Suicide and Life-Threatening Behavior 36(5) October 2006

The Language of Suicidology

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This 2005 Louis I. Dublin Award Address explores some of the basic difficulties and controversies inherent in the development and universal acceptance of a nomenclature for suicidology. Highlighted are some of the unresolved challenges with agreeing upon a mutually exclusive set of terms to describe suicidal thoughts, intentions, motivations, and self-destructive behaviors.

There now is converging research evidence that clinically important differences exist among suicide ideators, suicide attempters and multiple attempters; yet it is not unusual to read research studies or media accounts where suicide-related terms are not defined, used interchangeably, or have different meanings depending on the author(s). Many of these studies do not use the same definitions for the outcome variables nor rigorously define the populations being studied. In order to understand, assess, treat, predict, or prevent suicide and suicidal behaviors, we must be able to accurately specify and define the types and the subtypes of suicide and suicidal behaviors (nomenclature), and clearly categorize the different clinical presentations into distinct groups (classification).

NOMENCLATURE AND CLASSIFICATION SCHEMES

There have been prior attempts to codify nomenclature and classification schemes (Shneidman, 1968). The Beck classification and nomenclature scheme (Beck et al., 1973; Beck, Resnick, & Lettieri, 1974) identified three categories (completed suicide, suicide attempt, and suicidal ideation), each of which had five defining criteria (certainty, lethality, intent, mitigating circumstances, and methods). Maris (1992) proposed a multi-axial classification of suicidal behaviors and ideation that had five categories (completed suicide, nonfatal suicide attempts, suicidal ideation, mixed or uncertain mode, and indirect self-destructive behavior) with 11 measurable categories for classification. The WHO/EURO Multicentre Study on Parasuicide (Platt et al., 1992), conducted in 19 European countries, also used a standardized nomenclature (see Ellis, 1988; Hawton & van Heeringen, 2000; Maris, Berman, & Silverman, 2000; and Schmidtke, Bille-Brahe, De Leo, & Kerkhof, 2004 for a more detailed discussion). Nevertheless, the universal acceptance and usage of these classification schemes have been hindered by the lack of agreed-upon nomenclature (terms), operational definitions, measures of intent, lethality measures, and measurements for suicidal behaviors. One recurrent difficulty has been the rush to develop classification schemes before there has been uniform acceptance of mutually exclusive terminology and their definitions.

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This paper will attempt to elucidate some of these issues and offer some perspectives.

STANDARDIZING A NOMENCLATURE

The need for, and importance of, a standard nomenclature have been recognized by many suicide researchers and clinicians (Dear, 2001; De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2004; Linehan, 2000; Maris et al., 2000; Marusic, 2004; Mayo, 1992; O'Carroll et al., 1996; Rosenberg et al., 1988; Rudd, 1997; Rudd & Joiner, 1998). Further, as the field develops, more terms are being added without regard for clarity and purity of communication. In the field of linguistics, Bergenholtz (1975) refers to an uncontrolled drive by scholars to create new terms, or to use existing terms in new ways. The net result is that, all too often, the same concept is denoted using different terms, while at the same time identical terms often mean different things, depending on whom one reads (Peeters, 2000).

As noted by Simon Winchester (1998) in his popular book about the making of the Oxford English Dictionary, the concept of a dictionary was to be "an inventory of the language," not a guide for its usage. O'Carroll et al. (1996) felt that a nomenclature forms the basis for, but is distinct from, a formal classification scheme. Unlike a classification system, a nomenclature does not aim to be exhaustive or to precisely mirror reality; the aim is communication, utility, and understanding (De Leo et al., 2004). Definitions should not be explanations. Defining a word or behavior is not the same as saying why the word exists, or what causes the behavior. Operational definitions, on the other hand, suggest how the word or behavior should be measured (Maris et al., 2000), so the first challenge is to establish a universally accepted core nomenclature.

A nomenclature is a set of commonly understood, widely acceptable, comprehensive terms that define the basic clinical phenomena of suicide and suicide-related behaviors and is based on a logical and minimum set of necessary component elements that has utility (e.g., can be easily applied). The purpose of a nomenclature is to facilitate communication among clinicians, researchers, and public health practitioners by providing terms that can be applied in different settings and populations. An ideal nomenclature should enhance clarity of communication, be theory neutral (applicable across all theoretical perspectives), culturally normative (avoid cultural beliefs and biases, judgments, and values), and contain mutually exclusive terms that encompass the entire spectrum of suicidal thoughts and actions.

Clinical Advantages

Rudd (2000, pp. 58–59) has elegantly identified the advantages of a standard nomenclature for clinical practice: (1) improved clarity, precision, and consistency of a single clinician's practice of risk assessment, management, and treatment both over time for an individual patient and across suicidal patients; (2) improved clarity, precision, and consistency of communication(s) among clinicians regarding issues of risk assessment, ongoing management, and treatment; (3) improved clarity in documentation of suicide risk assessment, clinical decision making, related management decisions, and ongoing treatment; (4) elimination of inaccurate and potentially pejorative terminology; (5) improved communication (and rapport) between the clinician and patient; and (6) elimination of the goal of prediction by recognizing the importance and complexity of implicit and explicit suicide intent in determining ultimate clinical outcome. Similar advantages are applicable to research studies with the goal of being able to compare populations and findings across studies.

