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Rebuilding the Tower of Babel: A Revised Nomenclature for the Study of Suicide and Suicidal Behaviors Part 2: Suicide-Related Ideations, Communications, and Behaviors

Morton M. Silverman, MD, Alan L. Berman, PhD, Nels D. Sanddal, MS, Patrick W. O'Carroll, MD, MPH, and Thomas E. Joiner, Jr., PhD

A revised and refined version of the O'Carroll et al. (1996) nomenclature for suicidology is presented, with a focus on suicide-related ideations, communications, and behaviors. The hope is that this refinement will result in the development of operational definitions and field testing of this nomenclature in clinical and research settings. This revision would not have been possible without the international collaboration and dialogue addressing the nomenclature of suicidology since the O'Carroll et al. nomenclature appeared in 1996.

Although it is doubtful that we will ever be able to construct universally unambiguous criteria to comprehensively characterize suicidal behaviors (and, overall, firmly establish the intention behind them), for scientific clarity it would be highly desirable that the set of definitions and the associated terminology be explicit and generalizable.

De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006, p. 5)

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Morton Silverman is a Clinical Associate Professor of Psychiatry at the University of Chicago, Senior Advisor to the Suicide Prevention Resource Center (Newton, MA), and Educational Consultant to the Denver VA VISN 19 MIRECC; Alan Berman is Executive Director of the American Association of Suicidology; Nels Sanddal is President and CEO of Critical Illness and Trauma Foundation, Inc., Bozeman, MT; Patrick O'Carroll is Regional Health Administrator, Public Health Region X; and Thomas Joiner, Jr. is the Bright-Burton Professor of Psychology at The Florida State University.

Address correspondence to Morton M. Silverman, MD, 4858 S. Dorchester Avenue, Chicago. IL., 60615–2012; E-mail: msilverman@suicidology.org

Although a number of investigators have adopted the O'Carroll et al. (1996) nomenclature and applied it in their studies (Bryan & Rudd, 2003; Daigle & Cote, 2006; Goldston, 2003; Kidd, 2003; Rudd & Joiner, 1998; Wagner, Wong, & Jobes, 2002), and others have acknowledged its role in highlighting the need for clarification of terms (Dear, 1997, 2001; De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2004, 2006; Hjelmeland & Knizek, 1999; Linehan, 1997, 2000; Marusic, 2004; Rudd, 1997, 2000; Rudd, Joiner, Jobes, & King, 1999), the nomenclature has not been widely used in the research and clinical communities. The rationale behind the rebuilding of the O'Carroll et al. nomenclature is to increase the ability of clinicians, epidemiologists, policy makers, and researchers to better communicate with each other and study similar populations at risk for suicide-related ideations, communications, and behaviors (Silverman, Berman, Sanddal, O'Carroll, & Joiner, this issue).

THE REVISED NOMENCLATURE

In our revised nomenclature outline (Table 1), we had to account for terms in general usage that we felt would be difficult to eliminate or easily re-name. We had the most difficulty with the terms *suicidal threat*, *suicidal gesture*, and *suicidal plan*. In the end, we eliminated suicide gesture, mainly because of the pejorative quality it has acquired over time (Daigle & Cote, 2006). We created a superset category called suicide-related communication to account for suicidal threat and suicide plan. A suicide-related communication can include a suicide note (suicidal threat) or a systematic formulation of a program of action that can lead to self-injury (suicide plan). Further, we tried to streamline the nomenclature by eliminating the suffix "-related" and, in so doing, clearly change the supersets to suicidal ideation, suicidal communication, and suicidal behavior. However, despite the brevity and succinctness that these new terms would convey, we realized that the added adjective "-related" was neces-

TABLE 1
Revised Nomenclature

An outline indicating superset/subset relationships of the revised nomenclature for self-injurious thoughts and behaviors (with elaboration on suicidal thoughts and behaviors)

Self-Injurious Thoughts and Behaviors

A. Risk-Taking Thoughts and Behaviors
1. With Immediate Risk
   a. results in no injury
   b. results in injury
   c. results in death
2. With Remote Risk
   a. results in no injury
   b. results in injury
   c. results in death

B. Suicide-Related Thoughts and Behaviors
1. Suicide-Related Ideations
   a. With No Suicidal Intent
      (1) casual
      (2) transient
      (3) passive
      (4) active
      (5) persistent
   b. With Undetermined Degree of Suicidal Intent
      (1) casual
      (2) transient
      (3) passive
      (4) active
      (5) persistent
   c. With Some Suicidal Intent
      (1) casual
      (2) transient
      (3) passive
      (4) active
      (5) persistent
2. Suicide-Related Communications
   a. With No Suicidal Intent
      (1) verbal or nonverbal; passive or active (**Suicide Threat, Type I**)
      (2) a proposed method of achieving a potentially self-injurious outcome (**Suicide Plan, Type I**)
   b. With Undetermined Degree of Suicide Intent
      (1) verbal or nonverbal; passive or covert (**Suicide Threat, Type II**)
      (2) a proposed method of achieving a potentially self-injurious outcome **(Suicide Plan, Type II**)

