward focusing on the person (the actor) and a recognition of the importance of identifying suicide intention at the primary health-care level, including in emergency department settings (De Leo et al., 2004, 2006; Schmidtke et al., 2004).

After the study ended, members of the multicenter study revised the initial WHO nomenclature on the basis of some of their observations from the study (De Leo et al., 2004). They established the key components of fatal and nonfatal suicidal behaviors: self-initiated; with or without intent to die; and outcome. One criticism is that although they collapsed "parasuicide," "deliberate self-harm," and "attempted suicide" under one term, (i.e., "non-fatal suicidal behaviour"), this term can be applied with or without the presence of intent to die. Thus, intent to die is not a defining characteristic of suicidal behaviors. This system also does not account for the possibility of undetermined or uncertain behavioral states associated with intent to die.

Columbia University Suicidality Classification (2005)

Suicidologists at Columbia University were approached by the U.S. Food and Drug Administration (FDA) to assist them in reviewing all of the adverse event reporting associated with drug trials involving children and adolescents. The FDA was concerned about whether some of the adverse events being reported were appropriately being labeled as "suicidality." Under contract to the FDA, the Columbia team developed a "Classification Scheme"—which is a nomenclature of terms and definitions. These researchers reviewed all of the adverse events reports to determine how many actually were related to suicidal behaviors. The "Classification Scheme" was also used for the review of adverse event reporting for drug trials with adults (Posner et al., 2007). It was hoped that this classification scheme would ideally lead to a better systematic assessment of suicidality and improved identification of high-risk groups for research protocols (clinical registries).

Subsequent to conducting the FDA analysis, the Columbia group developed the Columbia Suicidality Severity Rating Scale (C-SSRS). This measures the degree of suicidal ideation and the level of lethality. Suicidal ideation is measured on a 1–5 point scale (from "wish to die," "active suicidal ideation," "method," "intent," to "plan"). Hence, the assessment of intent, motivation, and plans are part of the measurement of suicidal ideation. Suicidal behavior is measured on five levels: (1) actual attempt; (2) interrupted attempt; (3) aborted attempt; (4) preparatory act or behavior; and

(5) nonsuicidal self-injury. Lethality is measured on a 0–4 scale with the level of severity defined as the frequency, duration, controllability, deterrents, and reasons for ideation.

CDC Self-Directed Violence Surveillance System (2011)

In the spring of 2003, the CDC began to develop surveillance definitions for self-directed violence, on the basis of their prior work in developing surveillance definitions for other forms of violence. Over the ensuing years, this process included two major meetings of national experts in the field of suicidology and injury surveillance, as well as external (national and international) and internal review. The surveillance terms and definitions that were agreed upon are self-directed violence (analogous to self-injurious behavior), which can be categorized into nonsuicidal self-directed violence or suicidal self-directed violence; undetermined self-directed violence; suicide attempt, interrupted self-directed violence by self or other; suicide; and other suicidal behavior including preparatory acts. In 2011, *Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements* (Crosby et al., 2011) was published. When the training of surveillance personnel is completed, the Self-Directed Violence Classification System will be able, for the first time ever, to collect consistent data on suicide attempts nationwide (Crosby et al., 2011).

Denver VA VISN 19 MIRECC Self-Directed Violence Classification System (2012)

Beginning with the Silverman et al. (2007b) nomenclature as a template, researchers at the Denver Veterans Administration's Mental Illness Research, Education, and Clinical Care Center (MIRECC) collaborated with the CDC to develop a nomenclature and classification system that identifies both suicidal and nonsuicidal self-directed violence. The Self-Directed Violence Classification System has clinical utility and can be used across the U.S. Department of Defense and the Veterans Administration Hospital system (Brenner et al., 2011). There are 22 mutually exclusive terms and definitions that describe the range of suicidal thoughts and behaviors. The Self-Directed Violence Classification System focuses on the final pathway of clinical behaviors and outcomes rather than a taxonomy that includes etiology. This system is currently being used in clinical trials and in clinical settings within the Veterans Administration Hospital system.

Key Questions

Why do we need a classification system? How does it advance the identification, treatment, and prevention of suicide-related phenomena? A public health approach affords a framework to determine the incidence and prevalence of a public health problem, and the risk and protective factors associated with the problem, and offers clues as to the transmission or progression of the problem. In order to approach suicidal thoughts and actions from a public health perspective, we must first have the tools to conduct surveillance. One of the key tools is a classification system that accurately identifies and measures the problem.

I would argue that two of the most important goals in the field of suicidology are to prevent the onset and expression of suicide-related thoughts and actions, and to provide timely and appropriate interventions and management for those who already have expressed suicide-related thoughts and behaviors. Preventive interventions can take many forms, including health promotion, “upstream prevention,” stress reduction, mental health literacy, stress reduction, and so on. Therapeutic interventions can include psychotherapy, medications, hospitalizations, safety plans, resiliency training, and so on. Therapeutic interventions can also be seen as preventive interventions for those deemed to be at future risk, including those who have already expressed suicide ideations and behaviors, the survivors of those who have lost a loved one to suicide, those who have witnessed a death by suicide, or those suffering from psychiatric disorders.