Research Advantages

Without clear definitions it becomes problematic to compare studies between and among different research groups, countries or surveyed populations. For example, in

2001–2003, Kessler, Berglund, Borges, Nock, and Wang (2005) found that U.S. citizens (ages 18–54) self-reported that, within the last 12 months, 3.3% had suicidal ideation, 1.0% had a plan, and 0.6% experienced suicide attempts. The CDC's Youth Risk Behavior Survey monitors high school students' (grades 9–12) self-reports on a range of health behaviors. In 2003, within the last 12 months, 16.9% seriously considered attempting suicide, 16.5% made a plan, and 8.5% attempted suicide (CDC, 2005). Trying to reconcile or interpret these numbers is problematic, because these terms are all self-defined and these thoughts and behaviors are all self-reported.

DEFINING SUICIDE

If we accept the premise that suicidal ideation and motivation (cognitions), intent (emotions), threats (verbalizations), and gestures and attempts (behaviors) are related to suicide (death, or the cessation of thinking, feeling, and behaving), then we must first define the term *suicide* so that we have a starting point to reference and define all the other related cognitions, emotions, and behaviors. Maris et al. (2000) identified six definitions of suicide in the literature and De Leo et al. (2004) reported eight frequently reported definitions of suicide. Merging the two lists, with the inclusion of additional definitions found in the scientific literature, yielded a total of 15 commonly referenced definitions of suicide (see Table 1). Most of these definitions are theoretically bound, representing perspectives from sociology, psychiatry, psychology, public health, and philosophy, among others.

These definitions have essentially defined suicide in one of three ways: a deliberate act of self-destruction that results in death; a conscious self-directed act with the intent to die; or a willful self-inflicted life-threatening act resulting in death (Marusic, 2004; Retterstol, 1993). The key differences in these definitions are based on the theoretical orientations (e.g., psychology, sociology, etc.) and cultural influences (e.g., beliefs and value systems) of their creators. Investigators have identified four shared key aspects inherent in any definition: (1) outcome of the behavior (death); (2) agency of the act (self-inflicted—done by oneself and to oneself); (3) intention to die in order to achieve a different status; and (4) consciousness (awareness) of the outcome, including being indirect or passive (De Leo et al., 2004; Farberow, 1980; Maris et al., 2000). Thus, a comprehensive definition of suicide rests on unequivacable criteria for clarifying the intent to die and determining whether an individual was aware, in advance, of the consequences of their behavior (whether direct, indirect, or passive).

The three components that coroners use to legally distinguish suicide from other deaths due to natural causes, accidental death, and homicide (e.g., The NASH classification) are: (1) death as the result of injuries, poisoning, or suffocation; (2) self-inflicted; and (3) intentionally inflicted (O'Carroll et al., 1996; Rosenberg et al., 1988). This classification, however, leaves the concept of "intentionally inflicted" undefined, and limits the method of death to just a consideration of injuries, poisoning, or suffocation.

Measuring Psychological Intent and Medical Lethality

For there to be suicidal behavior there needs to be an established intent to die and a measurable medical lethality associated with the behavior. These two constructs can be evaluated by asking the individual (self-report), or they can be inferred from the potential lethality of the behavior, the circumstances surrounding the behavior, or the presence of a suicide note. Linehan (2000) suggests that there are two measures of intent: implicit intent (intent inferred from the behavior itself) and explicit intent (intent directly communicated by the individual). As Wagner, Wong, and Jobes (2002) have observed, the presence and degree of suicidal intent often is difficult to determine due to the ambivalence of the individual as to whether they really wanted