TABLE 1
Continued

- c. With Some Degree of Suicidal Intent
  - (1) verbal or nonverbal; passive or covert (**Suicide Threat, Type III**)
  - (2) a proposed method of achieving a potentially self-injurious outcome (**Suicide Plan, Type III**)
- 3. Suicide-Related Behaviors
  - a. With No Suicidal Intent
    - (1) without injuries (**Self-Harm, Type I**)
    - (2) with injuries (**Self-Harm, Type II**)
    - (3) with fatal outcome (**Self-Inflicted Unintentional Death**)
  - b. With Undetermined Degree of Suicide Intent
    - (1) without injuries (**Undetermined Suicide-Related Behavior, Type I**)
    - (2) with injuries (**Undetermined Suicide-Related Behavior, Type II**)
    - (3) with fatal outcome (**Self-Inflicted Death with Undetermined Intent)**
  - c. With Some Degree of Suicidal Intent
    - (1) without injuries (**Suicide Attempt, Type I**)
    - (2) with injuries (**Suicide Attempt, Type II**)
    - (3) with fatal outcome (**Suicide**)

Additional Modifiers for B2 (a, b, c) and B3 (a, b, c):
- A. Intrapersonal focus—to change internal state (escape/release)
- B. Interpersonal focus—to change external state (attachment/control)
- C. Mixed focus

sary after all, because we were also trying to subsume under these superset categories such concepts as suicide threat, suicide plan, and deliberate self-harm, which may not, in their strictest usage, be purely secondary to suicidal ideation, communication, or behavior, but, rather, to conditions closely related to these superset categories.

The revised nomenclature in Table 1 derive from the Operational Criteria for the Determination of Suicide (OCDS) definition of *suicide*, which differ somewhat from the World Health Organization's (WHO) definitions (Rosenberg et al., 1988; WHO, 1986). A full discussion of the OCDS system and the WHO definitions can be found elsewhere (De Leo et al., 2006; O'Carroll et al., 1996). The component elements that uniquely define each suicide-related thought and behavior are illustrated in Tables 2 and 3, whereas the relationships between the proposed terms for suicide-related behaviors and currently used terminology may best be understood by reference to Table 4.

A related issue, discussed among suicidologists on the Internet, involved the distinction between *behavior*, which can be construed as either a discrete event or a continuous process that is repeatable, and an *act*, which may signify a more goal-directed event. Here, again, in deciding how to revise and refine, we encountered what seemed to be splitting hairs. We chose to keep with our plan to try to maintain the commonly used

TABLE 2
Suicide-Related Thoughts and Behaviors

- Suicide-Related Ideations
- Suicide-Related Communications
  - Suicide Threat I (no intent)
  - Suicide Threat II (undetermined intent)
  - Suicide Threat III (some intent)
  - Suicide Plan I (no intent)
  - Suicide Plan II (undetermined intent)
  - Suicide Plan III (some intent)
- Suicide–Related Behaviors
  - Self-Harm (no intent)
    - Self-Harm, Type I (no injury)
    - Self-Harm, Type II (injury)
    - Self-Inflicted Unintentional Death (fatal outcome)
  - Undetermined Suicide-Related Behavior (undetermined degree of suicidal intent)
    - Undetermined Suicide-Related Behavior, Type I (no injury)
    - Undetermined Suicide-Related Behavior, Type II (injury)
    - Self-Inflicted Death with Undetermined Intent (fatal outcome)
  - Suicide Attempt (some degree of suicidal intent)
    - Suicide Attempt, Type I (no injury)
    - Suicide Attempt, Type II (injury)
    - Suicide (fatal outcome)

TABLE 3
Suicide-Related Behaviors

With No Suicidal Intent (**Self-Harm**)
Without Injuries (**Self-Harm, Type I**)
With Injuries (**Self-Harm, Type II**)
With Fatal Outcomes (**Self-Inflicted Unintentional Death**)
With Undetermined Degree of Suicidal Intent (**Undetermined Suicide-Related Behavior**)
Without Injuries (**Undetermined Suicide-Related Behavior, Type I**)
With Injuries (**Undetermined Suicide-Related Behavior, Type II**)
With Fatal Outcome (**Self-Inflicted Death with Undetermined Intent**)
With Some Degree of Suicidal Intent (**Suicide Attempt**)
Without Injuries (**Suicide Attempt, Type I**)
With Injuries (**Suicide Attempt, Type II**)
With Fatal Outcome (**Suicide**)

parlance as best as possible, and therefore left the term *behavior* in the original definitions, albeit acknowledging that, more often than not, what is being labeled by the observer is a discrete event ("act") as opposed to a potentially continuous process ("behavior").

