PASSIVE SUICIDAL IDEATION: A CLINICALLY RELEVANT RISK FACTOR FOR SUICIDE

by

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Passive Suicidal Ideation: A Clinically Relevant Risk Factor for Suicide

Abstract

by

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Passive suicidal ideation has demonstrated a significant relationship with depression and suicide, making it an important component to include in suicide risk assessment. The present study examined passive suicidal ideation using a 2-item scale to determine how it relates to suicide risk in 180 depressed veterans from a psychiatric outpatient and day treatment program at the Louis Stokes Cleveland Veterans Affairs Medical Center. Participants were assessed for a depressive disorder using a structured clinical interview and completed self-report measures of depression, suicidal behaviors, hopelessness, and negative life events. Individuals with passive suicidal ideation scored significantly higher on measures of depression, suicidal behavior, and hopelessness than non-suicidal individuals and scored more closely to active ideators. Specific recent and past stressful life events appear to be related to experiencing passive or active ideation. Passive suicidal ideation is an important risk factor for suicide that should be routinely assessed by clinicians and physicians.
Introduction

Depression is a debilitating mental health issue affecting approximately 16.6% of Americans at any given point in their lives (Kessler, Chiu, Demler, & Walters, 2005) and can have profound effects on everyday functioning. Depression causes an enormous economic burden, with estimated costs at $83.1 billion in 2000 (Greenberg et al., 2003). These costs will likely continue to increase since depression is projected to be one of the top three leading causes of disease burden by 2030 (Mathers & Loncar, 2006). Not only are there significant economic costs associated with depression, but individuals with major depression and subclinical depression also have higher mortality rates (Cuijpers & Smit, 2002). Major depression causes the greatest decrement in health when compared with chronic diseases, such as angina and diabetes (Moussavi et al., 2007). Identifying risk factors and creating effective treatments are important to lessen the burden depression has on individuals and society.

Among depressed individuals, 60-70% experience some degree of suicidal ideation (Möller, 2003). Although not all individuals who experience suicidal ideation make a suicide attempt, about 30% of suicide ideators will eventually attempt (Nock, Borges, Bromet, Alonso et al., 2008). Among individuals with a history of one or more suicide attempts, 13-19% will actually die by suicide (Suominen et al., 2004). Additionally, of individuals who die by suicide, more than 90% are affected by at least one Axis I psychiatric diagnosis, often a form of depression (Henriksson et al., 1993).

Although depression is a risk factor for suicide attempts, not all individuals with depression will attempt or complete suicide. Levels of suicide risk are affected by the presence and severity of a variety of depressive symptoms, including weight or appetite...
loss, insomnia, feelings of worthlessness, and suicidal ideation (McGirr et al., 2007). Other factors affect the level of suicide attempt and completion risk, including prior psychiatric hospitalizations, substance use, stressful life events (DeJong, Overholser, & Stockmeier, 2010), and low self-esteem (Bhar, Ghahramanlou-Holloway, Brown, & Beck, 2008). Given there are a number of factors that affect suicide risk, it is tremendously important to identify the factors that are the most salient indicators in order to intervene at an optimal time.

Suicide Statistics: General and Veteran Populations

In 2010, suicide was the 10th leading cause of death for all ages (Murphy, Xu, & Kochanek, 2012) and accounted for over 35,000 deaths per year in the United States (Centers for Disease Control and Prevention (CDC), 2011). In individuals aged 10-54, suicide climbs to one of the top five leading causes of death (Xu et al., 2010). Estimates of U.S. adults show that 1.9-8.8% of people will attempt suicide at one point in their lives, 3.9% make a plan, and 5.6-14.3% express having suicidal thoughts (Nock, Borges, Bromet, Cha et al., 2008). Although the occurrence of suicidal thoughts, plans, gestures, or attempts in U.S. adults did not decrease during the 1990s, there has been an increase in individuals seeking treatment (Kessler, Berglund, Borges, Nock, & Wang, 2005). Given this discrepancy, individuals may not experience symptom relief even though they are actively seeking help. As a result, it is important to identify the most salient treatments for depression and suicide to effectively relieve symptoms in an efficient manner.

Veterans are two times more likely to die by suicide than non-veterans (Kaplan, Huguet, McFarland, & Newsom, 2007). Veterans seeking treatment from Veteran’s Affairs services have even higher rates of suicide, about seven or eight times that of the
general population (Zivin et al., 2007). Individuals in the veteran population often share many of the risk factors associated with suicide. Veterans are more likely to own and know how to use firearms (Kaplan, Huguet, McFarland, & Mandle, 2012; Sher, Braquehais, & Casas, 2012) and to be habituated to fear of painful experiences, including suicide (Sher et al., 2012). Veterans may be at an increased risk for death by suicide since these individuals have lethal means to act on their suicidal thoughts. Characteristics of veterans at elevated risk for suicide include being male, younger or older, non-Hispanic, depressed, substance using, and likely to have been hospitalized in the last year for psychiatric reasons (Zivin et al., 2007). Veterans with activity limitations and 12 years or more of education are at an increased risk for suicide (Kaplan et al., 2007). Additionally, elderly veterans who complete suicide are less likely than younger veteran suicide completers to have a psychiatric diagnosis and receive sufficient treatment (Thompson et al., 2002). Providing optimal treatment to veterans with a psychiatric diagnosis is important in reducing the likelihood that these individuals will attempt suicide. There is evidence that veterans are at greater risk for suicide, but empirical research has been relatively scarce in this population.

Models of Depression and Suicide

There are a number of models that attempt to explain the etiology of depression and suicide. Despite researchers’ efforts to provide a comprehensive model for use in the treatment and prevention of suicide, there is no one model that captures the complexity of suicide risk. Although there was an increase in treatment sought for emotional problems throughout the 1990s, the number of suicides remains quite stable (Kessler, Berglund,
Borges, Nock, & Wang, 2005), which speaks to clinicians’ lack of understanding about the path to suicide.

Current models of suicidal behavior follow a diathesis-stress framework in which psychological, biological, and psychiatric factors interact to increase suicide risk (Nock, Borges, Bromet, Cha et al., 2008). According to this model, individuals who attempt suicide have a biological dysregulation in the brain. This biological dysfunction alone is not related to suicidal behavior, but when a psychosocial stressor activates it, the risk for suicide increases (Mann, 2003).

Individuals may have cognitive distortions and negative beliefs about the world, others, and the self that can lead to long-term maladaptive behavior patterns and symptoms of depression (Kovacs & Beck, 1978), that overtime may increase risk for suicide. Within a suicidal crisis, an individual may experience a stressor that triggers the maladaptive cognitions and information processes biases that often characterize psychiatric disturbances. As the cognitions increase in frequency, intensity, and duration an individual may begin to experience suicidal ideation and/or behavior that illustrates an intent to end one’s life (Wenzel & Beck, 2008). Using a cognitive framework to understand suicide, hopelessness also emerges as a relevant risk factor (Beck, Brown, Berchick, Stewart, & Steer, 1990). Without hope for the future, individuals may turn to suicide as a way to escape from a difficult situation that they believe will not get better.

Although these two models provided valuable information to better understand depression, none of these models provides a fully comprehensive understanding for the etiology, course, and treatment of suicide. To address the gap in the literature surrounding comprehensive theories regarding suicide, researchers developed the Interpersonal
Theory of Suicide. This theory explains three constructs that are related to suicidal behavior: a lack of belongingness, perceived burdensomeness, and acquired capability for suicide (Van Orden et al., 2010). Repeated exposure to physically painful or fear-inducing experiences further increases the risk for suicidal behavior (Van Orden, et al., 2010). The more individuals experience negative life events, the greater the risk for suicide. Significant life stressors, particularly interpersonal conflicts, put an individual at a greater risk for suicide (Foster, 2011). The Interpersonal Theory of Suicide attempts to merge previous theories that address risk factors individually to create one valid theory.

Individuals who have depression are at risk for having suicidal ideation and attempting suicide (Möller, 2003; Nock, Borges, Bromet, Alonso et al., 2008). Although depressed individuals are at risk for suicide, not all depressed individuals will become suicidal. The severity of depression and level of suicidality is influenced by many factors. The aim of the present study is to better understand this progression and to be able to identify individuals who would most benefit from an intervention.

Researchers need to emphasize the importance of the current state of the individual when assessing suicide risk. Although there is evidence for traits that are associated with suicidal ideation, significant amounts of variance are left over after accounting for certain depressive traits (Goldston, Reboussin, & Daniel, 2006). Depression and suicide severity may heavily depend on the state of stress an individual is experiencing, which is influenced by outside factors, such as negative or stressful life events. Stressful life events are significantly more common among suicide completers when compared with living controls (Khan, Mahmud, Karim, Zaman, & Prince, 2008).
Some individuals who are confronted with these stressful life events may experience passive suicidal ideation, or a desire to die. Stressful life events are likely to propel someone to have suicidal thoughts, which begin as passive thoughts about desire for death. When a person experiences additional stressful life events, active suicidal ideation may occur, eventually leading to a suicide attempt. Adults 50 years of age and older who have family discord and a change in employment are at a greater risk for attempting suicide even after controlling for sociodemographic covariates (e.g. years of education completed, employment status, and total annual household income) and mental disorders (Duberstein, Conwell, Conner, Eberly, & Caine, 2004). Transient states of stress contribute to overall suicide risk. The current study will examine the role of stressful life events for individuals who may be at risk for suicide.

**Suicide Risk Factors**

Mood disorders substantially increase the risk for suicide given that 90-95% of individuals who die by suicide were previously diagnosed with a psychiatric disorder (Cavanagh, Carson, Sharpe, Lawrie, 2003). Not only are individuals with mood disorders at higher risk for suicide, but those with impulse-control difficulties, substance abuse, psychotic, and personality disorders are also at higher risk (Nock, Borges, Bromet, Cha et al., 2008). Comorbidity of these disorders further elevates suicide risk (Hawton, Houston, Haw, Townsend, & Harriss, 2003). Individuals with a psychiatric disorder may already be unstable and have difficulties with impulse control. Once these issues are coupled with other problems, including substance abuse, individuals may become more depressed and more likely to attempt suicide. If individuals with mood disorders have previously
attempted suicide, the characteristics of those past suicide attempts, including intensity and duration of crises, are also some the best predictors of future behavior (Joiner & Rudd, 2000).

Individuals with certain demographic characteristics are at greater risk for suicide, including those who are male (Nock & Kessler, 2006), divorced (Stack, 2000), separated (Kposowa, 2000), widowed at a young age (Luoma & Pearson, 2002), non-Hispanic White or Native American (Nock, Borges, Bromet, Cha et al., 2008), adolescents (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999), or older adults (Conwell, Duberstein, & Caine, 2002). Veterans are likely to have many of these characteristics, making them a population that is at high risk for suicide. Thought processes related to suicide risk include hopelessness about the future (Beck et al., 1990), feelings of burdensomeness (Joiner et al., 2002; Van Orden, Lynam, Hollar, & Joiner, 2005) and lack of reasons for living (Britton et al., 2008) or lack of life meaning (Orbach, Mikulincer, Gilboa-Schechtman, & Sirota, 2003). The present study will address some of these factors, including hopelessness and lack of life meaning, and determine how they relate to suicide risk.

Stressful Life Events and Suicide Risk

Stressful life events can have a serious impact on an individual’s levels of depression and risk for suicide. There are many types of events that may be particularly stressful, such as unemployment, divorce, assault, life-threatening illness, or serious interpersonal conflict. When compared with controls, suicide attempters had higher rates of acute stressful life events, such as partner conflicts and employment issues (Baca-Garcia et al., 2007). Within one week of a suicide attempt, 47% of individuals reported
conflict with a boyfriend, girlfriend, or spouse (Weyrauch, Roy-Byrne, Katon, & Wilson, 2001). Among individuals who attempted suicide, 63% experienced financial concerns and 53% experienced unemployment the week prior to the attempt (Weyrauch et al., 2001). Interpersonal conflict with a significant other and a loss of financial resources seem to increase risk for a suicide attempt.

Timing of adverse life events is also important to consider when assessing for suicide risk. Among first-time and repeat attempters, stressful life events occurring in the last 6 months were associated with an increased likelihood of attempt compared with non-attempters (Pompili et al., 2011). In repeat attempters, stressful life events occurring from birth to age 15 were also associated with an increased risk of a future attempt (Pompili et al., 2011). These findings suggest that recent stressful life events in first-time and repeat attempters make individuals more vulnerable to attempt suicide than if they had not experienced negative events. Additionally, individuals who have attempted suicide in the past, experiencing negative life events in childhood, may be at a greater risk for a subsequent attempt. Victims of childhood sexual abuse have been shown to have a greater likelihood of experiencing depression and self-harm, including suicidal ideation and suicide attempts, for both men and women (Boudewyn & Liem, 1995; Spokas, Wenzel, Stirman, Brown, & Beck, 2009). Childhood sexual abuse may lead individuals to experience more depressive symptomatology, which may lead to suicidal ideation and/or attempts. Childhood sexual abuse has also been shown to correlate with hopelessness (Meadows & Kaslow, 2002), a prominent predictor of suicide (Beck, Brown, et al., 1990).

**Suicidal Ideation Nomenclature**
Current suicidal ideation and a history of suicide attempts are important predictors for a future suicide attempt (Mann, 2002). Although not every individual who experiences suicidal ideation will attempt, about 30% of ideators will eventually attempt (Nock, Borges, Bromet, Alonso et al., 2008). Suicidal ideation puts an individual at greater risk for suicide, but there are still many individuals who do not ever attempt or complete suicide. The clinical importance of differentiating between ideators who will make an attempt from ideators who will not attempt is vital in order to better assess suicide risk.

Identifying individuals who are at highest risk for suicide attempts remains a challenge. Many researchers do not explore suicidal ideation thoroughly and consistent nomenclature is not currently used (Silverman, 2006). Suicidal ideation can be described in a variety of ways and ranges from ideas about death and dying to specific plans to attempt suicide. More generally, suicidality has become a comprehensive term describing many aspects of suicide from thoughts to behaviors, falling just short of death by suicide (Silverman, 2006). Using general terms, including suicidal ideation, does not allow for researchers and clinicians to better assess suicide risk. Without a consistent nomenclature, researchers’ definitions of various terms in suicidology will differ and prevent clinicians from being able to more effectively intervene with this at-risk population.

Consistent and specific definitions for various suicide terms would be beneficial for future research. Previous research conceptualized suicidal intent in two different ways: an implicit attempt, in which intent was inferred from a specific behavior, and an explicit attempt, in which intent was directly communicated by an individual (Linehan,
Similarly, the present study aims to differentiate between two types of suicidal ideation, passive and active, within the context of suicide risk assessment. Thoughts lead to actions. Having a better conceptual understanding of suicidal thoughts may provide insight into how individuals act (or not) on these thoughts. Identifying specific differences between active and passive suicidal ideation may allow clinicians to target individuals most at risk and provide the most effective treatment.