TABLE 1
Fifteen Frequently Referenced Definitions of Suicide

Definitions	Source	Year
All cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result.	Emile Durkheim	1897/1951
Suicide is (1) a murder (*selbstmord*) (involving hatred or the wish-to-kill), (2) a murder by the self (often involving guilt or the wish-to-be-killed), and (3) the wish-to-die (involving hope-lessness).	Karl Menninger	1938
All behavior that seeks and finds the solution to an existential problem by making an attempt on the life of the subject.	Jean Baechler	1975
Suicide is a conscious act of self-induced annihilation, best understood as a multi-dimensional malaise in a needful individual who defines an issue for which suicide is perceived as the best solution.	Edwin S. Shneidman	1985
An act with a fatal outcome which the deceased, knowing or expecting a fatal outcome, had initiated and carried out with the purpose of provoking the changes he desired.	World Health Organization	1986
A fatal willful self-inflicted life-threatening act without apparent desire to live; implicit are two basic components—lethality and intent.	Joseph H. Davis	1988
Death, arising from an act inflicted upon oneself with the intention to kill oneself.	Mark L. Rosenberg et al.	1988
Death from injury, poisoning, or suffocation where there is evidence (either explicit or implicit) that the injury was self-inflicted and that decedent intended to kill himself/herself.	Centers for Disease Control (OCDS definition)	1988
Self-initiated, intentional death.	André Ivanoff	1989
The definition of suicide has four elements: (1) a suicide has taken place only if a death occurs, (2) it must be of one's doing, (3) the agency of suicide can be active or passive, and (4) implies intentionally ending one's own life.	David J. Mayo	1992
Suicide is, by definition, not a disease, but a death that is caused by a self-inflicted intentional action or behavior.	Morton Silverman & R. Maris	1995
The act of killing oneself deliberately initiated and performed by the person concerned in the full knowledge or expectation of its fatal outcome.	World Health Organization	1998
Death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death.	S. K. Goldsmith, T. C. Pellmar, A. M. Kleinman, & W. E. Bunney	2002
Fatal self-inflicted self-destructive act with explicit or inferred intent to die. Multiaxial description includes: Method, Location, Intent, Diagnoses, and Demo-graphics.	Institute of Medicine	2002
An act with a fatal outcome which the deceased, knowing or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes.	Diego DeLeo et al. 2004	

to die, or the individual's denial, minimization, or inflation of their suicidal intent, either to achieve a desired end or to manage their own anxiety. One approach to measuring intent is to seek a correlation between the expected and actual outcome of the method used; however, self-report of intent can be quite unreliable. Furthermore, it is not easy

to infer intent when basing the decision on the medical lethality of the behavior and its outcome (Linehan, 1986). Brown et al. (2004) found that the accuracy of expectations about the likelihood of dying moderates the relationship between suicide intent and medical lethality.

The medical lethality and the circumstances that led to the self-harm also may be difficult to determine, because here, too, the clinician is often dependent on self-report. The determination of whether a behavior is truly a suicide attempt can involve a great deal of subjectivity and inference, and be based on the degree of the clinician's past experience and training. Assigning weights to intent and lethality is often a balancing act that is influenced by additional factors, such as the gender of the individual and whether there is external information from reliable sources.

Measuring suicide intent is believed by some to be more useful than measuring the lethality of the attempts (Harriss, Hawton, & Zahl, 2005). From a research perspective, accurate assessment of intent is necessary to characterize a study sample in a way that maximizes participant homogeneity within categories, and subsequently maximizes validity and communicability of the findings (Kidd, 2003). Assessment of intent is critical to the operationalization of suicidal behaviors, but many studies do not include assessment of intent in their effort to operationalize the range of suicidal behaviors (Linehan, 2000).

DEFINING SUICIDE ATTEMPT

Inasmuch as the definition of suicide includes the elements of self-inflicted injury with the intent to die, any meaningful definition of *suicide attempt* should also incorporate a high likelihood of death, as well as one's true intent to kill oneself. Kessler, Borges, and Walters (1999) found that among U.S. citizens (aged 15–54 years) in 1990–92, 13.5% self-reported having suicidal ideation at some point in their lifetime, 3.9% reported a lifetime suicide plan, and 4.6% reported a suicide attempt sometime in their life. Of the attempters, 39.3% made a "serious" life-threatening attempt, 13.3% made a "serious" attempt but did not use a "fool-proof" method, and 47.3% made a "cry for help" and did not want to die. Thus, close to 50% of those who reported at least one suicide attempt are defining that behavior as a "cry for help." Kreitman, Philip, Greer, and Bagley (1969) stated that "the term 'attempted suicide' is highly unsatisfactory, for the excellent reason that the great majority of patients so designated are not in fact attempting suicide" (pp. 746–747). Meehan, Lamb, Saltzman, and O'Carroll (1992) found that for every ten self-reported attempts, only one resulted in hospitalization. Two others resulted in some form of medical attention. The intent and lethality of the other 70% was unknown, seriously compromising the validity of self-reported "suicide attempts." In reviewing these studies, O'Carroll et al. (1996) concluded that, "Because the term 'attempted suicide' potentially means so many different things, it runs the risk of meaning nothing at all" (p. 238). The term is vastly overused and misunderstood, and often is used to describe other forms of self-injury and psychological distress.

At present, *suicide attempt* continues to have different meanings to different people. Some have offered alternatives terms such as "parasuicide" (Kreitman, 1977), "nonfatal suicidal behaviors" (Canetto & Lester, 1995), and "deliberate self-harm" (Zahl & Hawton, 2004). These terms are generally applied to self-injurious behaviors, whether suicide intent is present or not; however, as has been pointed out by others, these terms are more heterogeneous than "suicide attempt," because they can include behaviors spanning the entire range of suicide intent and medical lethality (Linehan, 1986; Wagner et al., 2002). Furthermore, each of these terms have been defined and used in multiple ways (see Table 2). The use of multiple definitions and terms for nonfatal self-destructive behaviors creates linguistic, operational, theoretical, and clinical confusion. The term *deliberate self-harm*

TABLE 2
Some Alternative Definitions of Nonfatal Self-Harm Behaviors

WHO/EURO Multicentre Study on Parasuicide (Platt et al., 1992)
An act with nonfatal outcome, in which an individual deliberately initiates a nonhabitual behavior that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical sequences.