As O'Carroll et al. cautioned, it is of great importance that readers understand that neither Table 1 nor Figures 1 and 2 are meant as a clinically applicable *classification* of suicide-related thoughts and behaviors, nor are they meant to reflect causal or behavioral pathways. Rather, they are simply meant to clarify which terms represent subsets or supersets of other terms; however, such an outline displays only the universe of terms that we feel should comprise the nomenclature of suicide-related thoughts and behaviors. For purposes of comparison, Figures 1 and 2 show the mutually exclusive relationships among these terms. Once validated, this revised nomenclature might well become the common vocabulary for the field.

When thinking about the different terminologies in clinical terms, whereby the clinician can understand the suicidal behavior as a form of coping with or responding to different contexts (internal and external), we conceptualized *suicide-related ideation* as an example of weighing options, *suicide threat* as a form of a coping communication to regain control or attachment, *self-harm* as a deficient coping response to obtain a time out or to reset an imbalance between stressors and resources, and *suicide* as a final solution to obtain release or escape (often from psychological pain). We base our definitions on the presence or absence of suicidal intent. There are some, however, who suggest that such definitions are nonscientific (Egel, 1999), imprecise, vague, and not easily quantifiable or qualifiable (De Leo et al., 2006; Mayo, 1992).

Definitions for the New Nomenclature

When we began the task of revising the nomenclature we were cognizant of the number of terms that still existed in the research and clinical literatures. We again reviewed existing nomenclatures and theoretical models to ascertain the key elements that are most frequently associated with the suicidal process and the terms used to describe these cognitions, emotions, and behaviors (Silverman et al., this issue). In their review of the historical definitions of suicide, De Leo et al. (2006) found a number of common key aspects from all the definitions: "The outcome of the behavior, the agency of the act, the intention to die or stop living in order to achieve a different status, the consciousness/awareness of the outcomes" (p. 7). We determined that we needed to account only for a small number of terms that captured the essential components. These terms are: *suicide-related ideations*, *suicide-related communications* (suicide threats and suicide plans), and *suicide-related behaviors* (self-harm, suicide attempts, and suicide). Rather than adding additional terms to the suicide nomenclature to account for combinations and permutations of clinical variables (e.g., presence or absence of intent, self-injury, and outcome), we chose to simplify the terminology by demarcating subtypes (Type I, Type II, etc.) that would account for the variations within each suicide-related category.

The definitions of the terms below are

TABLE 4
Conversion Table of Terminology

EXISTING TERMS	REVISED TERMS
Accidental Suicide	Self-Inflicted Unintentional Death
Completed Suicide	Suicide
Intentional Self-Harm	Self-Harm Types I–II
Intentional Self-Injury	
Deliberate Self-Harm	
Instrumental Suicide-Related Behavior	Suicide Threat, Types I–III
Nonsuicidal Self-Injury	Self-Harm, Types I–II
Parasuicide	Suicide Attempt, Types I–II
Suicidal Behaviors	Suicide-Related Behaviors
	Suicide-Related Ideations
	Suicide-Related Communications
Suicidality	Suicide-Related Behaviors
Suicide Attempt	Suicide Attempt, Types I–II
Suicide Gesture	Self-Harm, Types I–II
Suicide Plan	Suicide Plan, Types I–III
Suicide Threat	Suicide Threat, Types I–II
Thought/Ideation	Suicide-Related Ideations

presented in their logical branches, rather than alphabetically, so that their relationships to other terms are clearer. Table 2 and Figures 1 and 2 provide a visual reference of these relationships. A basic and overriding premise is that our nomenclature only refers to those ideations, communications (threats and plans), and behaviors that are self-initiated. Our nomenclature schema is based on the key concepts of differentiating between the presence or absence of suicidal intent, and the presence or absence of injury. We purposely avoided adding a third domain of lethality (or degree of injury) because we currently lack any agreed-upon definition or measure. Here, injury refers only to self-inflicted injuries, implying, by definition, that they are potentially self-destructive or suicidal in nature—leaving aside the measurement of the degree to which they may be lethal. Figures 3 and 4 illustrate the relationship of the key components and terms for suicide-related behaviors.

Suicide-Related Communications

The first set of terms falls broadly under *Suicide-Related Communications*: Any interpersonal act of imparting, conveying, or transmitting thoughts, wishes, desires, or intent for which there is evidence (either explicit or implicit) that the act of communication is not itself a self-inflicted behavior or self-injurious. We included under this category those verbal and nonverbal communications that may have suicidal intent but have no injurious outcome. This broad definition includes two subsets. A *Suicide Threat* is any interpersonal action, verbal or nonverbal, without a direct self-injurious component, that a reasonable person would interpret as communicating or suggesting that suicidal behavior might occur in the near future. A *Suicide Plan* is a proposed method of carrying out a design that will lead to a potentially self-injurious outcome; a systematic formulation of a program of action that has the potential for resulting in self-injury.