**Defining Active Suicidal Ideation**

Active suicidal ideation can be defined as any thoughts about harming oneself or plans for taking one’s own life (Schulberg et al., 2005; Raue, Meyers, Rowe, Heo, & Bruce 2007). Clinicians often view active suicidal ideation as the most significant predictor for suicide. Some researchers differentiate between individuals with active ideation alone and individuals who have both active ideation and a suicide plan or poor impulse control (Raue et al., 2007). The thought patterns associated with active ideation may differ from other forms of ideation. Teasing apart specific thought patterns may help to identify particular cognitions that put individuals most at risk for attempting suicide or dying by suicide.

**Defining Passive Suicidal Ideation**

There is evidence that passive suicidal ideation, or desire to die, is also an important factor to consider when assessing suicide risk (Baca-Garcia et al., 2011). Passive suicidal ideation can be viewed as feeling that life is not worth living or that the person would be better off dead if they were dead (Schulberg et al., 2005; Raue et al., 2007). One-third of individuals with a past suicide attempt had passive suicidal ideation, but no active ideation or plan (Baca-Garcia et al., 2011).
The cross-sectional nature of suicide research poses a challenge for furthering clinicians’ understanding of passive suicidal ideation. Longitudinally tracking suicidal individuals who pose a serious threat for their safety would be unethical without an attempt to intervene and provide treatment. If an individual at time one endorses items that are immediate red flags for suicide risk, the researcher has an ethical obligation to provide treatment to this individual. Although preventing a suicide attempt is of utmost importance to protect the welfare of participants, important information regarding longitudinal risk factors for suicide can be lost. As a result, cross-sectional data may not be ideal, but they are often used in suicide research due to its limited nature.

Understanding the decision to attempt suicide is crucial in order assess suicide risk. Though active and passive suicidal ideation both contribute to suicide risk, identifying the differences between these two groups may provide insight into the progression from suicidal ideation to suicidal behavior. Whether active suicidal ideators are at greater risk or equal risk compared to individuals with passive ideation, this information is clinically relevant and important. If similar levels of risk are present between active ideators and passive ideators, it is important for clinicians to assess both types of ideation to determine the best intervention strategy to prevent a suicide attempt.

In older adult patients ages 60 to 80 who are experiencing their second episode of a Major Depressive Disorder, active and passive ideators appear to be more alike than different on various measures (Szanto et al., 1996). Passive ideators were defined as individuals who described a passive death wish (e.g., feeling they would be better off dead). Active ideators were defined as individuals who reported a strong desire and a specific plan to commit suicide. Both active and passive ideators scored similarly on
measures of hopelessness, indicating the clinical importance of assessing for passive suicidal ideation (Szanto et al., 1996). Passive ideators may be at the same level of risk for suicide as active ideators. The present study aims to identify the similarities and differences between active and passive ideators to help clinicians more effectively assess suicide risk.

Active and Passive Suicidal Ideation in the Current Study

Considering the high rates of depression and suicide among veterans, this population could greatly benefit from research on suicide risk. Comparing and contrasting passive from active suicidal ideators is an important topic to consider in depression and suicide research. Although clinicians sometimes overlook passive suicidal ideation, it may be an important risk factor for suicide that requires additional consideration (Baca-Garcia et al., 2011).

In a recent study comparing individuals with active suicidal ideation and a passive desire for death (Baca-Garcia et al., 2011), the highest rate (25.9%) of a lifetime suicide attempt occurred in the group that had both active and passive suicidal ideation. Additionally, individuals with a passive desire for death had a higher rate of lifetime suicide attempts (5.41%) than individuals who expressed active suicidal ideation alone (2.75%) (Baca-Garcia et al., 2011). These findings suggest that assessing for passive suicidal ideation would be equally important as assessing for active suicidal ideation within the context of suicide risk. Moreover, assessing for both active and passive suicidal ideation provides even more clinically useful information because individuals who endorse both are at greatest risk for attempting suicide.
The present study will explore differences and similarities between passive and active suicidal ideators in a veteran population. Currently, researchers and clinicians do not see passive suicidal ideation as a significant risk factor for suicide since the desire may not seem as strong as in those with active ideation. A passive desire for death is still a desire that may put individuals at similar levels of risk to those with specific plans and intent. Exploring these differences and similarities may help identify additional salient predictors for suicide attempts that may have previously been overlooked, such as passive death wishes. Once identified, these predictors will allow clinicians to develop targeted treatments for veterans struggling with depression and suicide.

Specific Goals and Hypotheses

Despite empirically supported demographic risk factors for suicide, clinicians still fail to identify which individuals have the greatest risk for suicide. Depression is also a nonspecific risk factor for suicide, but is insufficient to identify who is most at risk. Although active suicidal ideation is a well-known risk factor for suicide attempt, additional research is needed to determine whether passive suicidal ideation contributes to clinicians’ understanding of suicidal behavior.

The current study examined the differences between depressed veterans with passive suicidal ideation, active suicidal ideation, and no suicidal ideation in a psychiatric outpatient and day treatment setting. Individuals with passive ideation endorsed two items, “I would be better off if I were dead” and “My family would be better off if I were dead”, reported not having any specific plan to attempt suicide, been thinking about suicide lately, or have a moderate to strong desire to kill themselves. Patients with active ideation endorsed items about having a specific plan for suicide, been thinking about
suicide lately, and have a moderate to strong desire to kill themselves. Some individuals in the active ideation group also endorsed the two above passive ideation items. Participants with no active ideation will have no desire to kill themselves, no specific plan, no recent suicidal thoughts, and do not feel they or their families would be better off if they were dead. Findings helped to determine whether passive suicidal ideation contributes to our understanding of suicide risk at a level comparable to active suicidal ideation.

To better understand suicidal behavior, the current study attempted to uncover whether these behaviors occur more frequently in individuals with active ideation than passive ideation. Although the data are cross-sectional, historical variables, such as past suicide attempts and stressful life events (both past and present), were assessed and may provide insight to help answer this question. Depression severity, degree of hopelessness, and suicidal ideation were assessed to better understand the relationship between depression and suicide. Stressful life events were explored to determine if they are related to lifetime suicide attempts and suicide risk. The presence of only past stressful life events in attempters may provide evidence that suicidal behaviors are trait-like and persist in the absence of an acute crisis. The presence of recent stressful life events may provide evidence that suicidal behaviors are state-like and dependent on external, situational factors, rather than internal characteristics of the individual. The present study aimed to determine which negative life events, past or present, are associated more with suicidal ideation. Findings may provide insight into how clinicians can most effectively target individuals at greatest risk for suicide.

_Hypotheses_
1. Individuals with active, passive, and no suicidal ideation will not differ significantly from one another on demographic factors, including age, race, gender, employment status, and marital status.

2. Participants who endorse the 2-item Passive Suicidal Ideation Scale will have significantly higher scores on the BDI-II, BHS, and BSSI when compared with non-suicidal participants. Passive ideators will score closer to active ideators than non-ideators on the BDI-II, BHS, and BSSI.

3. Individuals with passive suicidal ideation and individuals with active suicidal ideation are more likely to have a lifetime suicide attempt compared to individuals with no suicidal ideation.

4. Individuals with passive suicidal ideation and individuals with active suicidal ideation will have significantly more negative life events, both past and recent, than individuals with no suicidal ideation.

Method

Participants

Participants included 180 adult psychiatric outpatients recruited from the psychiatric Day Hospital program and from outpatient mental health clinics at the Veterans Affairs Medical Centers in Cleveland and Brecksville, Ohio. Individuals spoke English as their primary language and met diagnostic criteria for a depressive disorder according to the Structured Clinical Interview for DSM-IV (SCID: First, Spitzer, Gibbons, & Williams, 1995). Individuals were excluded from the study if any of the following criteria were met: (1) non-English speaking, (2) age less than 18 years, or (3) current diagnosis of bipolar disorder, dementia, schizophrenia, schizoaffective disorder,
mental retardation, or an organic brain syndrome. Outpatients with the above diagnoses were excluded because their depressive illness is likely to be distinctly different from patients who experience a primary diagnosis of depressive disorder.

A total of 180 participants provided informed consent to participate in the study. Forty (22.2%) individuals who did not meet criteria for a Major Depressive Disorder (MDD) were dropped from the analyses to keep the three ideation groups most similar to one another. A new total of 140 participants was used for subsequent analyses. Participants ranged in age from 27 to 76 years old (mean = 53.20, SD = 8.92). The majority of participants were Non-White (65.70%) male (81.40%) veterans. Most participants were unmarried (69.30%) and were currently unemployed (82.10%).

All 140 participants met criteria for a Major Depressive Disorder (MDD) based on the Structured Clinical Interview for DSM-IV (SCID: First et al., 1995). Diagnoses included Major Depressive Disorder (MDD), recurrent episode (n = 129, 92.1%) and MDD, single episode (n = 11, 7.9%). The duration of the current episode ranged from 2 weeks to 43 years, with a mean of 5.9 years.

Measures

*Structured Clinical Interview for DSM-IV* (SCID: First et al., 1995) is a semi-structured diagnostic interview used to assess for the presence of Axis I major mental disorders included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV: American Psychiatric Association, 2000). The frequency, chronicity, and severity of symptoms are assessed using a series of “yes or no” and open-ended questions. The first portion of the SCID contains a series of screening questions used to target key symptoms that require further investigation if endorsed by the patient. The latter parts of the SCID
contain sections for various classes of psychiatric diagnoses, including mood, psychotic, anxiety, substance use, somatoform, and eating disorders. After thorough evaluation of mood disorders, screening questions are asked for all other disorders. If an individual endorses a screening question for a particular section, the interviewer administers that specific module to assess for the presence or absence of core symptoms of the individual disorders. In the current study, each patient was asked all questions in the module for depression. The SCID is considered the most reliable and valid measure used to assess psychiatric disorders (Löwe et al., 2004). Concurrent validity for the SCID in diagnosing Major Depressive Disorder has been established with the Composite International Diagnostic Interview Version 3.0 (Haro et al., 2006) and the self-report Diagnostic Inventory for Depression (Zimmerman, Sheeran, & Young, 2004). Good interrater reliability (kappa = .84) and test-retest reliability (kappa = .93) have been confirmed for Axis I disorders (Schneider et al., 2004; Zanarini & Frankenburg, 2001).

All research staff completed all training requirements before beginning SCID administrations. First, all interviewers were expected to complete a full graduate course on psychiatric diagnosis. Second, all interviewers had to watch the official SCID training tapes, where they observed the SCID developers conduct a diagnostic interview. Then, novice interviewers were expected to observe a trained SCID interviewer in the completion of the SCID. Over several training sessions, the novice interviewer was expected to display skills in the explanation of the study, the request for participation, the consent process, the completion of all questionnaire measures, the completion of the SCID interview including an accurate scoring of the final diagnosis, thanking the
participant after all data has been collected, and providing feedback regarding the goals and purpose of the study.

*Beck Depression Inventory-II* (BDI-II: Beck, Steer, & Brown, 1996) is a 21-item self-report scale used to measure the presence and severity of affective, cognitive, somatic, and motivational symptoms of depression. Individuals were asked to choose from four statements and identify the statement that most accurately describes how they have been feeling over the past week. Individual items are scored 0 (neutral) to 3 (most severe). If an individual chooses more than one response, the most symptomatic item is scored. The total score for the BDI-II is a summation of the items and can range from 0 to 63, with higher scores indicating more severe depression. Scores of 0 to 19 indicate minimal to mild depression. Scores of 20 to 28 indicate moderate depression and scores of 29 to 63 indicate severe depression (Beck, Steer, & Brown, 1996). High internal consistency with coefficient alphas of .90 and above has been demonstrated among psychiatric outpatients (Beck, Steer, Ball, & Ranieri, 1996) and recent suicide attempters (Joe, Woolley, Brown, Ghahramanlou-Holloway, & Beck, 2008). One-week test-retest reliability of .93 has also been reported (Beck, Steer, & Brown, 1996). Convergent and discriminant validity have been supported in the literature. The BDI-II is positively correlated with the Hamilton Rating Scale for Depression in African Americans who have recently attempted suicide (Joe et al., 2008). In clinically depressed adult outpatients, the BDI-II is more positively correlated with the Depression subscale of the Symptom Checklist-90-Revised than the Anxiety subscale (Steer, Ball, Ranieri, & Beck, 1997), demonstrating both convergent and discriminant validity. Among older adults, the BDI-II is negatively associated with the Short Psychological Well-Being Scale, and
strongly and positively correlated with the Center for Epidemiologic Studies Depression Scale (CES-D) and the Perceived Stress Scale (Segal, Coolidge, Cahill, & O’Riley, 2008).

*Passive Suicidal Ideation Scale* is a new measure being evaluated in the present study. It is a 2-item scale designed to identify individuals who are currently experiencing passive suicidal ideation. Individuals respond “yes or no” to questions such as whether the participant feels he/she would be better off dead or if the participant’s family would be better off if he or she were dead. Individuals who respond “yes” to both questions are identified as passive ideators. If individuals respond “yes” to only one of the two questions, they were not included in the passive suicidal ideation category. These two questions were used to differentiate patients who display passive suicidal ideation from those who have active suicidal ideation or no suicidal ideation. Individuals in the passive ideation group cannot meet criteria for active suicidal ideation.

Although there is no scale being used to identify individuals with active suicidal ideation, there are specific criteria in the current study that must be met in order for an individual to be a part of the active ideation group. Participants must endorse specific items on the Beck Scale for Suicidal Ideation including “Have you been thinking about suicide lately?”, “I have a moderate to strong desire to kill myself”, and “I have a specific plan to kill myself”. Because these items were used to categorize individuals in the active suicidal ideation group, these items were excluded from the scale in subsequent analyses. Individuals currently experiencing active ideation may also by experiencing passive ideation simultaneously. Active ideators may also meet criteria for passive suicidal
ideation. In order to make clear distinctions between active and passive suicidal individuals, the above criteria must be met for both passive and active suicidal ideation.

Beck Hopelessness Scale (BHS: Beck, Weissman, Lester, & Trexler, 1974) is a 20-item self-report scale intended to measure one’s negative expectations about the future. Participants were asked to respond true or false to a statement based on how the statement applies to his/her future expectations. Each item is scored 0 or 1, with 0 being false and 1 being true. Nine items are keyed false and 11 items are keyed true, so that the total hopelessness score is a sum of the scores on the individual items. BHS scores range from 0 to 20, with higher scores indicating more negative views about the future. A score of 10 or more indicates severe levels of hopelessness and increased risk for suicide (Beck, Steer, Kovacs, & Garrison, 1985). Psychometric properties of the BHS in clinical and non-clinical populations have been adequate (Dozois & Covin, 2004). Adequate internal consistency has been demonstrated among psychiatric patients (Dyce, 1996; Young, Halper, Clark, Scheftner, & Fawcett, 1992). Correlations between BHS and BDI scores have been similar for university and clinical populations (Alford, Lester, Patel, Buchanan, & Giunta, 1995). BHS scores are significantly related to MMPI-2 scales that measure depression, low self-esteem, and self-alienation and unrelated to other personality scales, which supports the BHS’s convergent and discriminant validity (Thackston-Hawkins, Compton, & Kelly, 1994). The BHS can be used to identify individuals at high risk for suicide (McMillan, Gilbody, Beresford, & Neilly, 2007).