O'Carroll et al. (1996) Definition of Suicide Attempt
A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence (either explicit or implicit) that the person intended at some (nonzero) level to kill himself/herself. A suicide attempt may or may not result in injuries.

National Strategy for Suicide Prevention (2001) Definition of Suicide Attempt
A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

National Strategy for Suicide Prevention (2001) Definition of Suicidal Act
A potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries.

Goldsmith et al. (2002) Definition of Suicide Attempt
A nonfatal, self-inflicted destructive act with explicit or inferred intent to die. (*Note*: important aspects include the frequency and recency of attempt(s), and the person's perception of the likelihood of death from the method used, or intended for use, medical lethality, and/or damage resulting from method used, diagnoses, and demographics.)

Hawton et al. (2003) Definition of Deliberate Self-Harm
Deliberate self-harm includes nonfatal self-poisoning and self-injury, irrespective of motivation.

DeLeo et al. (2004) Definition of Nonfatal Suicidal Behavior (with or without injuries)
A nonhabitual act with nonfatal outcome that the individual, expecting to, or taking the risk, to die or to inflict bodily harm, initiated and carried out with the purpose of bringing about wanted changes.

AAS/SPRC (2006) Definition of Suicide Attempt
A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person had the intent to kill him/herself, but failed, was rescued or thwarted, or changed one's mind. A suicide attempt may or may not result in injuries.

AAS/SPRC (2006) Definition of Deliberate Self-Harm
Intentional self-injurious behavior where there is no evidence of intent to die. DSH includes various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses, or exhibiting deliberate recklessness.

(DSH) is being used widely in Europe to include nonfatal intentional self-poisoning and self-injury, irrespective of motivation (Hawton, Zahl, & Weatherall, 2003). This broader term for self-harming behavior takes into account the fact that motivation for self-harming behavior is often complex (Hjelmeland et al., 2002). Self-poisoning is defined as the intentional self-administration of more than the prescribed dose of any drug, whether or not there is evidence that the act was intended to cause self-harm, and includes poisoning with non-ingestible substances and gas, overdoses of recreational drugs, and se-

vere alcohol intoxication where clinical staff consider such cases to be acts of self-harm. *Self-injury* is defined as any injury recognized by clinical staff as having been intentionally (deliberately) self-inflicted (Harriss et al., 2005; Hawton, Fagg, Simkin, Bale, & Bond, 1997). Of note is that the application of these terms to intentional behaviors resides with the judgment of clinicians.

Meehan et al. (1992) suggest that in order to better differentiate the behaviors currently included under the rubric *suicide attempt*, a series of questions are needed with independent verification from a knowledgeable source such as an emergency room physician, in addition to the self-report from the individual. The series of questions should elicit a description of the injury that occurred, if any, so that independent raters may judge the potential lethality of the event; whether medical attention or hospitalization followed; and whether the self-injury was indeed intended to cause one's own death. Without such data, and assurances that the data are reliable and valid, Meehan et al. concluded that we cannot accurately understand the phenomenon of suicidal behavior. Furthermore, they point out that, "Most significant among the limitations. . . . There is no way to determine if the youths' recollections and the attributions accurately reflect their psychological state at the time of the suicide attempts" (p. 43). Currently no standardized or widely accepted set of questions or investigations exist to address these limitations.

The inherent ambiguity of the term *suicide attempt* is not limited to the individuals who self-report suicidal behaviors. Wagner et al. (2002) asked 14 expert suicidologists and 59 general mental health clinicians to judge whether each of ten vignettes of actual adolescent self-harm behaviors was, indeed, a suicide attempt. Low levels of agreement were found within each group surveyed, even when half of the general mental health clinicians were provided with the O'Carroll et al. (1996) definition of suicide attempt. The suicide attempt judgments made by the general mental health clinicians who were not provided a standard definition were not very reliable, but the judgments of the expert suicidologists were no better. Clinicians provided with a definition were no more reliable than those without the definition. These results may be due to how professionals weigh the individual contributions of suicidal intent and medical lethality in their decisions about judging suicide attempts. The general clinicians seemed to have relied on intent more heavily than lethality in making their decisions. Wagner et al. concluded that it is difficult to perfect a binary definition, and opted for a definition that is inherently imprecise "so as to allow for several shades of gray" (p. 287). They borrowed an approach from the fuzzy logic subfield of engineering and applied it to the concept of suicide attempt, suggesting that the term is meaningful despite being inherently uncertain and imprecise. They suggest that there is no entirely objective measure that captures variations in suicide attempt-ness, and suggest the development of several different sets of operational criteria for a suicide attempt, which vary depending upon the specific purpose or setting.