We wish to know what characteristics and degrees of thoughts and actions (e.g., frequency, duration, timing, intensity) place an individual at continued risk in the present, near term, or future for similar thoughts and actions. We also wish to know which thoughts and/or actions are ones that require immediate, near-term, or long-term attention, and to what degree of intervention. For example, all suicidal ideations are not similar, suicide intent differs from suicide motivations, suicide planning can take make different forms, and suicide attempts can be stratified by level of intent, frequency, and lethality of means. Hence, which types or forms of ideation require more investigation, attention, and intervention? Is suicide planning a more developed extension or serious evolution of suicide ideation, or is suicide planning a separate classification from suicide ideation?

Future Directions

Variations in the way self-injurious and self-harm terms are defined and operationalized in relation to suicide ideation and behaviors have resulted in a diverse array of constructs, studies, and levels of analyses, few of which allow for satisfying systematic comparison. What is needed are studies that examine salient dimensions of suicidal thoughts and behaviors (subjective and structural) within and across contexts with an eye to contextual and demographic mediators, moderators, interactions, and group-level variations (Whitlock, Wyman, & Moore, 2014).

Furthermore, a classification system that meets the needs of all interested parties—epidemiologists, statisticians, researchers, clinicians, public health practitioners, and so on—must adhere to a framework and set of criteria. In the process of meeting the following criteria, a number of challenges and questions must be addressed:

Validation: No classification system has been fully tested to date in terms of determining whether the terms (and their definitions) actually accurately describe the phenomenology, and, in fact, separate out (e.g., distinctly classify) the range of thoughts, actions, and behaviors associated with the suicidal process.

Reliability: Is a specific classification system consistent over time with the same individuals and with similar populations? Another aspect is whether different clinicians or researchers (sometimes with different theoretical or cultural orientations) can reach agreement on which categories should be assigned for a particular presentation (inter-rater agreement or reliability; Sartorius et al., 1993).

Utility: Are the guidelines accompanying the use of the classification system easily understood? Are the essential components of each definition clearly understood or defined? Can we arrive at a specific classification category quickly (i.e., by the least possible number of questions asked or inquiries made)? Is it easy to use? Does it have clinical utility in different settings (outpatient; inpatient; emergency department; research lab)?

Generalizability: Does the classification system contain categories or terms suitable for dealing with the range of self-injurious presentations seen in different cultural settings and countries with different populations (“goodness of fit”)? In short, is the classification culturally sensitive, without theoretical underpinnings, translatable to other languages, and so on.

Comparability: None of the existing systems have been compared against each other using the same population of individuals with the range of suicide-related thoughts and behaviors (e.g., suicidal ideation, intent, planning, or attempt).

Predictability: What value does a classification system have in predicting or foreseeing further suicidal thoughts or behaviors? For example, does suicide ideation predict suicide attempts, or what types of suicide attempts predict eventual death by suicide?

Levels of Risk: There has never been a study that uses a well-defined and validated classification system to arrive at, or derive, levels of suicide risk. What combination of symptoms or behaviors, and to what degree (what are the essential characteristics of ideation, intent, planning, or attempt), are the essential elements for determining a level of risk (e.g., low, medium, high, acute)?

Outcome: Of utmost importance is whether the classification of individuals results in meaningful outcomes. In other words, there has never been a study linking specific interventions with specific classifications (e.g., suicide ideation, intent, planning, or attempt), or determinations of levels of risk. In short, what specific interventions work best for individuals classified as exhibiting suicidal ideation, intent, planning, or attempt? What interventions work best for individuals determined to be at low, medium, high, or acute risk?

Conclusions

Measures of suicide and nonfatal suicidal behavior continue to be hindered by the lack of a standard nomenclature and classification system (Brenner et al., 2011; De Leo et al., 2006; Silverman et al., 2007a, 2007b), clear operational definitions (Garrison, McKeown, Valois, & Vincent, 1993; Silverman & Maris, 1995), and standardized lethality measures (Berman, Shepherd, & Silverman, 2003).

Apart from the “traditional” difficulties in defining the range of nonfatal suicidal and self-harm behaviors, there remains the need for uniformity in classifying “ideation” (e.g., death wishes, morbid thoughts, suicide ideation, transient, chronic, intense). Standardization would be very useful in describing the attributes of: “survivors” of the death of a loved one or peer by suicide (e.g., bereavement, grief, mourning, surviving); those who have engaged in suicide attempts (e.g., lived experience); and those involved in euthanasia and assisted suicide (e.g., voluntary, involuntary, active, passive, self-euthanasia).