Beck Scale for Suicide Ideation (BSSI: Beck, Kovacs, & Weissman, 1979) is a 21-item self-report measure designed to identify the presence of suicidal thoughts and evaluate their severity. Patients rated each item on a scale of 0 to 2, with 2 being most
severe. The last two items address the number of previous suicide attempts and the intention to die with regard to the last attempt. The BSSI is useful in quantifying the degree of suicidal ideation in psychiatric patients and can serve as a warning sign when evaluating suicide risk (Steer, Kumar, & Beck, 1993). The BSSI has demonstrated strong internal consistency with coefficient alpha greater than .93 among psychiatric outpatients (Beck, Steer, & Ranieri, 1988; Holi et al., 2005), and .89 among psychiatric inpatients (Beck et al., 1979; Beck et al., 1988). Evidence of interrater reliability was found in a psychiatric inpatient sample (Beck et al., 1979). The BSSI has moderate test-retest reliability \((r = .54)\) with psychiatric inpatients (Beck et al., 1998). BSSI subscales of Motivation and Preparation are strongly correlated with number of previous suicide attempts and suicide intent as related to the most recent attempt, suggesting evidence of convergent validity (Holden & DeLisle, 2005). BSSI scores highly correlate with clinician ratings of suicidal ideation with correlation coefficients ranging from .90 for psychiatric inpatients to .94 for psychiatric outpatients (Beck et al., 1988). The BSSI also predicts suicidal ideation (Cochrane-Brink, Lofchy, & Sakinofsky, 2000). Individuals who score a 3 or higher are approximately seven times more likely to die by suicide than those scoring less than three (Brown, Beck, Steer, & Grisham, 2000).

*Modified Life Experience Scale* (MLES) is a self-report measure of current and lifetime stressors that has been modified from the original Life Experiences Survey (LES; Sarason, Johnson, & Siegel, 1978). The MLES consists of 21 stressful life events, including occupational difficulties, health complications, relationship problems, loss of loved ones and acts of violence. Subjects were asked to indicate whether or not each event occurred in their lives. If an event occurred, subjects must respond if it occurred
recently (within the past 3 months), long ago (more than 3 months ago), or both. Each item is scored 0-3 (0 = recently, 1 = long ago, 2 = never, 3 = both long ago and recently). The current study divided this scale into two components, one to measure recent life events and another to measure past life events. Each item on the measure of recent life events was scored (0 = no, 1 = yes) to reflect whether an individual had experienced an event either recently or both recently and long ago. A total score was found by summing the answers and ranged from 0-21, with higher numbers indicating more recent stressful life events. Each item on the measure of lifetime stressful events was scored (0 = no, 1 = yes) to reflect whether an individual had experienced an event long ago (more than three months ago). A total score was found by summing the answers and ranged from 0-21, with higher numbers indicating more lifetime stressful life events. Test-retest reliability was reported for the original LES (\(r = .63\) and \(r = .64\); Sarason et al., 1978). The LES is significantly correlated with a number of stress related measures, including the State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970), demonstrating adequate construct validity (Sarason et al., 1978). Specifically, the negative events subscale of the original LES is significantly correlated with measures of depression (Chang, 1997). Adaptations of the LES are regularly used in research (Bailey, Koepsell, & Belcher, 1984).

*Demographic information.* Participants were asked to give basic demographic information, including age, race, gender, employment status, and marital status.

*Procedures*

All study procedures have been approved by the Institutional Review Boards of both Case Western Reserve University and the Department of Veterans Affairs Medical
Center. Participants were recruited in a variety of ways. First, study flyers were placed in public waiting areas throughout the psychiatric Day Hospital and outpatient mental health clinics so that interested participants may contact the study coordinator. Also, various treatment providers (e.g. VAMC psychiatrists, psychologists, social workers, and nurses) were asked to distribute flyers to interested patients who met criteria for the study. Members of the research team contacted VAMC treatment providers directly to obtain names of patients who met criteria for the study. These patients were then contacted to set up a meeting time if they were interested and eligible to participate. Lastly, Dr. Josephine Ridley, Director of the Day Hospital program and Responsible Investigator of the study, recruited eligible patients from the psychiatric Day Hospital program.

After names of potential participants were given to the research team, members of the research staff may have opted to review the patients’ medical records to determine preliminary eligibility and avoid bringing in patients who may be ineligible for the study due to exclusionary diagnoses (i.e. bipolar disorder, dementia, schizophrenia, mental retardation, or an organic brain syndrome). Patients who contacted the research team in response to the flyer were also likely to have their medical records reviewed in order to rule out exclusionary diagnoses. During the initial telephone screening process, the research team asked potential participants basic screening questions related to depression to determine whether they were appropriate candidates for study participation, such as “Do you feel depressed most of the day, nearly everyday?”, “Have you noticed a loss of interest in things?” and “Have you ever been diagnosed with bipolar depression?”. If it was determined based on the potential participants’ answers to basic screening questions that the interested patients were eligible for the study, a member of the research team
scheduled a time to meet with the patient to complete all study procedures. Most interviews took place at the VAMC Wade Park facility, in a private room within Psychology Services.

All study visits were conducted by clinical psychology graduate students who have completed human subjects’ research training requirements and have been trained in all study procedures. Upon arrival at the VAMC, potential participants were escorted to a private room where a trained member of the research staff guided them through the consent forms. The purpose of the study, study procedures, risks and benefits of participation, and privacy and confidentiality were described in detail. Participants were encouraged to ask questions about participation. Individuals who agreed to participate in the study and sign the consent form then completed the SCID interview with the researcher in order to determine the presence of a depressive disorder and other comorbid diagnoses. Psychiatric diagnoses determined by the researcher were compared with diagnoses listed in the participants’ medical record. In the case of a significant discrepancy between SCID diagnosis and VAMC staff diagnosis, participants’ data were not included in the study. For example, if the SCID diagnosis is schizophrenia and the VAMC chart diagnosis is depression, these data were excluded. Because limited resources prevented the research team from obtaining inter-rater agreement regarding the SCID diagnosis, using the VAMC chart diagnosis for comparison allowed us to have a secondary validation of the patient’s diagnosis. Making sure there is agreement between the two diagnoses allows for greater confidence in the accuracy of a participant’s diagnosis. Following the SCID interview, participants completed a packet of self-report questionnaires. If a participant endorsed having thoughts about killing him/herself and
having a specific plan for an attempt, the director of the Day Hospital program was
notified immediately to intervene and ensure patient safety. Upon completion of the study
visit, the researcher compensated participants $10 in cash or gift card (depending on the
availability of funds) for their time.

A number of procedures were utilized in order to maintain confidentiality of
research participants. Each participant was assigned a unique identifier that cannot be
linked to any identifiable information. Study interview forms and questionnaires were
marked with the unique identifier, and the consent form was the only form with the
participants’ names. Consent forms were kept in locked cabinet in a locked office at the
VAMC separate from study data so participants identifying information cannot be
matched with their responses on questionnaires.

Data Analytic Plan

Descriptive Statistics

Descriptive statistics were used to describe the characteristics of this sample.
Distributions of gender, ethnicity, employment status, and marital status of the
participants will be calculated in addition to mean age. Mean scores and standard
deviations will be examined for the BDI-II, Passive Suicidal Ideation Scale, BHS, and
BSSI. Descriptive statistics were used to determine whether differences exist between
depressed individuals with active suicidal ideation, passive suicidal ideation, and
depressed individuals with no suicidal ideation.

Testing of Hypotheses
1. **Individuals with active, passive, and no suicidal ideation will not differ significantly from one another on demographic factors, including age, race, gender, employment status, and marital status.**

A chi-square test was used to assess for any mean differences among active, passive, and non-suicidal ideators on demographic factors, including race, gender, employment status, and marital status. A one-way between groups analysis of variance (ANOVA) was conducted to assess for mean age differences among these three groups. A significant difference among active, passive, and no suicidal ideators would be indicated by a significant $F$ value ($p \leq .05$). If the $F$ value is significant, a Tukey post-hoc test would be utilized to discover where the differences among the groups occur. Any significant demographic differences found were controlled for in further analyses.

2. **Participants who endorse the 2-item Passive Suicidal Ideation Scale will have significantly higher scores on the BDI-II, BHS, and BSSI when compared with non-suicidal participants. Passive ideators will score closer to active ideators than non-ideators on the BDI-II, BHS, and BSSI.**

A series of one-way between groups Analysis of Covariance (ANCOVA) were conducted to explore how depression severity (BDI-II), hopelessness (BHS), and suicidality (BSSI) contribute to the type of suicidal ideation an individual experiences. If demographic variables are found to be significant in the preliminary analyses, those variables will be entered as covariates. Participants were examined according to three groups: individuals with active suicidal ideation, those with passive suicidal ideation, and those with no suicidal ideation. The BDI-II, BHS, and BSSI were the dependent variables being evaluated. A significant difference among the three groups on mean BDI-II, BHS, and
BSSI scores would be indicated by a significant $F$ value ($p \leq .05$). If the $F$ value is significant, a Tukey post-hoc test would be utilized to discover where the differences between the groups occur.

3. **Individuals with passive suicidal ideation and individuals with active suicidal ideation will be more likely to have a lifetime suicide attempt compared to individuals with no suicidal ideation.**

A chi-square analysis was conducted in order to evaluate the relationship between type of suicidal ideation and a lifetime suicide attempt. A relationship between type of suicidal ideation and a lifetime past suicide attempt will be considered significant if the chi-square value is significant ($p \leq .05$). If the chi-square value is significant, a post hoc test cannot be utilized to discover where the differences between the groups occur. However, comparing the percentages of non-ideators, passive ideators, and active ideators who have ever attempted suicide can provide meaningful information.

4. **Individuals with passive suicidal ideation and individuals with active suicidal ideation will have significantly more negative life events, both past and recent, than individuals with no suicidal ideation.**

A series of one-way between groups Analysis of Variance (ANOVA) tests were conducted to explore differences between three types of suicidal ideation with regard to negative life events. Past and recent stressful life events were analyzed separately to determine whether timing of events affected the type of suicidal ideation an individual experienced. Past negative life events and recent negative life events were used as the dependent variables. Demographic factors (i.e. age, race, gender, employment status, and marital status), if found to be significant in preliminary analyses, will be entered as
covariates. A significant difference among the three groups on mean scores for past stressful life events and recent stressful life events would be indicated by a significant $F$ value ($p \leq .05$). If the $F$ value is significant, a Tukey post-hoc test would be utilized to discover where the differences between the groups occur.

Results

All statistical analyses were conducted with SPSS version 20.0. In the event of missing data, a number of rules were followed to ensure the integrity of the data. Participants missing 3 or more data points on a measure were dropped from analyses. Cases were excluded pairwise, meaning they were only excluded from analyses that required the missing data. For subjects who omitted only one or two items across all scales, the intermediate response option was inserted in its place (BDI = 1.5, BHS = 0.5, BSSI = 1). However, for participants who omitted one or more items on the MLES, those items were removed from their total score and not used in subsequent analyses.

Non-ideators ($n = 130$), passive ideators ($n = 24$), and active ideators ($n = 23$) were compared on various demographic variables. There were no significant differences between the three groups on age and gender. Significant differences occurred between the three groups with regard to race ($\chi^2 (2) = 5.92, p = .05$), marital status ($\chi^2 (2) = 6.73, p < .05$), and employment status ($\chi^2 (2) = 6.51, p < .05$). As anticipated, passive ideators and active ideators were more likely than non-ideators to have a history of suicide attempts ($\chi^2 (2) = 14.89, p < .05$) and prior psychiatric hospitalizations ($\chi^2 (2) = 14.33, p < .05$).

To keep the three groups most similar to one another, individuals without a diagnosis of Major Depressive Disorder were dropped from the study. Individuals with different depressive disorders, such as Adjustment Disorder or Dysthymia, may display
different symptoms patterns compared to those with Major Depressive Disorder. All 40 participants who were dropped belonged to the non-ideator group. Dropping participants who did not meet criteria for Major Depressive Disorder allowed us to more accurately investigate differences among the three ideation groups.

Non-ideators ($n = 93$), passive ideators ($n = 24$), and active ideators ($n = 23$) were compared on the same demographic variables and had similar results (see Table 1). There were no significant differences between the three groups on age and gender. Ethnicity ($1 = \text{White}, 2 = \text{Non-White}$), marital status ($1 = \text{married}, 0 = \text{unmarried}$), and employment status ($1 = \text{employed}, 0 = \text{unemployed}$) were coded in a dichotomous yes/no manner. Because the sample sizes of passive ideators and active ideators are substantially smaller than non-ideators, using dichotomous variables allows us to keep more degrees of freedom, allowing for more accurate estimations of variability between the three groups.

Significant differences occurred with regard to ethnicity ($\chi^2 (2) = 7.34, p = .03$), marital status ($\chi^2 (2) = 6.74, p = .03$), and employment status ($\chi^2 (2) = 7.42, p = .02$). As anticipated, passive ideators and active ideators were more likely than non-ideators to have a history of suicide attempts ($\chi^2 (2) = 13.77, p < .001$), have multiple suicide attempts ($\chi^2 (2) = 8.67, p < .05$), and psychiatric hospitalizations ($\chi^2 (2) = 9.20, p < .01$). There were no significant differences between groups regarding comorbid substance use disorders. Approximately 15% of the sample of 140 patients had a comorbid substance use disorder and about 13% had post-traumatic stress disorder. Because the length of depressive symptoms ranged from two weeks to forty-three years, a one-way between groups Analysis of Variance (ANOVA) was conducted to test for significant differences
among the groups. There were marginally significant differences between the three
groups on depression duration ($F(2,132) = 2.65, p = .07$).

Reliability analyses were conducted for each measure used in the study.
Cronbach’s alpha coefficients demonstrated internal consistency that ranged from good to excellent for each measure: Beck Depression Inventory-II ($\alpha = .90$), Beck Hopelessness Scale ($\alpha = .95$), Beck Scale for Suicide Ideation, ($\alpha = .94$), and the Modified Life Experience Scale ($\alpha = .81$). Because the two items in the Passive Suicidal Ideation Scale and the items used to categorize the active ideators are dichotomous, the reliability analyses were conducted using Kuder-Richardson Formula 20. This type of reliability measures the internal consistency of dichotomous items. The internal consistency of the two-item scale ($r = .96$) and the three active ideation items ($r = .93$) was excellent. Because there are only two items that make up the Passive Suicidal Ideation scale, caution regarding the confidence of the internal consistency of the items is warranted. Using additional items to categorize individuals with passive suicidal ideation would help increase confidence that the items are truly measuring the same construct. Because it is difficult to accurately measure reliability of a two-item scale, a chi-square analysis was conducted to determine the relationship between the two items. The results of the chi-square analysis revealed that the two items were significantly associated with one another ($\chi^2 (1) = 113.47, p < .001, \phi = 0.91$). There were 38 (27%) individuals in the sample who endorsed both passive suicidal ideation items and 93 (66%) individuals who did not endorse either of the two items. Of the 42 (30%) participants who believed they would be better off if they were dead, 38 (91%) also believed that their families would be better off if they were dead. Of the 41 (29%) individuals who believed their families would be
better off if they were dead, 38 (93%) also believed that they would be better off if they were dead.