As long as the term remains poorly defined, it becomes impossible to accurately know by self-report how many individuals have had a history of a prior suicide attempt. As a result it becomes difficult to develop meaningful and specific intervention strategies for high-risk groups, especially if they are not identified as such (Kidd, 2003).

SYNONYMS AND EUPHEMISMS

If we accept that there is no standardized nomenclature for suicidology, then we can appreciate why there are so many synonyms in use to describe aspects of the suicidal process. Tables 3–7 provide some examples of terms found in the research and clinical literature which approximate or substitute for more commonly used terminology and concepts. In my opinion these synonyms and euphemisms obfuscate our communications.

TABLE 3
Synonyms for Suicidal Ideation

Considering Suicide
Contemplating Suicide
Fleeting Thoughts of Suicide
Morbid Ruminations
Prone to Suicide
Suicidal Flashes
Suicidal Ideology
Suicidal Preoccupations
Suicidal Thoughts

TABLE 5
Synonyms for Suicide Threat or Gesture

Instrumental Suicide-Related Behavior
Metasuicide
Perisuicidal Behavior
Pseudosuicidal Behavior
Self-Cutting
Self-Injury
Self-Mutilation
Suicidal Acting Out
Suicide Manipulation
Suicidiform Behavior

The State of Being Suicidal

What is meant when we say that an individual is suicidal.? Does such a state imply the presence (implicit or explicit; active or passive; imminent or chronic) of ideation, motivation, intent, gesturing, threatening, planning, or attempting, or some combination of these different cognitive, emotional, and behavioral states? If there is no universally accepted definition of suicide, then it becomes difficult, if not impossible, to define *suicidal*, or to classify an individual as being suicidal. For example, the National Institute of Mental Health (1995) defined suicidal behavior as including "ideation, verbalization, threats, plans, attempts, deliberate self-injuries, and other self-destructive behaviors that may be suspect."

From my perspective, one of the obfuscations in terminology is the ubiquitous use of the term *suicidality*. This term also has many definitions, including, but not limited to: ideation without plan, ideation with plan, suicide gesture (i.e., episode in which an individual had suicidal intent and means at hand, but did not attempt suicide), and suicide attempt (Bridge, Barbe, Birmaher, Kolko, & Brent, 2005). Suicidality has become an all-inclusive term to capture the full range of suicidal thoughts and behaviors—just short of death by suicide; however, the National Strategy for Suicide Prevention (2001) defined it as "a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide" (p. 203).

Many studies discuss "the emergence of suicidality" as an outcome or dependent variable, as if one can combine thoughts, intent, access to means, gestures, and attempts all into one category that is homogeneous and describes one group of individuals with similar states and traits. The term lacks the specificity that is needed in order to communicate accurately (see Table 8). With so much latitude in its definition, it becomes challenging to determine whether possessing or expressing suicidality is a trait or state of being suicidal. Nevertheless, I am afraid that this term is here to stay.

TABLE 4
Synonyms for Suicidal Intent

Death Wish
State of Suicidality
Suicidal Attitude
Suicidal Hope
Suicidal Inclinations
Suicidal Tendencies
Suicide Desire
Suicide Wish
Unrelenting Preoccupation with Suicide

Qualifiers and Modifiers

There exists a range of qualifiers and modifiers to the above terms that cover aspects of timing, duration, frequency, intensity, quality, dosage, context, and setting (Table 9). In addition there are qualifiers and modifiers for the risk factors and symptoms

TABLE 6
Synonyms for Suicidal Attempt

Aborted Suicide Attempt	Non-Lethal Suicide
Attempted Suicide	Parasuicide
Courting Death	Resurrected Suicide
Cry for Help	Risk-Taking Behavior
Death Rehearsals	Self-Assaultive Behavior
Death Seeker	Self-Destructive Behavior
Deliberate Self-Harm	Self-Directed Violence
Expression of Suicidality	Self-Harm Behavior
Failed Attempts	Self-Inflicted Behavior
Failed Completion	Self-Initiated Behavior
Instrumental Suicide-Related Behavior	Self-Injurious Behavior
Life-Threatening Behavior	Self-Mutilative Behavior
Near Fatal Suicide Attempt	Suicidal Episode
Near Lethal Attempt	Suicidal Manipulation
Near Lethal Completion	Suicidal State
Near Lethal Self-Harm	Suicide Moment
Near Miss Attempt	Suicide Rehearsals
Non-Lethal Self-Injurious Act	Suicide-Related Behavior

often associated with suicide and suicidal behaviors (Table 10). These terms are also not uniformly defined or used, are very value laden, and are time sensitive.