Because suicide-related phenomena often have interpersonal motivations, we thought of suicide-related communications as a half-way point between private thoughts about suicide (cognitions) and actions directed at self-injury (behaviors). Communication is interpersonal in nature and involves putting into words how one might advance

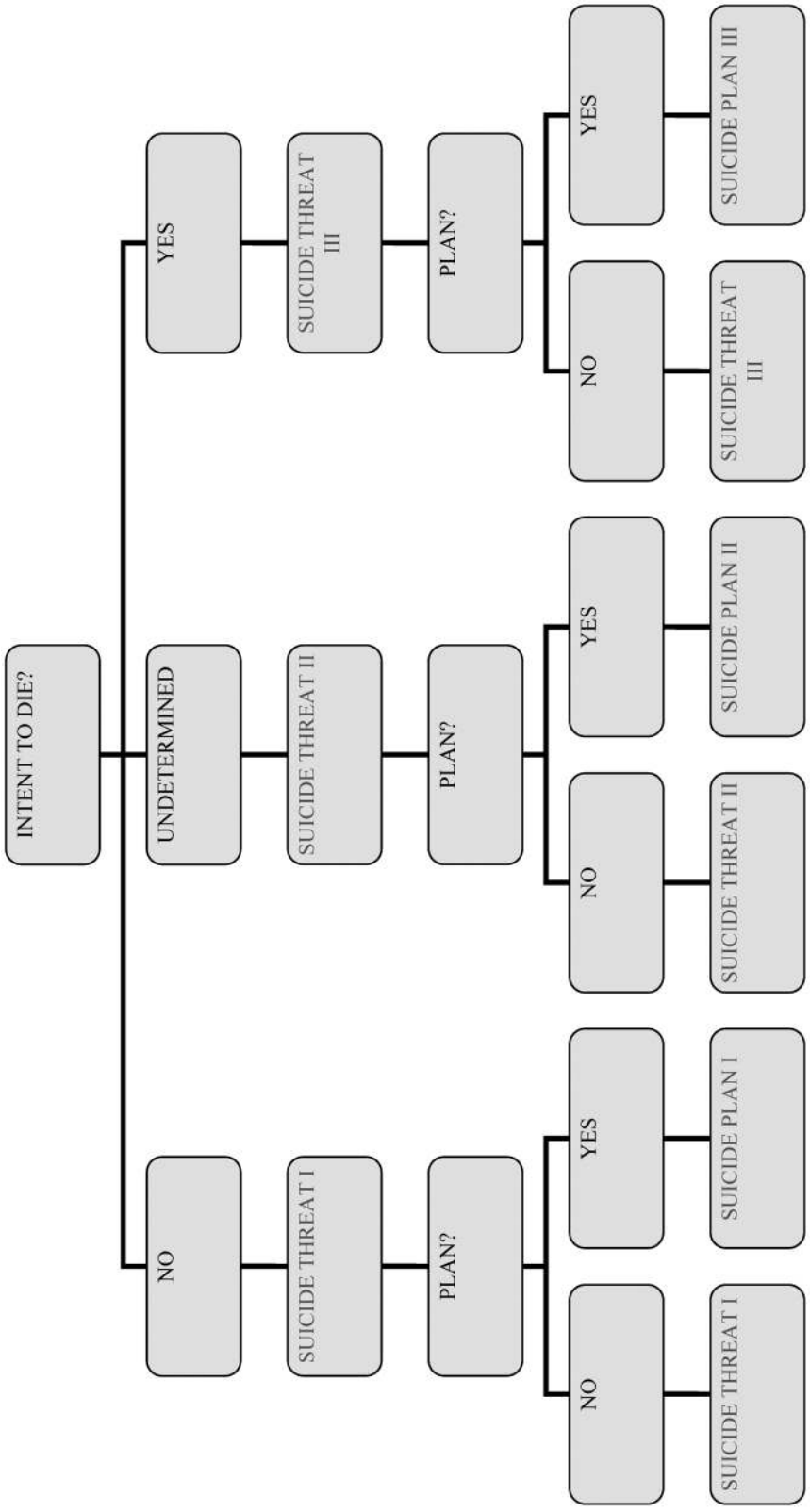

Figure 1. Suicide-related communications.