The Passive Suicidal Ideation Scale

The Passive Suicidal Ideation Scale demonstrated convergent validity. The two items were positively correlated with BDI-II, BHS, and BSSI scores. Cohen’s (1988) guidelines for interpreting correlations were used: a correlation of .10 to .29 indicated a small effect, a correlation of .30 to .49 indicated a medium effect, and a correlation of .50 to 1.0 indicated a large effect. Individuals who felt they would be better off dead were more likely to have higher depression severity scores \(r (134) = .61, p < .01\), higher hopelessness scores \(r (132) = .61, p < .01\), and higher levels of suicidality \(r (127) = .83, p < .01\). Participants who felt their families would be better off if they were dead were more likely to have higher depression severity scores \(r (136) = .61, p < .01\), higher hopelessness scores \(r (134) = .60, p < .01\), and higher levels of suicidality \(r (129) = .77, p < .01\).

Items on the Passive Suicidal Ideation Scale were compared on demographic variables (see Table 2). An independent samples t-test was performed to examine differences in mean age and whether a participant endorsed the passive ideation items. There were no significant differences between mean age and responses to participants feeling they would be better off dead \((M = 51.88, SD = 8.03)\) compared to those that felt they would not be better off if they were dead \((M = 53.53, SD = 9.35, t (134) = 0.99, p = \text{ns})\). Similarly there were no significant differences between mean age and participants feeling that their families would be better off if they were dead \((M = 52.49, SD = 7.95)\).
compared to those who felt their families would not be better off if they were dead ($M = 53.39, SD = 9.37, t (136) = 0.54, p = ns$).

Chi-square analyses were conducted to explore associations between the remaining demographic variables and the passive suicidal ideation items. There were no significant differences between gender and individuals feeling they would be better off dead ($\chi^2 (1) = 0.30, p = ns$) and feeling their families would be better off if they were dead ($\chi^2 (1) = 0.35, p = ns$).

There were significant differences between employment status and participants feeling they would be better off dead and feeling that their families would be better off if they were dead. Individuals who were unemployed were significantly more likely to feel they would be better off if they were dead ($\chi^2 (1) = 6.35, p < .05$) and that their families would be better off if they were dead ($\chi^2 (1) = 5.87, p < .05$) than those who were employed. Significant differences occurred between ethnicity and participants feeling that they would be better off dead and participants feeling their families would be better off if they were dead. Significantly more Whites ($\chi^2 (1) = 7.45, p < .05$) felt they would be better off if they were dead and their families would be better off if they were dead ($\chi^2 (1) = 4.80, p < .05$) than Non-Whites. There were significant differences between marital status and participants feeling they would be better off if they were dead. Individuals who were not married were significantly more likely to feel that they would be better off if they were dead than married individuals ($\chi^2 (1) = 5.45, p < .05$). No significant associations occurred between marital status and individuals feeling that their families would be better off if they were dead ($\chi^2 (1) = 3.44, p = ns$).
Individuals who had a lifetime suicide attempt were significantly more likely to feel they would be better off dead ($\chi^2 (1) = 10.08, p < .01$) and feel that their families would be better off if they were dead ($\chi^2 (1) = 12.56, p < .01$) than individuals who had never attempted suicide. Similarly, participants who have ever been hospitalized for psychiatric reasons were significantly more likely to feel they would be better off dead ($\chi^2 (1) = 8.52, p < .01$) and feel that their families would be better off if they were dead ($\chi^2 (1) = 9.61, p < .01$) than those who have never been hospitalized for psychiatric reasons.

*The Active Ideation Items*

The three active suicidal ideation items demonstrated convergent validity. The items on the scale were positively correlated with BDI-II, BHS, and BSSI scores. Individuals who were thinking about suicide lately were more likely to have higher depression severity scores ($r (138) = .46, p < .01$), higher hopelessness scores ($r (134) = .51, p < .01$), and higher suicidality scores ($r (131) = .76, p < .01$). Participants who had a moderate to strong desire to kill themselves were more likely to have higher depression severity scores ($r (138) = .50, p < .01$), higher hopelessness scores ($r (134) = .57, p < .01$), and higher levels of suicidality ($r (131) = .87, p < .01$). Individuals who had a specific plan were more likely to have higher depression severity scores ($r (137) = .34, p < .01$), higher hopelessness scores ($r (133) = .44, p < .01$), and higher levels of suicidality ($r (133) = .72, p < .01$). The three active suicidal ideation items were all significantly related to one another (all $p$s $< .01$). Individuals who were thinking about suicide lately were significantly more likely to have a moderate to strong desire to kill themselves ($\chi^2 (1) = 94.96, \varphi = 0.82$) and a specific plan ($\chi^2 (1) = 86.78, \varphi = 0.79$). Individuals who had
a moderate to strong desire to kill themselves were significantly more likely to have a specific plan ($\chi^2(1) = 89.59$, $\phi = 0.80$).

There were 23 (16%) individuals in the sample who endorsed all three active suicidal ideation items and 102 (73%) individuals who did not endorse any of the three items. Of the 34 (24%) participants who had a moderate to strong desire to kill themselves, 24 (17%) also had a plan, and 29 (21%) were thinking about suicide lately. Of the 33 (24%) individuals who were thinking about suicide lately, 23 (16%) individuals also had a plan. Lastly, 24 (17%) had a specific suicide plan.

The active suicidal ideation items were compared on demographic variables (see Table 3). An independent samples t-test was performed to examine differences in mean age and whether a participant endorsed the active suicidal ideation items. There were no significant differences between mean age and responses to participants thinking about suicide lately ($M = 51.00$, $SD = 8.68$) compared to those who were not thinking about suicide ($M = 53.88$, $SD = 8.92$, $t(138) = 1.63, p = ns$). There were no significant differences between mean age and individuals having a specific suicide plan ($M = 52.96$, $SD = 7.00$) compared to those who did not have a plan ($M = 53.19$, $SD = 9.31$, $t(137) = 0.12, p = ns$). Similarly, there were no significant differences between mean age and individuals have a moderate to strong desire to kill themselves ($M = 51.65$, $SD = 8.02$) compared to those who did not have a desire to kill themselves ($M = 53.70$, $SD = 9.17$, $t(138) = 0.25, p = ns$).

Chi-square analyses were conducted to explore associations between the remaining demographic variables and active suicidal ideation items. There were no significant differences between gender and participants thinking about suicide lately ($\chi^2$
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\[ (1) = 0.75, p = \text{ns} \], having a specific plan \( (\chi^2 (1) = 0.01, p = \text{ns}) \), or having a desire to kill themselves \( (\chi^2 (1) = 0.47, p = \text{ns}) \).

White individuals were significantly more likely to be thinking about suicide lately than Non-White individuals \( (\chi^2 (1) = 3.86, p \leq .05) \). Whites were marginally more likely to have a desire to kill themselves than Non-White individuals \( (\chi^2 (1) = 3.25, p = .07) \). However, no significant differences occurred between ethnicity and individuals having a specific plan \( (\chi^2 (1) = 0.65, p = \text{ns}) \). Individuals who were unemployed were significantly more likely to have a desire to kill themselves than participants who were employed \( (\chi^2 (1) = 3.80, p \leq .05) \). Unemployed participants were marginally more likely to be thinking about suicide lately than employed individuals \( (\chi^2 (1) = 3.58, p = .06) \). However, there were no significant differences between employment status and having a specific plan \( (\chi^2 (1) = 1.84, p = \text{ns}) \). Individuals who have ever been hospitalized for psychiatric reasons were significantly more likely to be thinking about suicide lately \( (\chi^2 (1) = 5.79, p \leq .05) \) and have a desire to kill themselves \( (\chi^2 (1) = 5.67, p \leq .05) \) than individuals who had never been hospitalized for psychiatric reasons. However, there were no significant associations between a lifetime psychiatric hospitalization and having a specific suicide plan \( (\chi^2 (1) = 2.79, p = \text{ns}) \).

Participants who were not married were significantly more likely to be thinking about suicide lately \( (\chi^2 (1) = 5.55, p \leq .05) \), have a specific plan \( (\chi^2 (1) = 5.77, p \leq .05) \), and have a desire to kill themselves \( (\chi^2 (1) = 6.03, p \leq .05) \) than married individuals.

Individuals who have ever attempted suicide were significantly more likely to be thinking about suicide lately \( (\chi^2 (1) = 11.65, p \leq .001) \), have a specific plan \( (\chi^2 (1) = 11.87, p \leq .001) \), and have a desire to kill themselves \( (\chi^2 (1) = 11.12, p \leq .001) \) than those who have never attempted suicide.
.001), and have a desire to kill themselves ($\chi^2 (1) = 16.44, p \leq .001$) than individuals who had never attempted suicide.

**Depression Severity, Hopelessness, and Suicidal Ideation**

A series of one-way between groups Analysis of Covariance (ANCOVA) tests were conducted to explore differences between three types of suicidal ideation on depression severity, hopelessness, and suicidality. The three groups displayed some significant differences (see Table 4). The first ANCOVA examined the association of ideation type on depression severity, as measured by the BDI-II, with ethnicity, employment status, and marital status as covariates. The demographic covariates, ethnicity ($F (1,139) = 0.20, p = ns$), employment status ($F (1,139) = 0.06, p = ns$), and marital status ($F (1,139) = 0.01, p = ns$), were not significantly related to scores on the BDI-II. There was a significant difference in BDI-II scores across the three groups ($F (2,139) = 35.40, p < .001$). Post hoc comparisons using Tukey’s test indicated that passive ideators and active ideators scored significantly higher ($p < .001$) than non-ideators on the depression severity measure. Additionally, passive ideators and active ideators did not score significantly different from each other on the BDI-II.

The second ANCOVA was conducted to explore the impact of ideation type on levels of hopelessness, as measured by the BHS, with depression severity as a covariate. Since the demographic factors were not significant in the previous ANCOVA, they were not included in the following analyses. The covariate, BDI-II, was significantly related to scores on the BHS ($F (1,136) = 50.19, p < .001$). There was a significant effect of the three ideation types on levels of hopelessness after controlling for depression severity ($F (2,136) = 10.95, p < .001$). Post hoc comparisons using Tukey’s test indicated that
passive ideators and active ideators scored significantly higher \( (p \leq .007) \) than non-ideators on the measure of hopelessness. Furthermore, passive ideators and active ideators did not score significantly different on the BHS.

A third ANCOVA was conducted to explore the impact of ideation type on suicidality, as measured by the BSSI, with depression severity and hopelessness as covariates. Because two items (specific plan and desire to kill oneself) from the BSSI were used to categorize active ideators, these items were removed from the BSSI total score for the following analysis. The covariate, BDI-II, was not significantly related to scores on the BSSI \( (F(1,129) = 1.13, p = \text{ns}) \). The covariate, BHS, was not significantly related to scores on the BSSI \( (F(1,129) = 2.65, p = \text{ns}) \). There was a significant effect of the three ideation types on levels of suicidality after controlling for depression severity and level of hopelessness \( (F(2,129) = 88.33, p < .001) \). Post hoc comparisons using Tukey’s test indicated that passive ideators and active ideators scored significantly higher \( (p < .001) \) than non-ideators on the measure of suicidality. Additionally, passive ideators scored significantly lower than active ideators on the BSSI \( (p < .001) \).

**Analysis of Stressful Life Events**

A series of one-way between groups Analysis of Variance (ANOVA) tests were conducted to explore differences between three types of suicidal ideation with regard to stressful life events. Recent and past stressful life events were analyzed separately to determine whether timing of events affected the type of suicidal ideation an individual experienced.

The first ANOVA was used to explore mean differences between non-ideators, passive ideators, and active ideators on recent stressful life events. Recent events were
defined as having occurred within the last three months. The number of recent life events
was summed and analyzed to compare differences across the three groups (see Table 4).
There were no significant differences between the three ideation groups on the number of
recent stressful life events experienced ($F(2, 133) = 1.33, p = ns$).

A second ANOVA was used to explore mean differences between non-ideators,
passive ideators, and active ideators on past stressful life events. Past stressful events
were defined as having occurred sometime over the individual’s life, but the event must
have occurred more than three months ago. The number of past stressful events was
summed and analyzed to compare differences across the three groups (see Table 4).
There were no significant differences between the three ideation groups on the number of
past stressful life events experienced ($F(2, 136) = 0.27, p = ns$).

Although no significant results were found regarding the summation of recent and
lifetime past events, there is evidence to support that specific life events can are
associated with an individual experiencing suicidal ideation or displaying suicidal
behaviors. Additional analyses were conducted to assess differences between non-
ideators, passive ideators, and active ideators on specific stressful life events. A series of
chi-square analyses were conducted with specific items from the Modified Life
Experiences Scale (MLES) to identify stressful life events that may be related to one of
the three types of suicidal ideation.

The first series of chi-square analyses were used to explore mean differences
between non-ideators, passive ideators, and active ideators regarding recent stressful life
events that have occurred within the last three months (see Table 5). Significant
differences between non-ideators, passive ideators, and active ideators were found with
regard to being recently fired from a job ($\chi^2(2) = 6.28, p < .05$), being recently hospitalized for psychiatric reasons ($\chi^2(2) = 15.73, p = .001$), and recently attempting suicide ($\chi^2(2) = 6.90, p < .05$). The three groups did not differ significantly on being a recent victim of a violent crime, recently experiencing sexual abuse, recently having a romantic relationship end when the participant did not want it to, recent physical abuse, recently having a close family member or friend die, recently coping with a drug or alcohol problem, or recently being hospitalized for severe medical reasons.

The second series of chi-square analyses were used to explore mean differences between non-ideators, passive ideators, and active ideators regarding individual lifetime stressful events (see Table 6). Significant differences between non-ideators, passive ideators, and active ideators were found with regard to past sexual abuse ($\chi^2(2) = 8.74, p < .05$). The three groups of ideators did not differ significantly various past stressful life events: being fired from a job, a victim of a violent crime, having an unwanted end to a romantic relationship, being a victim of physical abuse, having a close family member or friend die, having a problem with drugs or alcohol, being hospitalized for psychiatric reasons, or attempting suicide.

Post hoc Analyses

In order to evaluate the potential utility of using the Passive Suicidal Ideation scale to differentiate passive ideators from non-ideators and active ideators, post hoc analyses were conducted. Exploring the relationships between a recent loss event, a lifetime suicide attempt, and type of suicidal ideation may provide additional information about how depressed individuals become suicidal.
First, a chi-square analysis was to explore mean differences between the three ideation groups and whether individuals experienced a recent loss event (see Table 7). The recent loss event included recent job loss, recently being “dumped” by a significant other, or recently experiencing the death of a close family member or friend. Non-ideators, passive ideators, and active ideators were compared on whether they experienced neither a recent loss event and/or a lifetime suicide attempt (0 = neither, 1 = loss event only, 2 = lifetime attempt only, 3 = both). There were significant differences between the groups ($\chi^2(6) = 15.99, p = .01$). Because the number of individuals per group would be quite low for subsequent analyses, percentages from the chi-square analysis were compared. A higher percentage of non-ideators (40%) experienced neither a recent loss event nor a lifetime suicide attempt, compared to passive ideators (25%) and active ideators (14%). A trend in the opposite direction appears when individuals experienced both a recent loss event and a lifetime suicide attempt. A higher percentage of active ideators (48%) belonged to this category, compared to only 17% of non-ideators and 21% of passive ideators.