Removing Stigmatizing Terminology

Recently, Simon (2006) convincingly argued that the term *imminent* should be removed from our lexicon because of its lack of precise meaning. The continued use of certain ackward and possibly imprecise terms perpetuates the stigma associated with suicide and suicidal behaviors, and removing them from the lexicon may be helpful (see Table 11). For example, *successful attempt* can connote something positive about a negative act. The use of terms such as *unsuccessful attempt*, *failed attempt*, *failed suicide*, and *failed completion* can suggest that the preferred out-

TABLE 7
Synonyms for Suicide

Accidental Death/Suicide	Lethal Suicide Attempt
Committed Suicide	Miscalculation
Completed Suicide	Rational Suicide
Death by One's Own Hand	Self-Inflicted Suicide
Ending One's Life	Self-Murder
Failed Attempt	Self-Slaughter
Fatal Repeater	Subintentional/Subintended Death
Fatal Suicidal Behavior	Successful Attempt
Fatal Suicide	Successful Suicide
Fatal Suicide Attempt	Suicidal Execution
Hastened Death	Suicide Victim
Intentional Self-Murder	Unintentional Self-Harm
Intentional Suicide	Unintentional Suicide
Killing Oneself	

TABLE 8
What Do We Mean By Suicidality?

Expression of Suicidal Proclivity?
State of Being Suicidal?
Suicidal Attempt?
Suicidal Gesture?
Suicidal Ideation?
Suicidal Intent?
Suicidal Motivation?
Suicidal Proneness?
Suicidal Statements?
Suicidal Threat?

come of the behavior was definitely to die by suicide, without necessarily knowing the intent of the individual. Certain terms such as *completed suicide* can connote success, and *attempted suicide* can connote failure. Recently, the term *self-harm* has been adopted in preference to *deliberate self-harm* by the Royal College of Psychiatrists in response to concerns raised by mental health service consumers in the United Kingdom (Harriss et al., 2005). Along this same line, the term *committed suicide* can connote illegality (a crime) and dishonor (a moral judgment) which intensifies the stigma attached to the one who has died as well as to those who have been traumatized by the loss (Sommer-Rotenberg, 1998). Many survivors of the suicide of a loved one object to the view that the deceased made a conscious choice or a decision to die, rather believing that, in most situations, the individual's cognitions were impaired and they were in such psychological pain that it was impossible to make rational choices or decisions about ending their lives.

TABLE 9
Qualifiers/Modifiers

Absent vs. Minimal vs. Mild vs. Moderate vs. Moderate Severe vs. Severe vs. Extreme
Absent vs. Present
Accidental vs. Deliberate
Accidental vs. Planned
Active vs. Casual
Active vs. Passive
Acute vs. Fleeting vs. Chronic
Direct vs. Indirect
First-time vs. Repeat
Imminent vs. Short-Term vs. Long-term
Impulsive vs. Intentional
Intentional vs. Unintentional
Lethal vs. Near Lethal vs. Nonlethal
Low vs. Medium vs. High
Mild vs. Moderate vs. Severe
Morbid vs. Normal
Not present vs. Very Mild vs. Mild vs. Moderate vs. Moderately Severe vs. Severe vs. Extremely Severe
No vs. Low vs. Moderate vs. High vs. Very High
Overt vs. Covert
Persistent vs. Transient
Probable vs. Possible vs. Uncertain
Public vs. Semiprivate vs. Private
Recent vs. Remote
Reported vs. Inferred vs. Observed
Serious vs. Nonserious
Unlikely vs. Likely

TABLE 10
Qualities of Qualifiers

Timing:	Imminent vs. Short-Term vs. Long-Term
	Recent vs. Remote
Duration:	Acute vs. Chronic
Frequency:	First-time vs. Repeat
Intensity:	Mild vs. Moderate vs. Severe
	Low vs. Medium vs. High
Character:	Accidental vs. Deliberate
Context:	Impulsive vs. Reactive vs. Planned
Setting:	Public vs. Semiprivate vs. Private
Quality:	Active vs. Passive
Dosage:	Nonlethal vs. Sublethal vs. Lethal

TABLE 11
Possible Terms to be Removed from Lexicon

Attempted Suicide
Committed Suicide
Completed Suicide
Failed Attempt
Failed Completion
Fatal Suicide Attempt
Nonfatal Suicide
Suicide Nonfatal Suicide Attempt
Suicide Victim

If we accept the construct of ambivalence being present in every suicidal drama, then the person dying by suicide is dying, to some degree, despite his/her will or desire to live. Some suggest that self-annihilation may not be a rejection of life but, rather, a rejection of the ongoing pain of living. Suicidal behavior is not evidence of moral weakness or failure, and should not bring shame and rejection to those bereaved or affected by the act.

For me, *completed suicide* remains a problematic term. On the one hand, the term indicates a state that is clearly distinct from other conditions such as "nonfatal suicide attempt" or "nearly lethal suicide attempt;" On the other hand, it seems redundant and can suggest that the completion of a suicide was successful. Nevertheless, I doubt that we will be able to rid our lexicon of this term because it is used so ubiquitously, while my preferred terminology, "died by suicide," is less commonly used.

DIFFERENT DISCIPLINES HAVE DIFFERENT NEEDS

The field of suicidology draws upon the intellectual and clinical traditions of sociology, psychology, medicine, epidemiology, theology, and public health, among others. Each discipline has its own traditions of inquiry, vocabulary, nomenclature, classification systems, theoretical perspectives, and conceptual foundations. As a result, different audiences (e.g., epidemiologists, clinicians, prevention specialists, medical examiners/coroners, etc.) have different measures and outcomes that they seek in studying and reporting suicidal behaviors. Hence, the importance of psychological intent, motivation, access to means, and medical lethality may have different weightings for different purposes.