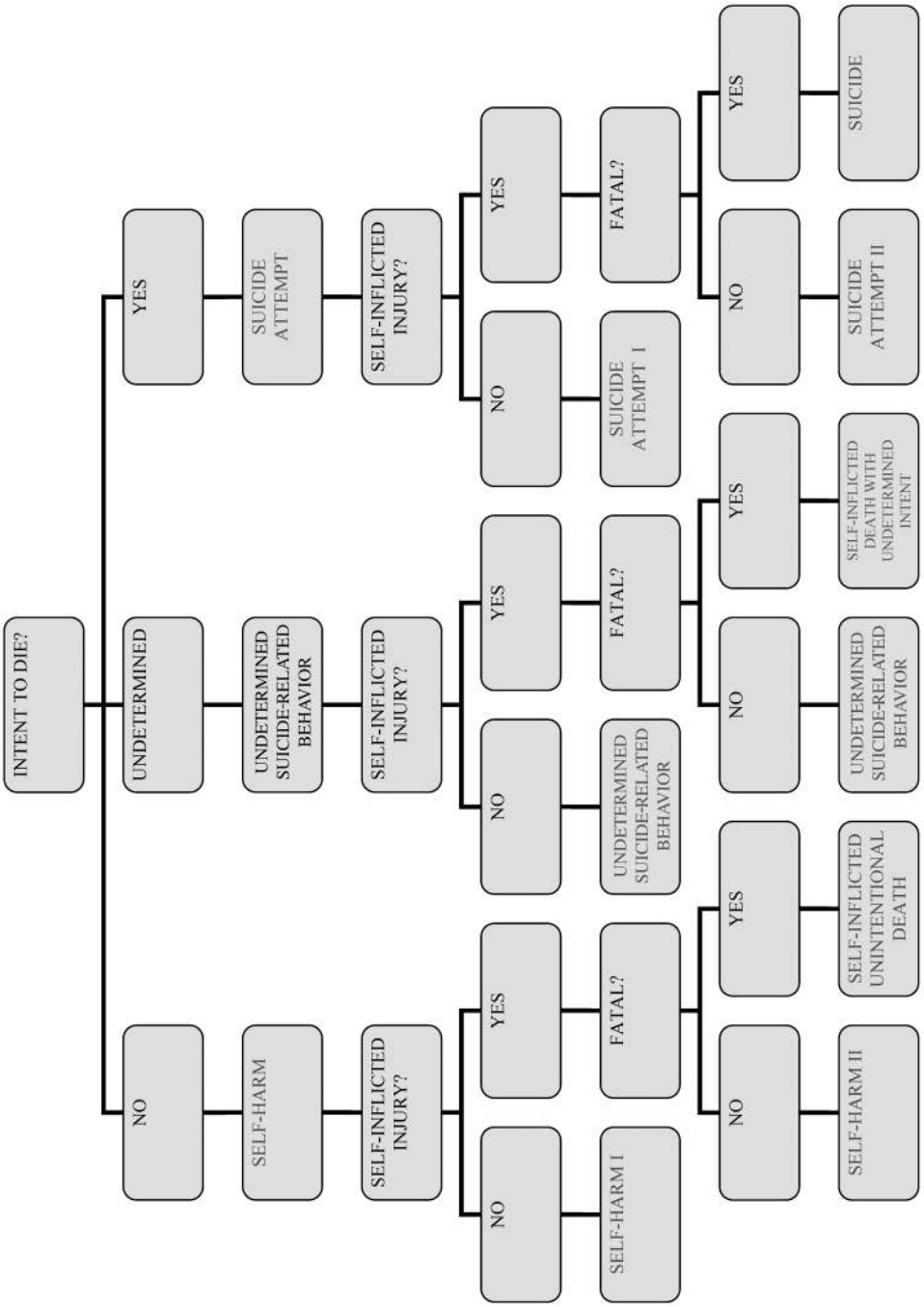

Figure 2. Suicide-related behaviors.

NOMENCLATURE FOR SUICIDE-RELATED BEHAVIORS			INTENT TO DIE BY SUICIDE	OUTCOMES		
				NO INJURY	NON FATAL INJURY	DEATH
SUICIDE-RELATED BEHAVIORS	SELF-HARM	WITH NO SUICIDAL INTENT				
		WITHOUT INJURIES SELF-HARM—TYPE I	NO	✓		
		WITH INJURIES SELF-HARM—TYPE II	NO		✓	
		WITH FATAL INJURIES SELF-INFLICTED UNINTENTIONAL DEATH	NO			✓
	UNDETERMINED SUICIDE-RELATED BEHAVIOR	WITH UNDETERMINED SUICIDAL INTENT				
		WITHOUT INJURIES UNDETERMINED SUICIDE RELATED BEHAVIOR —TYPE I	UNDETERMINED	✓		
		WITH INJURIES UNDETERMINED SUICIDE RELATED BEHAVIOR—TYPE II	UNDETERMINED		✓	
		WITH FATAL INJURIES SELF-INFLICTED DEATH WITH UNDETERMINED INTENT	UNDETERMINED			✓
	SUICIDE ATTEMPT	WITH SUICIDAL INTENT				
		WITHOUT INJURIES SUICIDE ATTEMPT—TYPE I	YES	✓		
		WITH INJURIES SUICIDE ATTEMPT—TYPE II	YES		✓	
		WITH FATAL INJURIES SUICIDE	YES			✓