**Discriminant Analyses**

A series of discriminant analyses were conducted to determine if specific clusters of items could distinguish the three groups from one another (see Table 8). Significant demographic variables, including ethnicity, employment status, and marital status were able to distinguish people in each ideator group with Wilks’ lambda = .87 ($p = .02$, $df = 6$). These items correctly classified people into their respective groups at a rate of 42.9%, which is higher than what we would expect by chance (33%).
A second discriminant analysis was used to determine whether a lifetime suicide attempt could differentiate individuals from each of the three ideator groups. Demographic variables in addition to a lifetime suicide attempt were able to distinguish the three groups from one another with Wilks’ lambda = .84 ($p < .001$, $df = 8$). Using demographic variables and a lifetime suicide attempt correctly identified individuals 60.6% of the time, which is significantly higher than what we would expect by chance (33%) or by using demographic variables alone (42.9%).

The last discriminant analysis was conducted to determine whether a recent loss event could differentiate individuals from each of the three ideator groups. A recent loss event, in combination with demographic variables and a lifetime suicide attempt, was able to distinguish the three groups from one another with Wilks’ lambda = .75 ($p < .001$, $df = 10$). The percent of correctly identified individuals rose only slightly from 60.60% to 61.8%. A recent loss event did not substantially increase the model’s ability to categorize participants into the correct ideation group. However, individuals’ responses to whether they have ever attempted suicide significantly increase the likelihood that the model will correctly categorize participants into their ideation groups.

Discussion

The present study examined three groups of depressed, psychiatric outpatients at a Veterans Affairs Medical Center. Depressed patients with no suicidal ideation, passive suicidal ideation, and active suicidal ideation were compared on measures of depression, hopelessness, and suicidality. The three groups some displayed significant differences on demographic factors, including ethnicity, employment status, and marital status. Participants reported a significant degree of depressive symptoms. Mean scores on the
Beck Depression Scale (BDI-II) were elevated for all three groups, placing participants in the moderate to severe range (Beck, Steer, & Brown, 1996). Mean scores on the Beck Hopelessness Scale (BHS) demonstrated that non-ideators reported mild levels of hopelessness, while passive ideators and active ideators reported severe levels of hopelessness. Consistent with hypothesis two, passive and active ideators scored significantly higher than non-ideators on measures of depression, hopelessness, and suicidality. There were no significant differences between passive and active ideators on measures of depression, hopelessness, and suicidality.

Because passive ideators scored more closely to active ideators, the data in the present suggest that passive ideators have a higher degree of depression severity, hopelessness, and suicide risk than non-ideators. The strong relationship between depression severity and suicidal ideation has been replicated repeatedly (Bostwick & Pankratz, 2000; Nock, Hwang, Sampson, & Kessler, 2010). The findings in the present study confirm past research (Szanto et al., 1996) that passive ideators and active ideators tend to have higher levels of hopelessness than non-ideators. Given this information, passive ideation should be considered a significant risk factor for a suicide attempt, comparable to the risk that is currently associated with active ideation. However, active ideators scored higher than passive ideators on the measure of suicidality, but passive ideators still scored significantly higher than non-ideators. This suggests that the BSSI may be a useful clinical tool to differentiate patients with passive ideation from patients with active ideation.

These findings have important clinical implications. Because many clinicians only assess for active suicidal ideation, they are likely not identifying patients who may be at
significant risk for a suicide attempt. Individuals with passive suicidal ideation have similar rates of past suicide attempts as individuals with active ideation. Considering that characteristics of prior suicide attempts are significant predictors of future attempts (Joiner & Rudd, 2000), passive ideators are at significant risk for a future attempt. The present study demonstrated that the assessment of passive suicidal ideation is an important part in reducing the risk for future suicide attempts. These findings are particularly relevant for the veteran population. Because many veterans have knowledge of and access to firearms (Kaplan, et al., 2012; Sher, et al., 2012), it is important for clinicians to assess for passive suicidal ideation to intervene before the veterans make and potentially execute a plan for suicide.

Past research has shown that a negative life event occurring within 6 months can greatly increase the risk for suicide (Pompili et al., 2011). Contrary to our hypothesis, non-ideators, passive ideators, and active ideators did not demonstrate a significant relationship with recent stressful life events. Passive ideators and active ideators did not experience a greater number of recent stressful life events than non-ideators. Previous research suggests that individuals who attempted suicide had higher rates of partner conflicts and employment issues than individuals who did not attempt suicide (Baca-Garcia et al., 2007). Items pertaining to interpersonal conflict and occupational status from the Modified Life Experiences Scale (MLES) were analyzed individually. The analysis of individual items from the Modified Life Experiences Scale (MLES) showed some significant differences between the three ideation groups.

There was a significant difference in the rate of recent job loss among non-ideators, passive ideators, and active ideators. The percentage of non-ideators who had
been recently fired from a job (8.70%) was much lower than the percentage of both passive ideators (25.00%) and active ideators (23.81%). Individuals who lost their jobs within the last three months may be at greater risk for having suicidal ideation, either passive or active, and may be at risk for attempting suicide. Individuals who recently lost their jobs are likely to be under significant stress. This enormous amount of stress may cause significant distress for some individuals and may cause them to start thinking that suicide is an escape from their financial difficulties. A job provides a purpose and a role in many people’s lives, acting as a protective social factor from suicide (Durkheim, 1897). Once this social integration and role is lost, individuals may feel they no longer belong to a particular group and may see themselves as a burden to society or their families. Previous research has demonstrated that thwarted belongingness and feelings of burdensomeness were significantly related to suicidal ideation after controlling for depression severity (Joiner et al., 2009; Van Orden et al., 2008). However, the cross-sectional data in the present study do not allow us to determine causality. It is difficult to determine whether individuals were feeling depressed and suicidal causing them to be less productive and, in turn, lose their job, or that individuals lost their job and then became depressed and suicidal. In future studies, it would be important to record data that explains why an individual lost his or her job to try to determine the causal relationship between suicidal ideation and recent job loss. Although participants’ self report may be biased, it may provide valuable information to determine whether they were unable to work because of depression or if losing their job propelled them into a depressive episode that included suicidal ideation.
The present study found that non-ideators, passive ideators, and active ideators differed significantly with regard to lifetime suicide attempts. The percentage of non-ideators who previously attempted suicide is much less (25.81%) than both passive ideators (45.83%) and active ideators (65.22%). Given higher rates of past suicide attempts among passive ideators and active ideators, this information is important when assessing future suicide risk. Because the characteristics of previous suicide attempts are some the best predictors of future behavior (Joiner & Rudd, 2000), individuals who have had a previous attempt and have either passive or active ideation may be at elevated risk for a future attempt. This finding is consistent with previous research in older adults, which found that non-ideators had a significantly lower number of suicide attempts than passive and active ideators (Szanto et al., 1996). Identifying individuals who have passive ideation or active ideation may provide clinicians with the ability to intervene with patients who are at an elevated risk for a suicide attempt.

Active ideators had a higher rate of past attempts than passive ideators, but still nearly half of passive ideators had previously attempted. The data are cross-sectional, therefore it is impossible to predict future suicide attempts using these data. Perhaps individuals who are currently experiencing passive ideation and have previously attempted suicide have not yet reached the same level of suicide risk severity as those with active ideation. Other factors, such as a build up of stressful life events, may propel someone to cross over the line from passive ideation to active ideation. Similarly, individuals who experience passive ideation but who have not had a previous attempt may never reach the point of active ideation. Furthermore, they may also never reach the point where they would eventually make an attempt.
Based on the present findings, clinicians should interpret passive suicidal ideation as a serious risk factor for a suicide attempt. It is extremely important for clinicians to assess for passive suicidal ideation, not just for active ideation. Even though individuals may not have an active suicide plan or a strong desire to die, they are likely to still be at significant risk for suicide. The new Passive Suicidal Ideation Scale is a clinically useful tool to assess suicide risk. In addition to asking questions about suicidal intent and whether the individual has a specific plan, asking the two passive suicidal ideation questions may be extremely beneficial in reducing risk for a suicide attempt. If individuals endorse feeling that they would be better off dead and that their families would be better off if they were dead, clinicians should take this information as a serious threat to their patients’ safety. The precautionary protocol that is in place for individuals who endorse active ideation should be taken when individuals also endorse passive ideation to reduce the likelihood of a suicide attempt. Providing treatment that addresses maladaptive thought patterns might be an important intervention strategy for individuals experiencing passive suicidal ideation. The findings from the present study support recent research (Baca-Garcia et al., 2011), which argues that passive suicidal ideation is a significant risk factor for a suicide attempt. Asking an individual about desire for death, or passive suicidal ideation, may provide information that is equally valuable to the assessment of active suicidal ideation when considering an individual’s risk for suicide.

The Passive Suicidal Ideation Scale used in the present study may provide a common nomenclature for clinicians to use when speaking about passive suicidal ideation. Given that rates of suicide continue to remain stable even though individuals continue to actively seek help (Kessler, Berglund, Borges, Nock, & Wang, 2005),
Clinicians need more effective ways of identifying individuals who are at most risk for suicide. The Passive Suicidal Ideation Scale may be a way for clinicians to categorize individuals who do not meet criteria for active suicidal ideation, but who also do not fit into the non-ideator group. Providing another level of depression and suicide severity between non-ideators and active ideators may help identify more individuals who are at serious risk for attempting suicide that may have previously been overlooked.

Using a common vocabulary to distinguish specific differences between non-ideators, passive ideators, and active ideators is crucial for future research. Researchers need to develop a common vocabulary regarding suicide to continue to help clinicians develop the most efficacious intervention strategies for individuals at greatest risk. Differentiating between those who experience passive ideation from those who experience active ideation on a consistent basis can allow researchers to target interventions for each individual group. Certain interventions may be more useful for passive ideators than active ideators. Without a common nomenclature, these differences between groups cannot be studied on a consistent, valid, and reliable basis. The present study begins the process of more fully understanding the differences between non-ideators, passive ideators, and active ideators with regard to suicide risk. This knowledge can be applied to future research on other populations and determine if passive suicidal ideation is found to be a consistent risk factor for suicide.

Whether researchers view suicidal ideation as a state-like phenomenon or a trait-like phenomenon, identification of passive ideation provides useful information to identify individuals who are at risk for suicide. Some researchers (Szanto et al., 1996) believe that suicidal ideation can result from a transient state of stress from a negative life
event that can be treated as a symptom of depression. If this assumption is true, intervening with individuals who are experiencing passive suicidal ideation may result in a de-escalation of suicidal ideation before an individual reaches active suicidal ideation. Intervening at the passive suicidal ideation stage may prevent the individual from actually making a suicide attempt. On the other hand, there may be evidence that a small subset of depressed individuals who experience suicidal ideation as a trait-like quality (Szanto et al., 1996) and is not just a symptom of depression. In this subset, it is more common for individuals who are experiencing suicidal ideation to make an attempt. If this hypothesis is valid, then it is important to consider how to intervene with this subset of individuals, which may require more intensive treatment intervention strategies.

Based on the findings of the present study, there is evidence that suicidal ideation results from a trait-like quality within the individual, not as a result of recent life stressors. There were no significant differences between non-ideators, passive ideators, and active ideators on the number of recent negative life events they experienced. After individual items were analyzed separately the only significant difference between groups, aside from a recent suicide attempt and psychiatric hospitalization, was being recently fired from a job. Moreover, the presence of a recent loss event did not significantly increase the accuracy of ideation group membership after a lifetime suicide attempt had been taken into account. It is possible that the current sample experienced suicidal ideation as a trait-like quality because recent life events seem to have little to no relationship with suicidality. Moreover, more than half (52%) of active ideators previously experienced sexual abuse, compared to 38% of passive ideators and 22% of non-ideators. The data do not give information about how long ago the sexual abuse
occurred. However, individuals who experienced sexual abuse as a child may have this trait-like quality that makes them more prone to becoming suicidal. Childhood sexual abuse may be a non-specific risk factor for suicide, similar to a diagnosis of depression.

Out of the 140 participants with Major Depressive Disorder, 47 (33.6%) were currently experiencing suicidal ideation. These individuals may have this trait-like quality that predisposes them to be at greater risk for attempting suicide. Individual recent negative life events, as measured in the current study, provide little additional information for clinicians to better predict the level of suicide risk for their patients. Therefore, it is important for clinicians to understand that individuals who have attempted suicide in the past are more likely to have future attempts even without the presence of recent stressful life events.

Individuals who experienced both a recent loss event (job loss, being “dumped” by a significant other, and experiencing the death of a close family member or friend) and had a lifetime suicide attempt were more likely to be currently experiencing active ideation. Approximately 48% of active ideators had both a recent loss event and a lifetime suicide attempt, compared to 21% of passive ideators and 17% of non-ideators. The combination of a recent loss event and prior suicide attempts are significantly related to individuals experiencing active suicidal ideation. Individuals who experienced recent loss and a prior attempt are more likely to have current active suicidal ideation and should be considered as high risk for subsequent attempt. However, a significant number of passive ideators (25%) did not experience a recent loss event, but had attempted suicide at some point in their lives. These individuals may be at risk for becoming active ideators if they experience a loss event in the near future. Assessing whether clients have
experienced a significant loss in their lives or have ever attempted suicide provides useful information when assessing suicide risk.

The findings from the present study are of particular relevance for the veteran population. There is little to no previous research investigating the role of passive suicidal ideation on a veteran population. Since veterans are twice as likely to die by suicide than non-veterans (Kaplan, Huguet, McFarland, & Newsom, 2007), better suicide assessment tools are needed in the veteran population. If clinicians can identify and intervene with veterans who endorse passive suicidal ideation before they reach the point of being actively suicidal, it is likely that fewer veterans will attempt and/or die by suicide. After a veteran has a plan and intent, it may be more difficult to intervene. However, if clinicians can identify veterans with passive suicidal ideation before they become actively suicidal, the risk of death by suicide will likely decrease.

In future studies, it would be beneficial to test the Passive Suicidal Ideation Scale on a general population that is more representative instead of looking only at a veteran population. If the present study’s results can be generalized to other populations, there are significant clinical implications. If passive ideators are found to be at a similar level of depression severity, then it is crucial for clinicians to begin screening their clients for passive ideation. Active ideation does provide meaningful evidence that an individual is at risk for suicide, but there is also evidence that passive ideators may be at a similar level of risk for suicide.

The use of a Passive Suicidal Ideation Scale provides valuable information about suicide risk. In future studies, it may be beneficial to increase the number of items on the scale to ensure the construct of interest, passive suicidal ideation, is being accurately
identified. When time and money are limited, however, the 2-item scale used in the present study may provide a cost-effective alternative. In a hospital setting where patients are often seen quite briefly, this brief 2-item scale may provide valuable information to clinicians and physicians to assess suicide risk.