The difficulty in accurately describing human behaviors that are mutually exclusive exists for other related scientific fields as well. In the field of alcohol studies, confusion exists in clearly delineating the following commonly used behavioral terms: binge drinking, responsible drinking, sensible drinking, dangerous drinking, heavy drinking, moderate drinking, and problem drinking. Specifically, the term *responsible drinking* does not reference the quantity, frequency measure, or even the circumstances associated with this behavior. This term has no uniform definition, implicitly blames alcohol problems on the drinker, yet encourages others to drink. There is no uniform agreement for differentiating between use, misuse, abuse, and recreational use of alcohol. The definition of *binge drinking* simply counts the number of drinks consumed, but does not take into account the time frame during which the drinks were consumed, the body weight of the individual, or the rate of consumption that determines the blood alcohol level, which, when elevated, can reach dangerous levels of impairment. Additionally it does not define the alcohol content of a drink. In the field of epidemiology, terms such as *risk*, *risk factors*, and *cause* are, at times, inconsistently and imprecisely used, fostering scientific miscommunication and misleading research and results (Kraemer et al., 1997). Furthermore, in risk research, imprecise terminology, or less than rigorous research reporting that results from imprecise and inconsistent terminology, can impede understanding the cause and course of diseases, and may lead to inadequate clinical decision making.

OBSTACLES TO CONSENSUS

There are multiple obstacles to arriving at a consensus regarding a standardized nomenclature, including systemic, practical, and organizational obstacles. Such obstacles include the establishment and measurement of such concepts as intent, motivation, and lethality (Berman, Shepherd, & Silverman, 2003), as well as determining which approach will be used to measure these constructs (e.g., clinical judgment vs. checklists vs. scales). Furthermore, determinations need to be made as to the appropriate weighing of the contributory roles of psychiatric diagnosis (biology), psychological perturbations (psy-

chache), emotional reactivity (impulsivity), and genetic predisposition. A very critical obstacle is the resistance to deleting certain poorly defined terms from our lexicon and substituting more precise terminology. For example, the term *completed suicide* arose to distinguish a death by suicide from other closely related terms (e.g., suicidal, suicidality, suicidal behaviors, nonfatal suicide, near lethal suicide attempt, etc.). Although well-established in our lexicon, the use of this term is objectionable to many.

CONCLUSIONS

The field of suicidology lacks a common nomenclature, operational definitions, common investigative protocols, and a classification system to know whether the type of clinical presentation observed or reported has a name, a prognosis, or a proven treatment. We lack the explicit protocols and procedures that allow us to rule in or rule out the presence of certain clinical types and clinical presentations, hence we have few evidence-based practices or standardized protocols that are linked to well-defined clinical presentations.

As the field of suicidology matures and the research and clinical endeavors become more sophisticated, however, we are becoming more sensitive to, and aware of, the cognitions, emotions, and behaviors that are associated with the full range of self-destructive behaviors. As the field advances the language of suicidology needs to accurately reflect our evolving understanding and knowledge base of suicide. We need to work toward standardizing definitions of terms in order to better communicate and better compare research and clinical populations. We need to minimize the subjectivity of labeling behaviors and develop mutually exclusive operational definitions with clinical examples. To that end I propose that an international summit be convened to address the language of suicidology.

REFERENCES

AMERICAN ASSOCIATION OF SUICIDOLOGY/ SUICIDE PREVENTION RESOURCE CENTER [AAS/SPRC]. (2006). *Resource sheet #2: The language of suicide. Core competencies for the assessment and management of individuals at risk for suicide*. Washington, DC: Author.

BAECHLER, J. (1975). *Suicides*. New York: Basic Books.

BECK, A. T., DAVIS, J. H., FREDERICK, C. J., PERLIN, S., POKORNY, A. D., SCHULMAN, R. E., ET AL. (1973). Classification and nomenclature. In H. L. Resnick & B. C. Hawthorne (Eds.), *Suicide prevention in the seventies* (pp. 7–21). Washington, DC: U.S. Government Printing Office.

BECK, A. T., RESNIK, H.L.P., & LETTIERI, D. J. (EDS.). (1974). *The prediction of suicide*. Bowie, MD: The Charles Press.

BERGENHOLTZ, H. (1975). Zur wortfeldterminologie. *Muttersprache*, *85*, 78–85.

BERMAN, A. L., SHEPHERD, G., & SILVERMAN, M. M. (2003). The LSARS-II: Lethality of suicide attempt rating scale—Updated. *Suicide and Life-Threatening Behavior*, *33*, 261–276.

BRIDGE, J. A., BARBE, R. P., BIRMAHER, B., KOLKO, D. J., & BRENT, D. A. (2005). Emergent suicidality in a clinical psychotherapy trial for adolescent depression. *American Journal of Psychiatry*, *162*, 2173–2175.