From an international perspective, for theoretical and traditional reasons, countries have been very divided in their use of terminologies. Internationalization of research

and the impact of electronic distribution of research findings and clinical observations have resulted in more pronounced difficulties in the comparability of research data and clinical guidelines in a cross-cultural dimension. For example, the implementation of the WHO START Study worldwide has highlighted the wide range of choices and traditions in labeling suicide-related phenomena. It is evident that cultural background, traditions, criminalization of suicide-related behaviors, stigma embedded in suicidal behaviors, health-system practices, and official recording procedures all combine to create serious obstacles to a sharable platform for labeling suicide-related ideations and behaviors in standardized ways.

Current difficulties in communicating among professionals as well as their patients include: limitations of hindsight bias and informant bias regarding the reporting of suicidal thoughts, intent, and behaviors (Duberstein & Conwell, 1997); difficulty in comparing and contrasting epidemiological surveys or clinical research studies; inconsistency of scale development and validation when most measures assume that the respondent already possesses a definition and understanding of the suicidal behaviors being measured; and lack of specificity and consistency of definition for such terms as suicide attempt, self-injurious behavior, and self-harm (Silverman, 2006). Furthermore, each clinical specialty, research group, or surveillance team has developed their own reporting forms and systems to gather similar information.

As a result, not only must we use the same terminology, but these terms must be easily understood, "user friendly," easily applied, and internally consistent. The terms must relate to each other in a way that has utility, meaning, and relevance to the real world of at-risk individuals.

Unless, and until, all members in the field of suicidology speak the same language and approach the classification of suicidal behaviors in a clear, concise, and consistent manner, communications among all those who work for the goal of suicide prevention will remain clouded.

Consensus in the development, implementation, and evaluation of clinical and preventive interventions is required (Silverman, 2006). All the components of the suicidal process then must be identified, labeled, and classified if we are ever to reach the point where we all can share information and observations to help identify and treat suicidal individuals and develop interventions to prevent the onset, maintenance, duration, intensity, frequency, and recurrence of suicidal thoughts and behaviors. Although challenging, and at times quite difficult, classifying individuals on the basis of the intent of their self-injury is a useful scientific and clinical endeavor (Nock & Kessler, 2006). Carefully defining key constructs, such as suicide attempts, will reduce variation in reporting and will enhance interpretation and communication of study results (Linehan, 1997; Meehan, Lamb, Saltzman, & O'Carroll, 1992).

Even if we are able to differentiate a range of self-destructive thoughts and behaviors into broad categories (such as suicide-related ideations, communications, and behaviors) and subcategories (such as suicide ideation, suicide attempt, and suicide), not all suicide ideations and behaviors are identical across domains (e.g., time, duration, frequency, context, degree of lethality, degree of planning). It would be a goal to have as few categories and subcategories as possible to classify individuals accurately, so that finer differentiations can be made among individuals presenting with self-destructive thoughts and behaviors.

Within each subcategory we need to provide more levels of detail and depth, to fully describe the clinical presentations in as many domains as possible. We need

to recognize and establish criteria for finer differentiation within each subcategory that are believed to be critical to understanding and classifying suicidal behaviors: levels of lethality, time frames, levels of intent, types of methods used, degree of planning, motivations, and so on.

In 2011, the National Academies of Science/Institute of Medicine released the report, *Toward Precision Medicine: Building A Knowledge Network for Biomedical Research and a New Taxonomy of Disease* (IOM, 2011). The report notes that a new taxonomy would integrate multiple parameters and “describe and define diseases based on their intrinsic biology in addition to traditional physical signs and symptoms; go beyond description and be directly linked to a deeper understanding of disease mechanisms, pathogenesis, and treatments; be highly dynamic, at least when used as a research tool, continuously incorporating newly emerging disease information”(p. 4). Although suicidal phenomena are not a disease, but a behavior (which may be influenced by underlying disease processes), there is a palpable lack of progress in our field toward developing a taxonomy for suicidal thoughts and behaviors that mirrors the above level of sophistication.

There remains a need for the establishment of an international task force to resolve differences among the existing nomenclatures, definitions, and classification systems. Such a Task Force on Nomenclature has been endorsed by the International Association for Suicide Prevention and the International Association for Suicide Research; however, it currently lacks funding to begin its work. The task force would try to generate an international nomenclature on all terms within the area of suicidology, inclusive of death wishes, assisted suicide, and bereavement. The aim is to obtain an international standardization of terminologies that may render research more comparable across the globe. Such a nomenclature must be compatible with DSM-5 and ICD-11, or at least provide a “crosswalk” between the agreed-upon terminology and these two disease classification systems. This would be an important contribution toward preventing suicide and suicidal behaviors.

The ultimate goal is to significantly lower the rates of suicides and suicidal behaviors, and lighten the burden these actions impose at all levels of our societies. To do so, it is critical to develop, validate, and adopt the best taxonomy in an iterative fashion, recognizing that behavioral symptoms or disorders may arise from multiple etiologies, and that the expression of these behavioral disorders involves interactions of innate and extrinsic factors. Developing a comprehensive and uniform nomenclature requires considerable collaborative effort on an international level.

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