The present study had a number of strengths. First, all data were collected with a clinical population. All individuals were seeking treatment for depression on an outpatient basis, either through the day hospital program or by a therapist and/or psychiatrist at the VAMC. Second, we were able to gather data on 140 veterans who had a moderate to severe depression diagnosis, Major Depressive Disorder. Of those 140 people, 47 were experiencing either passive or active suicidal ideation at the time of data collection. It can be difficult to recruit enough participants who are currently experiencing suicidal ideation for data analyses. Having access to patients in the day hospital program at the VA allowed us to gain access to more of these individuals. Third, we did not rely solely on questionnaire data from participants. Incorporating a semi-structured diagnostic interview allowed the researchers to gain a clinical picture of every participant. Moreover, the use of semi-structured interviews and clinician-administered suicide has been shown to significantly increase the accuracy of classification of individuals at most risk for suicide (Bongiovi-Garcia et al., 2009).

The present findings should be considered with the following potential limitations. First, some of the research data were collected by self-report questionnaires. Self-report assessments are prone to significant errors and biases related to the recall of autobiographical memories (Shiffman & Stone, 1998). Self-report is also subject to response bias and social desirability bias that can compromise the accuracy of the data.
Self-report data were collected to assess depression severity, levels of hopelessness, and levels of suicidality. A semi-structured diagnostic interview was also conducted to gain a clinical picture of participants and increase accuracy with regard to suicide risk. Second, due to a lack of current resources, inter-rater diagnostic agreement on the well-validated semi-structured diagnostic interview (SCID) could not be obtained to assess the presence of DMS-IV Axis I clinical disorders. Third, the current study did not include longitudinal follow-up data. No conclusions can be made about the predictive ability of any of the variables assessed. If longitudinal data were collected, it would allow us to examine if passive suicidal ideation predict futures suicide attempts. However, if a patient was assessed and found to be at risk for suicide, it was imperative that the researcher follows the study protocol and provides an intervention for a high-risk patient.

The sample in the current study has some potential limitations. Participants consisted of predominantly of male veterans, making the generalizability of the study limited. On rare occasions, participants mentioned that they were currently applying to obtain psychiatric disability from the government due to their psychiatric diagnosis. Veteran participants seeking governmental compensation may result in overreporting and distortion of symptoms that can prevent the accurate assessment of depression (Frueh, Gold, & de Arrellano, 1997). To address this potential issue during the detailed informed consent process, interviewers told participants that their answers had absolutely no bearing on their disability evaluations.

Passive suicidal ideation plays a significant role in the assessment of suicide risk. If individuals believe they would be better off dead and that their families would be better
off dead, they are at a significant risk for a suicide attempt. Although active suicidal ideation has been a focal point in research on suicide risk, individuals with passive suicidal ideation are at a similar level of risk. Similar scores on measures of depression, hopelessness, and suicidality between passive and active ideators suggests that both types of suicidal ideation should be interpreted as significant and requiring intervention. The present study raises an important point for our future data collection at the VAMC. In order to keep patients as safe as possible, researchers need to treat passive suicidal ideation as a serious risk factor for suicide. Precautionary protocol that is already in place for individuals with active suicidal ideation should also be applied to individuals with passive suicidal ideation. A more widespread use of the Passive Suicidal Ideation Scale by clinicians at the VAMC and in other settings may reduce the rates of individuals attempting and dying by suicide.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-Ideators (n = 93)</th>
<th>Passive Ideators (n = 24)</th>
<th>Active Ideators (n = 23)</th>
<th>Significance Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, M (SD)</td>
<td>53.55 (9.39)</td>
<td>52.25 (8.20)</td>
<td>52.78 (7.10)</td>
<td>$F(2, 139) = 0.23$</td>
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<tr>
<td>Gender (% Male)</td>
<td>87.64</td>
<td>85.71</td>
<td>85.71</td>
<td>$\chi^2(2) = 0.09$</td>
</tr>
<tr>
<td>Ethnicity</td>
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<td></td>
<td></td>
<td>$\chi^2(2) = 7.34^*$</td>
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<td>54.17</td>
<td>43.48</td>
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<td>45.83</td>
<td>56.52</td>
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<td>% African-American</td>
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<td>41.67</td>
<td>56.52</td>
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<tr>
<td>% Asian</td>
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<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>% Other</td>
<td>5.38</td>
<td>4.16</td>
<td>0.00</td>
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<tr>
<td>Marital Status (% married)</td>
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<td>21.74</td>
<td>8.70</td>
<td>$\chi^2(2) = 6.74^*$</td>
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<td>% First Marriage</td>
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<td>8.70</td>
<td>0.00</td>
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<tr>
<td>% Remarried</td>
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<td>0.00</td>
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<td>% Separated</td>
<td>10.11</td>
<td>13.04</td>
<td>4.35</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2005</td>
<td>2010</td>
<td>2015</td>
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<td>--------------------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>% Single, Never Married</td>
<td>22.47</td>
<td>30.43</td>
<td>34.78</td>
<td></td>
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<td>% Divorced</td>
<td>34.83</td>
<td>47.83</td>
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<tr>
<td>% Widowed</td>
<td>3.37</td>
<td>0.00</td>
<td>8.70</td>
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<tr>
<td>% Cohabitating</td>
<td>4.49</td>
<td>0.00</td>
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<tr>
<td>Employment (% employed)</td>
<td>18.60</td>
<td>0.00</td>
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<td>$\chi^2 (2) = 7.42^*$</td>
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<td>% Full-time</td>
<td>12.79</td>
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<tr>
<td>% Part-time</td>
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<tr>
<td>% Unemployed</td>
<td>47.67</td>
<td>70.83</td>
<td>63.64</td>
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<tr>
<td>% Other</td>
<td>33.72</td>
<td>29.17</td>
<td>31.82</td>
<td></td>
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<tr>
<td>Lifetime Suicide Attempt (% ever attempted)</td>
<td>25.81</td>
<td>45.83</td>
<td>65.22</td>
<td>$\chi^2 (2) = 13.77^{***}$</td>
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<tr>
<td>Lifetime Psychiatric Hospitalizations (% yes)</td>
<td>37.78</td>
<td>65.22</td>
<td>65.22</td>
<td>$\chi^2 (2) = 9.20^{**}$</td>
</tr>
</tbody>
</table>

*Notes.  *$p < .05$, **$p < .01$, ***$p < .001$.  

Table 2

Demographic Variables and Passive Suicidal Ideation Items

<table>
<thead>
<tr>
<th>Variable</th>
<th>Better off if I Were Dead</th>
<th>Significance Test</th>
<th>Family Better off if I Were Dead</th>
<th>Significance Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% yes % no</td>
<td></td>
<td>% yes % no</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td>( \chi^2 (1) = 0.30 )</td>
<td>( \chi^2 (1) = 0.35 )</td>
<td></td>
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<tr>
<td>Males</td>
<td>28.82 71.17</td>
<td></td>
<td>28.32 71.68</td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td>35.29 64.71</td>
<td></td>
<td>35.29 64.71</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td>( \chi^2 (1) = 7.45^* )</td>
<td>( \chi^2 (1) = 4.80^* )</td>
<td></td>
</tr>
<tr>
<td>Whites</td>
<td>46.81 53.18</td>
<td></td>
<td>42.55 57.45</td>
<td></td>
</tr>
<tr>
<td>Non-Whites</td>
<td>23.46 76.54</td>
<td></td>
<td>24.10 75.90</td>
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</tr>
<tr>
<td>Marital Status</td>
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<td>( \chi^2 (1) = 5.45^* )</td>
<td>( \chi^2 (1) = 3.44 )</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>16.21 83.79</td>
<td></td>
<td>18.42 81.58</td>
<td></td>
</tr>
<tr>
<td>Unmarried</td>
<td>37.23 62.77</td>
<td></td>
<td>34.74 65.26</td>
<td></td>
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<tr>
<td>Employment Status</td>
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<td>( \chi^2 (1) = 6.35^* )</td>
<td>( \chi^2 (1) = 5.87^* )</td>
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<tr>
<td>Employed</td>
<td>5.88</td>
<td>94.12</td>
<td>5.88</td>
<td>94.12</td>
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<td>----------</td>
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<tr>
<td>Unemployed</td>
<td>36.61</td>
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<td>Lifetime Suicide Attempt</td>
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<td>20.00</td>
<td>80.00</td>
<td>18.31</td>
<td>81.69</td>
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Notes. $p < .05^*, p < .01^{**}, p < .001^{***}$. 
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<th>Desire to Kill Oneself</th>
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<td>% no</td>
<td>% yes</td>
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<td>Employment Status</td>
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<td>80.70</td>
<td>11.87**</td>
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<td>80.70</td>
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Notes: $p \leq .05^*$, $p \leq .001^{**}$. 

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<td></td>
<td>40.00</td>
<td>14.44</td>
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<td>2.79</td>
<td>16.44**</td>
<td>5.67*</td>
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</table>

Notes: $p \leq .05^*$, $p \leq .001^{**}$. 

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</thead>
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<td>15.28</td>
<td>34.38</td>
<td>16.67</td>
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<td></td>
<td>67.19</td>
<td>84.72</td>
<td>65.63</td>
<td>83.33</td>
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<td>23.44</td>
<td>12.50</td>
<td>34.38</td>
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<td></td>
<td>2.79</td>
<td>5.67*</td>
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</table>

Notes: $p \leq .05^*$, $p \leq .001^{**}$. 

<table>
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<th>No</th>
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</thead>
<tbody>
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<td></td>
<td>11.65**</td>
<td>2.79</td>
<td>16.44**</td>
<td>5.67*</td>
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<td>11.87**</td>
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<tr>
<td></td>
<td>11.87**</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Table 4

Series of One-Way Between Analyses of Covariance Examining the Differences in Mood, Hopelessness, Suicidality, and Life Experiences among Non-Ideators, Passive Ideators, and Active Ideators

<table>
<thead>
<tr>
<th>Measure</th>
<th>Non-Ideators (n = 93)</th>
<th>Passive Ideators (n = 24)</th>
<th>Active Ideators (n = 23)</th>
<th>Significance Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Depression Inventory, $M \ (SD)$</td>
<td>22.44 (9.13)$^A$</td>
<td>39.57 (9.33)$^B$</td>
<td>36.32 (8.17)$^B$</td>
<td>$F \ (2,139) = 35.40^{*}$</td>
</tr>
<tr>
<td>Beck Hopelessness Scale, $M \ (SD)$</td>
<td>7.50 (5.57)$^A$</td>
<td>16.38 (4.34)$^B$</td>
<td>16.93 (4.04)$^B$</td>
<td>$F \ (2,136) = 10.95^{*}$</td>
</tr>
<tr>
<td>Beck Scale for Suicidal Ideation, $M \ (SD)$</td>
<td>1.34 (2.31)$^A$</td>
<td>12.82 (7.31)$^B$</td>
<td>18.90 (5.19)$^C$</td>
<td>$F \ (2,129) = 88.33^{*}$</td>
</tr>
<tr>
<td>Recent Stressful Life Experiences, $M \ (SD)$</td>
<td>4.34 (3.26)</td>
<td>5.17 (2.59)</td>
<td>5.52 (4.53)</td>
<td>$F \ (2,133) = 1.33$</td>
</tr>
<tr>
<td>Past Stressful Life Experiences, $M \ (SD)$</td>
<td>13.47 (4.55)</td>
<td>14.25 (4.67)</td>
<td>13.86 (6.04)</td>
<td>$F \ (2,136) = 0.27$</td>
</tr>
</tbody>
</table>

Notes. $^{*}p \leq .001$. Different superscripts indicate significant differences between groups using Tukey's post hoc comparisons with $p < .01$. BDI-II total score was analyzed after removing one item related to suicidal ideation. BSSI total score was analyzed after removing two items that contributed to the active suicidal ideation group.
Table 5

*Differences among Non-Ideators, Passive Ideators, and Active Ideators on Various Recent Stressful Life Events*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-Ideators (n = 93)</th>
<th>Passive Ideators (n = 24)</th>
<th>Active Ideators (n = 23)</th>
<th>Significance Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recently Fired from Job (% yes)</td>
<td>8.70</td>
<td>25.00</td>
<td>23.81</td>
<td>(\chi^2 (2) = 6.28^*)</td>
</tr>
<tr>
<td>Recent Victim of Violent Crime (% yes)</td>
<td>2.17</td>
<td>4.35</td>
<td>0.00</td>
<td>(\chi^2 (2) = 0.91)</td>
</tr>
<tr>
<td>Recent Sexual Abuse (% yes)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>(\chi^2 (2) = 0.00)</td>
</tr>
<tr>
<td>Recent Unwanted End to a Romantic Relationship (% yes)</td>
<td>10.00</td>
<td>16.67</td>
<td>14.29</td>
<td>(\chi^2 (2) = 0.95)</td>
</tr>
<tr>
<td>Recent Physical Abuse (% yes)</td>
<td>0.00</td>
<td>4.17</td>
<td>0.00</td>
<td>(\chi^2 (2) = 4.74)</td>
</tr>
<tr>
<td>Close Family Member Died Recently (% yes)</td>
<td>30.43</td>
<td>16.67</td>
<td>38.10</td>
<td>(\chi^2 (2) = 2.70)</td>
</tr>
<tr>
<td>Close Friend Died Recently (% yes)</td>
<td>21.74</td>
<td>20.83</td>
<td>28.57</td>
<td>(\chi^2 (2) = 0.51)</td>
</tr>
<tr>
<td>Recent Problem with Drugs or Alcohol (% yes)</td>
<td>28.26</td>
<td>41.67</td>
<td>28.57</td>
<td>(\chi^2 (2) = 1.66)</td>
</tr>
<tr>
<td>Recently Hospitalized for Severe Medical Problems (% yes)</td>
<td>15.22</td>
<td>16.67</td>
<td>38.10</td>
<td>(\chi^2 (2) = 5.92)</td>
</tr>
<tr>
<td>Recently Hospitalized for Psychiatric Reasons (% yes)</td>
<td>23.91</td>
<td>62.50</td>
<td>52.38</td>
<td>(\chi^2 (2) = 15.73^{**})</td>
</tr>
<tr>
<td>Recently Attempted Suicide (% yes)</td>
<td>4.35</td>
<td>16.67</td>
<td>19.05</td>
<td>(\chi^2 (2) = 6.90^*)</td>
</tr>
</tbody>
</table>

*Notes. \(^*p < .05\), \(^{**}p < .001.\) Recent events must have occurred within the last three months.*
Table 6