Figure 3. Nomenclature for Suicide-Related Behaviors.

from ideation to action (suicide plan), or how one might move from ideation to pre-action (suicide threat). If there is no suicidal intent associated with the communication, we label it *Suicide Threat, Type I*. If there is an undetermined level of suicidal intent, it is labeled *Suicide Threat, Type II*. If there is some degree of suicidal intent we call it *Suicide Threat,*

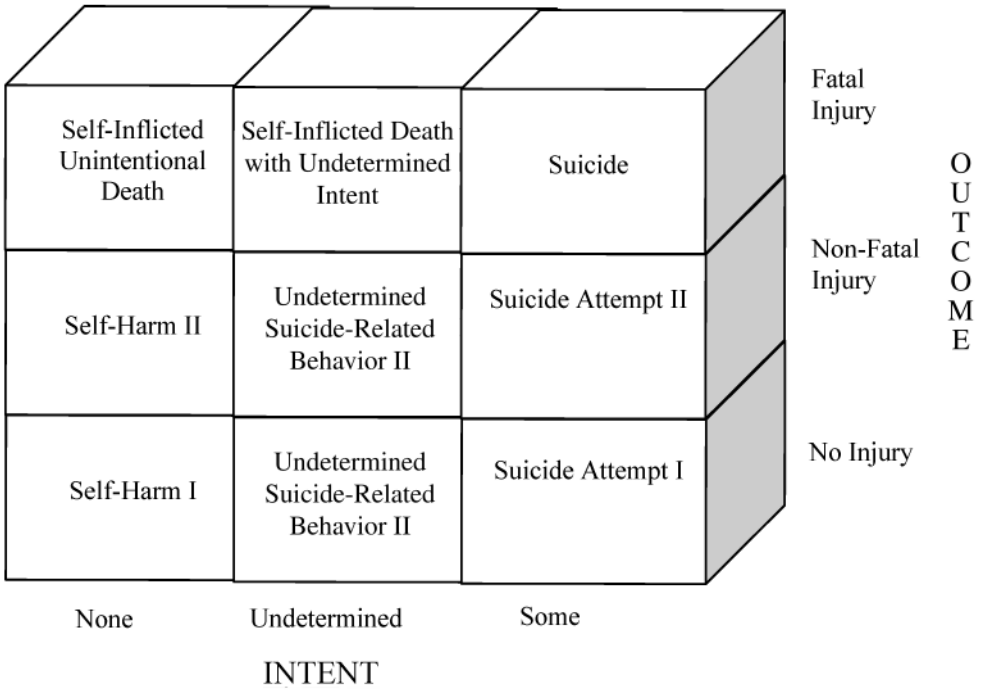

Figure 4. Schematic Representation of Suicide-Related Behaviors.

Type III. If there is no intent but the expression of a definite plan to end one's life, it is called a *Suicide Plan*, *Type I*. If there is an undetermined level of intent with a definite plan, it is called *Suicide Plan*, *Type II*. If there is some suicidal intent with a definite plan, we label it *Suicide Plan*, *Type III*.

Suicide-Related Behaviors

We chose the term *Suicide-Related Behaviors* over self-injurious behaviors or self-initiated behavior because it best captured our emphasis on behaviors that don't always result in death, but are "related" to the process or concept of self-inflicted death (De Leo, Bertolote, & Lester, 2002). Suicide-related behavior is a self-inflicted, potentially injurious behavior for which there is evidence (either explicit or implicit) either that: (a) the person wished to use the appearance of intending to kill himself/herself in order to attain some other end; or (b) the person intended at some undetermined or some known degree to kill himself/herself. Suicide-Related Behaviors can result in no injuries, injuries, or death. Suicide-related behaviors comprise self-harm, self-inflicted unintentional death, undetermined suicide-related behaviors, self-inflicted death with undetermined intent, suicide attempt, and suicide.