*Differences among Non-Ideators, Passive Ideators, and Active Ideators on Various Past Stressful Life Events*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-Ideators (n = 93)</th>
<th>Passive Ideators (n = 24)</th>
<th>Active Ideators (n = 23)</th>
<th>Significance Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fired from Job in Past (% yes)</td>
<td>62.64</td>
<td>47.83</td>
<td>57.14</td>
<td>$\chi^2 (2) = 1.71$</td>
</tr>
<tr>
<td>Past Victim of Violent Crime (% yes)</td>
<td>50.55</td>
<td>54.17</td>
<td>71.43</td>
<td>$\chi^2 (2) = 3.00$</td>
</tr>
<tr>
<td>Past Sexual Abuse (% yes)</td>
<td>21.74</td>
<td>37.50</td>
<td>52.38</td>
<td>$\chi^2 (2) = 8.74^*$</td>
</tr>
<tr>
<td>Past Unwanted End to a Romantic Relationship (% yes)</td>
<td>63.33</td>
<td>75.00</td>
<td>61.90</td>
<td>$\chi^2 (2) = 1.25$</td>
</tr>
<tr>
<td>Past Physical Abuse (% yes)</td>
<td>36.67</td>
<td>45.83</td>
<td>42.86</td>
<td>$\chi^2 (2) = 0.80$</td>
</tr>
<tr>
<td>Close Family Member Died in Past (% yes)</td>
<td>65.22</td>
<td>79.17</td>
<td>57.14</td>
<td>$\chi^2 (2) = 2.62$</td>
</tr>
<tr>
<td>Close Friend Died in Past (% yes)</td>
<td>64.04</td>
<td>69.57</td>
<td>47.62</td>
<td>$\chi^2 (2) = 2.56$</td>
</tr>
<tr>
<td>Past Problem with Drugs or Alcohol (% yes)</td>
<td>44.57</td>
<td>37.50</td>
<td>40.00</td>
<td>$\chi^2 (2) = 0.46$</td>
</tr>
<tr>
<td>Past Hospitalization for Severe Medical Problems (% yes)</td>
<td>48.91</td>
<td>54.17</td>
<td>45.45</td>
<td>$\chi^2 (2) = 0.36$</td>
</tr>
<tr>
<td>Past Hospitalization for Psychiatric Reasons (% yes)</td>
<td>26.37</td>
<td>20.83</td>
<td>33.33</td>
<td>$\chi^2 (2) = 0.90$</td>
</tr>
<tr>
<td>Past Suicide Attempt (% yes)</td>
<td>24.18</td>
<td>39.13</td>
<td>42.86</td>
<td>$\chi^2 (2) = 4.06$</td>
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</table>

*Notes. $^*p < .05$. Past events must have occurred more than three months ago.*
Table 7

*Chi-Square Analysis Examining Associations between a Recent Loss Event and a Lifetime Suicide Attempt among Non-Ideators, Passive Ideators, and Active Ideators*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-Ideators (n = 90)</th>
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<th>Active Ideators (n = 21)</th>
<th>Significance Test</th>
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<tr>
<td>Combination Item (Loss Event/Lifetime Suicide Attempt)</td>
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<td></td>
<td>$\chi^2 (6) = 15.99^*$</td>
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<tr>
<td>Neither Recent Loss Event nor Lifetime Attempt (% yes)</td>
<td>40.00</td>
<td>25.00</td>
<td>14.29</td>
<td></td>
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<tr>
<td>Loss Event Only (% yes)</td>
<td>34.44</td>
<td>29.17</td>
<td>23.80</td>
<td></td>
</tr>
<tr>
<td>Lifetime Attempt Only (% yes)</td>
<td>8.89</td>
<td>25.00</td>
<td>14.29</td>
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<tr>
<td>Both Loss Event and Lifetime Attempt (% yes)</td>
<td>16.67</td>
<td>20.83</td>
<td>47.62</td>
<td></td>
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</table>

*Notes.* $^*p \leq .01$. The recent loss event included recent job loss, recently being “dumped” by a significant other, or recently experiencing the death of a close family member or friend.
Table 8

*Discriminant Analysis of Clusters of Variables to Determine Ideation Group Membership*

<table>
<thead>
<tr>
<th>Function</th>
<th>Eigenvalue</th>
<th>Percent of variance</th>
<th>Canonical correlation</th>
<th>Wilks’ lambda</th>
<th>$\chi^2$</th>
<th>df</th>
<th>$p$</th>
<th>Percent correctly classified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics (ethnicity, employment status, marital status)</td>
<td>.13</td>
<td>89.70</td>
<td>.34</td>
<td>.87</td>
<td>15.67</td>
<td>6</td>
<td>.02</td>
<td>42.90</td>
</tr>
<tr>
<td>Demographics, Lifetime Suicide Attempt</td>
<td>.31</td>
<td>94.70</td>
<td>.49</td>
<td>.84</td>
<td>35.36</td>
<td>8</td>
<td>.000</td>
<td>60.60</td>
</tr>
<tr>
<td>Demographics, Lifetime Suicide Attempt, Recent Loss Event</td>
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<td>90.00</td>
<td>.47</td>
<td>.75</td>
<td>33.29</td>
<td>10</td>
<td>.000</td>
<td>61.80</td>
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</tbody>
</table>

*Note.* The recent loss event included recent job loss, recently being “dumped” by a significant other, or recently experiencing the death of a close family member or friend.
Appendix A

Recruitment Flyer

Are you:
✓ 18 years of age?

✓ Suffering from depression?

✓ Interested in contributing to the understanding of this disorder?

Please call Christine at 216-368-5350 for more information regarding participation in a research study investigating the causes and effects of depression. Please note: Compensation will be provided.
Appendix B

Recruitment Postcard

The Louis Stokes Cleveland VA Medical Center is inviting Veterans to participate in a research study on depression.

Veterans who are interested may contact Christine Moran at (216) 368-5350.

We are offering $10 for participation.

The research team will contact you via phone to follow up on your interest in the study.
Subject Name: ____________________________  Date: ________
Title of Study: Exploring the Recovery from Depression
Principal Investigator: James C. Overholser, Ph.D.  VAMC: Cleveland (541)
Consent Version Date: August 2012

DESCRIPTION OF RESEARCH BY INVESTIGATOR

NOTE: The consent form should include the following section headings:

I. Purpose of the Study  VI. Alternative Procedure(s)/Treatment(s)
II. Description of the Study  VII. Privacy, Confidentiality, and Use of Research Results
III. Inconveniences  VIII. Special Circumstances
IV. Discomforts/Risks/Side Effects  IX. Contact Information
V. Benefits

TO POTENTIAL PARTICIPANTS: Federal regulations require written informed consent before participation in a research study. This is to be certain that research volunteers know the nature and risks of the study, so they can make an informed decision about participation. You are asked to read the following information and discuss it with the investigator, so that you understand this research study and how it may affect you. Your signature on this form means that you have been fully informed and that you freely give your consent to participate. It is also important that you read and understand these principles that apply to all individuals who agree to participate in the research project below:

1. Taking part in the research is entirely voluntary.

2. You may not personally benefit from taking part in the research but the knowledge obtained may help the health care professionals caring for you to better understand the disease/condition and how to treat it.

3. You may withdraw from the study at any time without anyone objecting and without penalty or loss of any benefits to which you are otherwise entitled.

4. If, during your participation in the research project, new information becomes available concerning your condition (disease) or concerning better therapies, which may affect your willingness to continue in the research project, your
doctor will discuss the new information with you and will help you make a
decision about continuing in the research.

5. The purpose of the research, how it will be done, and what your part in the
research will be, is described below. Also described are the risks,
inconveniences, discomforts, and other important information, which you need
to make a decision about whether or not you wish to participate. You are
urged to discuss any questions, concerns, or complaints you have about this
research with the research staff members.

I. PURPOSE OF THE STUDY:

We are asking you to participate in a research study investigating depression. You
are being asked to participate because it is our understanding that you may be
experiencing symptoms of depression. The purpose of this research involves
gathering information about the optimal assessment and treatment of depression.
Information used by the research study includes your medical record (chart), the
information packets that you will be asked to complete, and the information
discussed in the brief interview.

II. DESCRIPTION OF STUDY:

If you agree to participate in the study, it will last for approximately one to one and
a half hours today and will take place at the Louis Stokes Cleveland Department of
Veterans Affairs Medical Center (LSCDVAMC). Participation in this study
involves completing several questionnaires and a short interview about depression
and other psychological problems. The first part of the study involves a series of
yes/no questions pertaining to depression or other psychological problems that you
may have encountered. The second part of today’s meeting involves the
completion of questionnaires pertaining to depression, hopelessness, coping, and
life meaning. If during the interview, you indicate thoughts of suicide, we will
offer to contact your mental health provider to discuss this with him/her on your
behalf. If we believe you are at immediate risk for suicide, we will contact Dr.
Ridley or another mental health provider to evaluate you, and you may be escorted
to the Psychiatric Emergency Room. You will be contacted by phone in
approximately three months to schedule the second phase of the study which may
occur by phone or in person at your next outpatient visit. The follow-up involves
the completion of questionnaires similar to the questionnaires that you will
complete today. Your participation today does not require you to participate in the
follow-up scheduled in three months. If you do agree to participate in the follow-
up, you will be asked to provide your first name and phone number on a separate
sheet.

III. INCONVENIENCES:
The information requested from you today will take approximately one hour to one and a half hours to complete. In addition to the information collected from you today, you will be contacted in three months (via telephone or in person) for a brief re-evaluation of your depressive symptoms and about the treatment you received. The interview will last approximately one hour. Your consent now simply allows the investigators to contact you later. At that time, you can decide whether or not you want to continue with the interview.

IV. DISCOMFORTS / RISKS / SIDE EFFECTS:

The risks of this study primarily involve talking about emotional issues and protecting your confidentiality. Although it is unlikely that you will be exposed to any risks by participating in this study, you will be asked a variety of questions about your life and emotions. Some of the questions may force you to confront various emotions as you discuss these different issues. If you experience distress during the initial interview you may discontinue with the study and will have opportunity to discuss your thoughts and feelings with the research assistant. If you experience distress after the interview you may contact any of your primary providers in the outpatient clinic to discuss your issues/concerns.

V. BENEFITS:

You will not directly benefit from participating in this study.

VI. ALTERNATIVE PROCEDURE(S) / TREATMENT(S):

Because this study offers no direct benefits to participants, your only alternative is to not participate.

VII. PRIVACY, CONFIDENTIALITY, AND USE OF RESEARCH RESULTS:

By joining this study, you give the investigators your permission for them to collect data from your medical records to determine if you are eligible and if you remain eligible to participate in the study.

Any information obtained about you in this study will be treated as confidential and will be safeguarded in accordance with the Privacy Act of 1974. Research records will be kept indefinitely in a locked file. In order to comply with federal regulations, records identifying you may be reviewed by authorized representatives of the Institutional Review Board of the LSCDVAMC, VA, authorized representatives of the Case Western Reserve University, Dr. Overholser, students authorized by him, or other federal regulatory officials responsible for oversight of human subject protection. By signing this document, you consent to such inspection.
Findings from this study may be presented at a professional meeting or published in a professional journal; however, no names or other information that would allow for subjects to be identified will be included in these presentations.

VIII. SPECIAL CIRCUMSTANCES:

Financial Considerations
Your participation in this research study will be done at no cost to you. You will be compensated for your time and effort for being in this research project in one of two ways. You will either be given $10.00 in cash or a $10 Walmart gift card for completion of both the initial interview and the information packet. The research assistant will determine which form of compensation you will receive, based on what is available at the time of your appointment. If you withdraw from the study before completing both the interview and the information packet, you will not be compensated in any way. The compensation will be handed to you by the study personnel when you complete and hand the information packet to the study personnel. In addition, you will be compensated again, either with $10 in cash or with a $10 Walmart gift card if you are contacted and complete the follow-up interview. The form of compensation will depend on what is available at the time of your research appointment. Again, the compensation will be handed to you when you turn in the completed information packet. If you complete both the initial interview and follow-up interview, you will have received $20.00 total, in cash and/or in the form of a Walmart gift card.

Ending Participation
You may stop your participation in this study at anytime. In addition, the investigators may stop your participation in this study without your consent, for example, if they think it will be in your best interest, if you don’t follow the study plan, if you experience a study-related injury, or for any other reason.

Voluntary Participation
If you are a student, resident, or employee of (LSCDVAMC, UH, Case, etc.), your scholastic or employment evaluations will be conducted by a rater who is not involved with, and most likely totally unaware of this study. In no way will your job or position be affected by your decision to join or not join this study.

IX. CONTACT INFORMATION

The following is a list of contact names and phone numbers.

To obtain answers to questions about the research contact the following:

• During the Day: [Dr. James Overholser at 216-368-2686 or Dr. Josephine Ridley at 216-791-3800 x5730]
• After Hours: [Dr. James Overholser at 216-368-2852 or call the VA Medical Center operator at (216) 791-3800 then dial 0 and have Dr. Josephine Ridley paged]
To voice concerns or complaints about the research contact the following:
• The Research Compliance Office at (216) 791-3800 ext. 4625, or
• The LSCDVAMC Patient Representative at (216) 791-3800 ext. 4026

To obtain answers to questions about your rights as a research participant contact the following:
• The Research Compliance Office at (216) 791-3800 ext. 4625 or
• The LSCDVAMC Institutional Review Board Office at (216) 791-3800 ext. 4658

In the event that you sustain a research related injury contact the following:
• During the Day: [Dr. James Overholser at 216-368-2686 or Dr. Josephine Ridley at 216-791-3800 x5730]
• After Hours: [Dr. James Overholser at 216-368-2852 or call the VA Medical Center operator at (216) 791-3800 then dial 0 and have Dr. Josephine Ridley paged]

In the event the study staff could not be reached contact the following:
• During the Day: [WP Psychiatric Emergency Room at (216) 791-3800 ext 6042]
• After Hours: [WP Psychiatric Emergency Room at (216) 791-3800 ext 6042]

In the event you wish to talk with someone other than the study staff contact the following:
• The LSCDVAMC Institutional Review Board Office at (216) 791-3800 ext. 4658

To provide input concerning the research process contact the following:
• The LSCDVAMC Institutional Review Board Office at (216) 791-3800 ext. 4658

To check whether a study is being conducted at the LSCDVAMC and whether study staff are permitted to represent the study contact the following:
• The LSCDVAMC Institutional Review Board Office at (216) 791-3800 ext. 4658
RESEARCH SUBJECTS' RIGHTS: I have read or have had read to me all of the preceding information.

Dr./Mr./Ms. ___________________________ has explained the study to me and answered all of my questions. I have been told of the risks or discomforts and possible benefits of the study. I have been told of other choices of treatment available to me.

I understand that I do not have to take part in this study, and my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may withdraw from this study at any time without penalty or loss of VA or other benefits to which I am entitled.

The results of this study may be published, but I will not be identified in publications by name, photograph, or other identifiers. My records, including my name and results of my participation, may be revealed as required by laws and regulations of state and federal agencies.

I understand my rights as a subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I will receive a signed consent form or a photocopy of it. I understand that in signing this consent form I do not waive my legal rights nor release the LSCDVAMC from liability for negligence.

Subject’s Signature________________________________________ Date _ _ / _ 

Signature of Subject’s Representative Date _ _ / _

(if subject not competent) print name__________________

Signature of Person Obtaining Consent________________________ Date _ _ / _
Appendix D

SCID DSM-IV DEPRESSION DIAGNOSIS

_______ Age of first depressive episode?

_______ No. of previous depressive episodes (not counting current episode)?

_______ (weeks) How long have you been feeling depressed? {2 weeks minimum for MDD}

{For MDD must have 5 of 9 of the following with either item 1 or 2 endorsed}

1. Yes No Depressed mood throughout most of the day?

2. Yes No Reduced interest or pleasure in most activities?

3A. Yes No Change in appetite: □ Increased appetite AND/OR □ Decreased appetite

3B. Yes No Change in weight: □ Lost weight AND/OR □ Gained weight

4. Yes No Sleep Disturbance: □ Insomnia AND/OR □

5. Yes No Psychomotor: □ Retardation AND/OR □ Agitation

6. Yes No Fatigue, loss of energy nearly every day?

7A. Yes No Low self-worth?

7B. Yes No Excessive or inappropriate guilt?

8A. Yes No Poor concentration?

8B. Yes No Indecisiveness?

9. Yes No Suicidal ideation? Yes No Ever Attempted? Yes No Attempted past month?
Exclusion Criteria

Yes  No  History of manic episodes?
Yes  No  Is depression due to a medical problem or drug use?
Yes  No  Is depression due to bereavement?

Melancholia Specifier

{Either of the following}

1. Yes  No  Reduced interest or pleasure in most activities?
2. Yes  No  Lack of reactivity, pleasant events do not even temporarily improve mood?

{3 or more of the following}

3. Yes  No  Distinct quality of mood, different from severe sadness or bereavement?
4. Yes  No  Diurnal variation with depression regularly worse in mornings?
5. Yes  No  Early morning awakenings?
6. Yes  No  Psychomotor retardation or agitation?
7. Yes  No  Significant anorexia or weight loss?
8. Yes  No  Excessive or inappropriate guilt?

Dysthymia

1. Yes  No  Depressed mood for most of the day without 2 months of remission of symptoms.

{2 or more of the following}

2. Yes  No  Poor appetite or overeating?
3. Yes  No  Insomnia or hypersomnia?
4. Yes  No  Low energy or fatigue?
5. Yes  No  Low self-esteem?

6. Yes  No  Poor concentration or difficulty making decisions?

7. Yes  No  Feelings of hopelessness?

**DIAGNOSIS**

1=MDD, single, with melancholia  
2=MDD, single, without melancholia 

3=MDD, recurrent, with melancholia  
4=MDD, recurrent, without melancholia 

5=Dysthymia  
6=Adjustment Disorder
## Comorbid Diagnoses

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Never Present</th>
<th>Maybe Present Now</th>
<th>Maybe Past Episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mania</td>
<td>Never Present</td>
<td>Maybe Present Now</td>
<td>Maybe Past Episode</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Never Present</td>
<td>Maybe Present Now</td>
<td>Maybe Past Episode</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>Never Present</td>
<td>Maybe Present Now</td>
<td>Maybe Past Episode</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>Never Present</td>
<td>Maybe Present Now</td>
<td>Maybe Past Episode</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Never Present</td>
<td>Maybe Present Now</td>
<td>Maybe Past Episode</td>
</tr>
<tr>
<td>Somatoform</td>
<td>Never Present</td>
<td>Maybe Present Now</td>
<td>Maybe Past Episode</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>Never Present</td>
<td>Maybe Present Now</td>
<td>Maybe Past Episode</td>
</tr>
</tbody>
</table>

Possible Diagnosis based on screening questions:

{Indicate symptoms present or absent}  Yes  No  Meets Diagnosis Criteria?

Possible Diagnosis based on screening questions:

{Indicate symptoms present or absent}  Yes  No  Meets Diagnosis Criteria?

Possible Diagnosis based on screening questions:

{Indicate symptoms present or absent}  Yes  No  Meets Diagnosis Criteria?
Appendix E

**BECK INVENTORY - II**

Please read each group of statements and pick the **one statement in each group** that best describes how you have been feeling during the PAST WEEK, INCLUDING TODAY. Be sure to read all statements in each group before making your choice. If two statements in a group apply equally well, circle both.

| A. | 0. | I do not feel sad. |
|    | 1. | I feel sad much of the time. |
|    | 2. | I am sad all the time. |
|    | 3. | I am so sad or unhappy that I can’t stand it. |

| B. | 0. | I am not discouraged about my future. |
|    | 1. | I feel more discouraged about my future than I used to be. |
|    | 2. | I do not expect things to work out for me. |
|    | 3. | I feel my future is hopeless and will only get worse |

| C. | 0. | I do not feel like a failure. |
|    | 1. | I have failed more than I should have. |
|    | 2. | As I look back, I see a lot of failures. |
|    | 3. | I feel I am a total failure as a person. |

| D. | 0. | I get as much pleasure as I ever did from the things I enjoy. |
|    | 1. | I don’t enjoy things as much as I used to. |
|    | 2. | I get very little pleasure from the things I used to enjoy |
|    | 3. | I can’t get any pleasure from the things I used to enjoy. |

| E. | 0. | I do not feel particularly guilty. |
|    | 1. | I feel guilty over many things I have done or should have done. |
|    | 2. | I feel quite guilty most of the time. |
|    | 3. | I feel guilty all of the time. |

| F. | 0. | I do not feel I am being punished. |
|    | 1. | I feel I may be punished. |
|    | 2. | I expect to be punished. |
|    | 3. | I feel I am being punished. |

| G. | 0. | I feel the same about myself as ever. |
1. I have lost confidence in myself.
2. I am disappointed in myself.
3. I dislike myself.

H. 0. I don't criticize or blame myself more than usual.
1. I am more critical of myself than I used to be.
2. I criticize myself for all of my faults.
3. I blame myself for everything bad that happens.

I. 0. I don't have any thoughts of killing myself.
1. I have thoughts of killing myself, but I would not carry them out.
2. I would like to kill myself.
3. I would kill myself if I had the chance.

YES NO I feel I would be better off dead.

YES NO I feel my family would be better off if I were dead.

YES NO I have definite plans about committing suicide.

YES NO I tried to kill myself recently (in the past 30 days).

YES NO I tried to kill myself some time ago (more than 30 days ago).

J. 0. I don't cry any more than I used to.
1. I cry more than I used to.
2. I cry over every little thing.
3. I feel like crying, but I can't.

K. 0. I am no more restless or wound up than usual.
1. I feel more restless or wound up than usual.
2. I am so restless or agitated that its hard to stay still.
3. I am so restless or agitated that I have to keep moving or doing something.

L. 0. I have not lost interest in other people or activities.
1. I am less interested in other people or things than before.
2. I have lost most of my interest in other people or things.
3. It’s hard to get interested in anything.
M. 0. I make decisions about as well as ever.
   1. I find it more difficult to make decisions than usual.
   2. I have much greater difficulty in making decisions than I used to
   3. I have trouble making any decisions.

N. 0. I do not feel I am worthless.
   1. I don’t consider myself as worthwhile and useful as I used to.
   2. I feel more worthless as compared to other people.
   3. I feel utterly worthless.

O. 0. I have as much energy as usual.
   1. I have less energy than I used to have.
   2. I don’t have enough energy to do very much.
   3. I don’t have enough energy to do any anything.

P. 0. I have not experienced any change in my sleeping pattern.
   1. I sleep somewhat more or somewhat less than usual.
   2. I sleep a lot more or a lot less than usual.
   3a. I sleep most of the day.
   3b. I wake up 1-2 hours early and can't get back to sleep.

Q. 0. I am no more irritable than usual.
   1. I am more irritable than usual.
   2. I am much more irritable than usual.
   3. I am irritable all the time.

R. 0. I have not experienced any change in my appetite.
   1. My appetite is somewhat greater or somewhat less than usual.
   2. My appetite is much greater or much less than usual.
   3a. I have no appetite at all.
   3b. I crave food all the time.
<table>
<thead>
<tr>
<th></th>
<th>0.</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.</td>
<td>I have not lost much weight, if any, lately.</td>
<td>I have lost more than 5 pounds.</td>
<td>I have lost more than 10 pounds.</td>
<td>I have lost more than 15 pounds.</td>
</tr>
<tr>
<td>T.</td>
<td>I can concentrate as well as ever.</td>
<td>I can’t concentrate as well as usual.</td>
<td>It’s hard to keep my mind on anything for very long.</td>
<td>I find I can’t concentrate on anything.</td>
</tr>
<tr>
<td>U</td>
<td>I am no more tired or fatigued than usual.</td>
<td>I get more tired or fatigued more easily than usual.</td>
<td>I am too tired or fatigued to do a lot of the things I used to do.</td>
<td>I am too tired or fatigued to do most of the things I used to do.</td>
</tr>
<tr>
<td>V.</td>
<td>I have not noticed any recent change in my interest in sex.</td>
<td>I am less interested in sex that I used to be.</td>
<td>I am much less interested in sex now.</td>
<td>I have lost interest in sex completely.</td>
</tr>
</tbody>
</table>
Appendix F

BHS: Please answer TRUE of FALSE to describe how you feel now.

True False 1. I look forward to the future with hope and enthusiasm.
True False 2. I might as well give up because I can't make things better for myself.
True False 3. When things are going badly, I am helped by knowing they can't stay that way forever.
True False 4. I can't imagine what my life will be like in 10 years.
True False 5. I have enough time to accomplish the things I most want to do.
True False 6. In the future, I expect to succeed in what concerns me most.
True False 7. My future seems dark to me.
True False 8. I expect to get more of the good things in life than the average person.
True False 9. I just don't get the breaks, and there's no reason to believe I will in the future.
True False 10. My past experiences have prepared me well for my future.
True False 11. All I can see ahead of me is unpleasantness rather than pleasantness.
True False 12. I don't expect to get what I really want.
True False 13. When I look ahead to the future, I expect I will be happier than I am now.
True False 14. Things just won't work out the way I want them to.
True False 15. I have great faith in the future.
True False 16. I never got what I want, so it's foolish to want anything.
True False 17. It is very unlikely that I will get any real satisfaction in the future.
True False 18. The future seems vague and uncertain to me.
True False 19. I can look forward to more good times than bad times.
True False 20. There is no use in really trying to get something I want because I probably won't get it.
Appendix G

Beck Scale for SI

Circle the one statement in each group that best describes how you have been feeling for the past week, including today. Be sure to read all of the statements in each group before making a choice.

A 0 I have a moderate to strong wish to live.
    1 I have a weak wish to live.
    2 I have no wish to live.

B 0 I have no wish to die.
    1 I have a weak wish to die.
    2 I have a moderate to strong wish to die.

C 0 My reasons for living outweigh my reasons for dying.
    1 My reasons for living or dying are about equal.
    2 My reasons for dying outweigh my reasons for living.

D 0 I have no desire to kill myself.
    1 I have a weak desire to kill myself.
    2 I have a moderate to strong desire to kill myself.

E 0 I would try to save my life if I found myself in a life-threatening situation.
    1 I would take a chance on life or death if I found myself in a life-threatening situation.
    2 I would not take the steps necessary to avoid death if I found myself in a life-threatening situation.

If you have circled the zero statements in both Groups D and E above, then skip down to Group T. If you have marked a 1 or 2 in either Group D or E, then go on to Group F.

F 0 I have brief periods of thinking about killing myself which pass quickly.
    1 I have periods of thinking about myself which last for moderate amounts of time.
    2 I have long periods of thinking about killing myself.

G 0 I rarely or only occasionally think about killing myself.
I have frequent thoughts about killing myself.
I continuously think about killing myself.

I do not accept the idea of killing myself.
I neither accept nor reject the idea of killing myself.
I accept the idea of killing myself.

I can keep myself from committing suicide.
I am unsure that I can keep myself from committing suicide.
I cannot keep myself from committing suicide.

I would not kill myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.
I am somewhat concerned about killing myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.
I am not or only a little concerned about killing myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.

My reasons for wanting to commit suicide are primarily aimed at influencing other people, such as getting even with people, making people happier, making people pay attention to me, etc.
My reasons for wanting to commit suicide are not only aimed at influencing other people, but also represent a way of solving my problems.
My reasons for wanting to commit suicide are primarily based upon escaping from my problems.

I have no specific plan about how to kill myself.
I have considered ways of killing myself but have not worked out the details.
I have a specific plan for killing myself.

I do not have access to a method or an opportunity to kill myself.
The method that I would use for committing suicide takes time, and I really do not have a good opportunity to use this method.
I have access or anticipate having access to the method that I would choose for killing myself and also have or shall have the opportunity to use it.

I do not have the courage or the ability to commit suicide.
I am unsure that I have the courage or the ability to commit suicide.
I have the courage and the ability to commit suicide.

I do not expect to make a suicide attempt.
I am unsure that I shall make a suicide attempt.
I am sure that I will make a suicide attempt.

I have made no preparations for committing suicide.
I have made some preparations for committing suicide.
I have almost finished or completed my preparations for committing suicide.

I have not written a suicide note.
I have thought about writing a suicide note or have started to write one, but have not completed it.
I have completed a suicide note.

I have made no arrangements for what will happen after I have committed suicide.
I have thought about making arrangements for what will happen after I have committed suicide.
I have made definite arrangements for what will happen after I have committed suicide.

I have not hidden my desire to kill myself from people.
I have held back telling people about wanting to kill myself.
I have attempted to hide, conceal, or lie about wanting to commit suicide.

I have never attempted suicide.
I have attempted suicide once.
I have attempted suicide two or more times.

If you have previously attempted suicide, please continue with the next statement group.

My wish to die during the last suicide attempt was low.
My wish to die during the last suicide attempt was moderate.
My wish to die during the last suicide attempt was high.
Appendix H

Modified Life Experience Scale

Please mark each event for whether or not it has happened to you. "Recently" means that it happened in the past 3 months. "Long ago" means that the event happened some time in your life, anytime more than 3 months ago. You can circle both if an event occurred both "Recently" and "Long ago".

<table>
<thead>
<tr>
<th>Event</th>
<th>Recently</th>
<th>Long Ago</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was hospitalized for medical problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was hospitalized for psychiatric problems</td>
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<td></td>
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<tr>
<td>I was arrested and I spent time in jail</td>
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<tr>
<td>I was a victim of a violent crime</td>
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<tr>
<td>I was seriously injured by another person</td>
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<tr>
<td>I was abused physically</td>
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<td></td>
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<tr>
<td>I was abused sexually</td>
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<tr>
<td>I had a problem with drugs or alcohol</td>
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<tr>
<td>I was treated for drug or alcohol abuse</td>
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<td></td>
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<tr>
<td>I was arrested for drunken driving</td>
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<tr>
<td>I was involved in a severe car accident</td>
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<tr>
<td>A close family member died</td>
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<tr>
<td>A good friend of mine died</td>
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<tr>
<td>Someone close to me committed suicide</td>
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<tr>
<td>I tried to kill myself</td>
<td></td>
<td></td>
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<tr>
<td>A close family member was fired or got laid off from a job</td>
<td></td>
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<td></td>
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<tr>
<td>I was fired or laid off from a job</td>
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<tr>
<td>I have too many bills and very little money</td>
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<tr>
<td>I started a new job</td>
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<tr>
<td>I moved into a new city (at least 50 miles from home)</td>
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<tr>
<td>I (or my partner) got pregnant or had a baby</td>
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<tr>
<td>A romantic relationship ended</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
References


attempts among first time suicide attempters, repeaters, and non-attempters.

*Psychiatry Research, 186*, 300-305.