The first major bifurcation of the nomenclature is based on intent to die, which is answered affirmatively, negatively, or with uncertainty (De Leo et al., 2004, 2006). If there was not an intent to die associated with the suicidal behavior, then a separate branch of the nomenclature is explored, starting with *Self-Harm*. Self-harm is defined as a self-inflicted, potentially injurious behavior for which there is evidence (either implicit or explicit) that the person did not intend to kill himself/herself (i.e., had no intent to die). Persons engage in self-harm behaviors when they wish to use the appearance of intending to kill themselves in order to attain some

other end (e.g., to seek help, to punish others, to receive attention, or to regulate negative mood). Self-harm may result in no injuries, injuries, or death. If the self-harm did not result in injury, it is defined as *Self-Harm, Type I*. If the self-harm resulted in nonfatal injury, it is defined as a *Self-Harm, Type II*. If the self-harm resulted in death, it is classified as a *Self-Inflicted Unintentional Death*, and defined as death from self-inflicted injury, poisoning, or suffocation where there is evidence (either explicit or implicit) that there was no intent to die. This category includes those injuries or poisonings described as unintended or accidental.

Due to the controversy generated by O'Carroll et al.'s prior dichotomous bifurcation of intent to die (yes/no), we recognized the need to add a third category—undetermined intent to die by suicide—when there is a self-inflicted, potentially injurious behavior where intent is unknown. For example, if a person is unable to admit positively to the intent to die, due to being unconscious, under the influence of alcohol or other drugs (and therefore cognitively impaired), psychotic, delusional, demented, dissociated, disoriented, delirious, or in another state of altered consciousness; or is reluctant to admit positively to the intent to die due to other psychological states, we categorize the self-injurious behavior as an *Undetermined Suicide-Related Behavior*. If the behavior was with an undetermined degree of suicidal intent and without injuries, it is called an *Undetermined Suicide-Related Behavior, Type I*. If there were injuries, it is called an *Undetermined Suicide-Related Behavior, Type II*. If the injuries were fatal, it is called a *Self-Inflicted Death with Undetermined Intent* (self-inflicted death for which intent is either equivocal or unknown).

We struggled over the use of the term *undetermined* versus *equivocal*, *unexplained*, *indeterminate*, *unknown*, or *probable* to distinguish this category from actions with no suicidal intent and actions with some degree of suicidal intent. We fully recognized that the medical examiner classification system does not allow for the clarification of undetermined categories. Nevertheless, we felt that this "undetermined" best described the situation when there is a self-inflicted potentially injurious behavior where intent is unknown.

Regarding observed behavior that previously might have been labeled a suicide gesture, if there is no suicidal intent, we suggest that the behavior be labeled as *Self-Harm, Type I* (no injury) or *Self-Harm, Type II* (with injury), because the purpose of the behaviors we used to call "gestures" was really to alter one's life circumstances (interpersonal or intrapersonal) in a manner that was without suicidal intent, but involved self-inflicted behaviors (whether or not it resulted in injuries). If there is an undetermined degree of suicidal intent, it is labeled as *Undetermined Suicide-Related Behavior, Type I* (no injury), or *Undetermined Suicide-Related Behavior, Type II* (with injury).

Suicide Attempt is now defined as a self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die. A Suicide Attempt may result in no injuries, injuries, or death. If there is some degree of suicidal intent, then we label it as *Suicide Attempt, Type I* (no injury), or *Suicide Attempt, Type II* (with injury), regardless of the degree of injury or lethality of method. If the suicide attempt resulted in death, it is defined as a *Suicide*. Hence, our use of the term *suicide attempt* relates specifically to a self-inflicted act with the intent to end one's life, and is distinguished from self-harm and undetermined suicide-related behavior. We had some misgivings about the term *completed suicide*, because we believe it is redundant and potentially pejorative, although we recognize the ubiquitous use in the parlance of suicidology. For purposes of the nomenclature, we decided to simply use the term *suicide* to denote when there was a self-inflicted death with evidence (either explicit or implicit) of intent to die. We believe that our simplified definition contains all the "fundamental requirements" as set forth by the WHO/EURO Multicentre Study on Parasuicide: "responsibility, awareness of the potential le-

thality of the act, intention to die/provoke those changes that the subject is assumed to prefer to living conditions otherwise perceived as unbearable" (De Leo et al., 2006, pg. 12).

Substituting Self-Harm *for* Instrumental Suicide-Related Behavior *and* Deliberate Self-Harm. O'Carroll et al. initially chose the term *instrumental suicide-related behavior* (ISRB) to encompass instrumental suicide-related behavior with or without injury, and with fatal outcome (accidental death). We were subsequently convinced that a better term for ISRB is *deliberate self-harm* (DSH), a term used by our colleagues, especially in Europe (Pattison & Kahan, 1983; Zahl & Hawton, 2004). The European definition of DSH is: intentional self-poisoning or self-injury, irrespective of motivation (Hawton et al., 2003). We decided that DSH conveyed the same meaning as ISRB, provided it did not include *suicide attempts* within its definition, and was more palatable to our colleagues than ISRB. DSH does not require for its usage the establishment of suicidal intent; however, *self-harm*, as used in the American research literature, is defined as a deliberate and often repetitive destruction or alteration of one's own body tissue without suicidal intent (Favazza, 1989; Favazza & Rosenthal, 1993). Inasmuch as the term suggests the connotation of deliberateness, consumers of mental health services in the United Kingdom petitioned the Royal College of Psychiatrists to change the term *deliberate self-harm* to *self-harm* (Hawton & James, 2005). We chose to follow that recommendation.

One potential complication with separating self-harm and suicide attempt into two separate categories is that it is possible for self-injurious intent and suicidal intent to be present in an individual at the same time. For example, individuals with borderline personality disorder who, by definition, are often self-injurious, also have a relatively higher rate of suicide than the general population. When an individual is unable to clearly communicate the type of intent that led to a self-injurious behavior (e.g., ambivalence about the intent to die), then the decision about how to label their behavior can be difficult. Using other definitions, research has shown that suicide attempters and those who die by suicide may be two separate, but overlapping populations (Beautrais, 2001). Using our revised nomenclature, those who engage in self-harm and those who engage in suicide attempts may have some overlapping features.

CONCLUSION

With a recent number of other nomenclatures to choose from (Brown, Jeglic, Henriques, & Beck, 2006; De Leo et al., 2006; Hammad, Laughren, & Racoosin, 2006; U.S. Dept., 2001) and a plethora of suicide-related terms to choose from (Silverman, 2006), what is a clinician, researcher, or policy maker to do? Case definition leads to clarification of incidence and prevalence (Phillips & Ruth, 1993). Epidemiological studies lead to development of treatment modalities and preventive intervention approaches (Moscicki, 1989, 1995). Treatment and prevention studies result in further refinement and development of approaches that eventually lead to the reduction and amelioration of the observed behavior (Silverman & Maris, 1995; Soubrier, 1999). Until such time as everyone adopts a common language with a common set of definitions, there is little likelihood that the data from research and clinical centers, as well as from different communities (let alone countries), can be compared, contrasted, and discussed with any degree of reliability and validity (Silverman, 1997).

The nomenclature provided here was built with an eye toward its application in clinical research. It was conceived with the expectation of translation into operational definitions, case examples, and field testing. It was designed to serve as an instrument to assist clinicians in better identifying those most at-risk for suicide-related behaviors in order to help keep them alive. It is obvious to us that the field needs to convene an international symposium of clinicians, researchers, preventionists, and policy makers to discuss the language of suicidology and to set a

course to empirically test the reliability and validity of a set of agreed-upon terms. Multinational, multicentered research studies using the same nomenclature are needed before we can answer such questions as the true incidence and prevalence of, and interrelationships between and among, suicidal thinking, behaviors whose outcome is self-injury, and those behaviors which, but for successful emergency medical interventions, would result in death.

We hope that a revised nomenclature will result in better surveillance and risk assessment, and, therefore, more effective management, intervention, treatment, and prevention of individuals at risk for suicide. As Rudd (1997) articulated, "a standard nomenclature is essential for good science." Furthermore, "in some respects, precise terminology and related clarification is a clinical intervention that can be used to reduce patient distress and facilitate a better therapeutic alliance" (Rudd, 2006, p. 13).

Future directions for our workgroup include the operationalization of the nomenclature through a clinical chart review. We plan to develop clinical cases and exercises, as well as algorithms and logic models using key constructs and rule in/rule out criteria. The purpose of operationalizing the nomenclature is to establish a set of questions and guidelines to inquire about intent, explicit or implicit behaviors, instrumentality, repeat behaviors, plans, threats, and ideation. Once the nomenclature is operationalized, we will seek to establish reliability and validity (concurrent, construct, and predictive validity) through field testing. This will establish whether the nomenclature is feasible and usable. A training manual with examples will be developed (e.g., coding forms and coding books).

A nomenclature consists of terms and definitions. The definitions are a description of the concept and not an explanation, and are not value-laden or theory-driven (Maris, Berman, & Silverman, 2000). A classification system is much more precise and would include categories for the levels of risk and intent; the lethality of methods and outcomes; the location of the behavior; the frequency of suicide-related thoughts and behaviors; as well as the severity, intensity, and duration of the suicide-related event. We see the development of a classification system as the end product of these current efforts.

Jamison (1999) observed that, "All suicide classification and nomenclature systems are, to a greater or lesser extent, flawed; and all, or almost all will have points that are well or uniquely taken" (p. 27). In the end, our primary considerations in revising the nomenclature were: (1) intelligibility over precision; (2) practicability over hard science; (3) consistency over convenience; and (4) retention of commonly used parlance over the invention of new terminology. We ask that the field test this nomenclature with "what if" and "what about" challenges to assist in further refinement and ultimately better understanding of, and intervention for, those who engage in suicide-related ideations, communications, and behaviors.

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