BROWN, G. K., HENRIQUES, G. R., SOSDJAN, D., BECK, A. T., ET AL. (2004). Suicide intent and accurate expectations of lethality: Predictors of medical lethality of suicide attempts. *Journal of Consulting and Clinical Psychology*, *72*, 1170–1174.

CANETTO, S. S., & LESTER, D. (1995). Women and suicidal behavior: Issues and dilemmas. In S. S. Canetto & D. Lester (Eds.), *Women and suicidal behavior* (pp. 3–8). New York: Springer.

CENTERS FOR DISEASE CONTROL AND PREVENTION [CDC]. (1988). CDC recommendations for a community plan for the prevention and containment of suicide clusters. *Morbidity and Mortality Weekly Report*, *37*, 1–12.

CENTERS FOR DISEASE CONTROL AND PREVENTION. (2005). *Youth risk behavior surveillance system.* Retrieved November 23, 2005, from http://www.cdc.gov/HealthyYouth/yrbs/index.htm

DAVIS, J. H. (1988). Suicidal investigation and classification of death by coroners and medical examiners. In J. Nolan (Ed.), *The suicide case: Investigation and trial of insurance claims. Tort and Insurance Practice Section* (pp. 33–50). Washington, DC: The American Bar Association.

DEAR, G. (2001). Further comments on the nomenclature for suicide-related thoughts and behavior. *Suicide and Life-Threatening Behavior*, *31*, 234–235.

DE LEO, D., BURGIS, S., BERTOLOTE, J., KERKHOF, A.D.M., & BILLE-BRAHE, U. (2004). Definitions of suicidal behavior. In D. De Leo, U. Bille-Brahe, A.D.M. Kerkhof, & A. Schmidtke (Eds.), *Suicidal behavior: Theories and research findings* (pp. 17–39). Washington, DC: Hogrefe & Huber.

DURKHEIM E. (1951). *Suicide: A study in sociology* (J. A. Spaulding & G. Simpson, Trans.). London: The Free Press. (Original work published 1897)

ELLIS, T. E. (1988). Classification of suicidal behavior: A review and step toward integration. *Suicide and Life-Threatening Behavior*, *18*, 358–371.

FARBEROW, N. L. (ED.). (1980). *The many faces of suicide: Indirect self-destructive behavior*. New York: McGraw-Hill.

GOLDSMITH, S. K., PELLMAR, T. C., KLEINMAN, A. M., & BUNNEY, W. E. (EDS.). (2002). *Reducing suicide: A national imperative*. Washington, DC: The National Academies Press.

HARRISS, L., HAWTON, K., & ZAHL, D. (2005). Value of measuring suicidal intent in assessment of people attending hospital following self-poisoning or self-injury. *British Journal of Psychiatry*, *186*, 60–66.

HAWTON, K., FAGG, J., SIMKIN, S., BALE, E., & BOND, A. (1997). Trends in deliberate self-harm in Oxford 1985–1995: Implications for clinical services and the prevention of suicide. *British Journal of Psychiatry*, *171*, 556–560.

HAWTON, K., & VAN HEERINGEN, K. (2000). *The international handbook of suicide and attempted suicide*. New York: Wiley.

HAWTON, K., ZAHL, D., & WEATHERALL, R. (2003). Suicide following deliberate self-harm: Long-term follow-up of patients who presented to a general hospital. *British Journal of Psychiatry*, *182*, 537–542.

HJELMELAND, H., HAWTON, K., NORDVIK, H., BILLE-BAHE, U., DE LEO, D., FEKETE, S., ET AL. (2002). Why people engage in parasuicide: A cross-cultural study of intentions. *Suicide and Life-Threatening Behavior*, *32*, 380–393.

IVANOFF, A. (1989). Identifying psychological correlates of suicidal behavior in jail and detention facilities. *Psychiatric Quarterly*, *60*, 73–84.

KESSLER, R., BERGLUND P., BORGES, G., NOCK, M., & WANG, P. S. (2005). Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990–1992 to 2001–2003. *Journal of the American Medical Association*, *293*, 2487–2495.

KESSLER, R., BORGES, G., & WALTERS, E. E. (1999). Prevalence of and risk factors for lifetime suicide attempts in the national comorbidity survey. *Archives of General Psychiatry*, *56*, 617–626.

KIDD, S. A. (2003). The need for improved operational definition of suicide attempts: Illustrations from the case of street youth. *Death Studies*, *27*, 449–455.

KRAEMER, H. C., KAZDIN, A. E., OFFORD, D. R., KESSLER, R. C., JENSEN, P. S., & KUPFER, D. J. (1997). Coming to terms with the terms of risk. *Archives of General Psychiatry*, *54*, 337–343.

KREITMAN, N. (1977). *Parasuicide*. New York: Wiley.

KREITMAN, N., PHILIP, A. E., GREER, S., & BAGLEY, C. R. (1969). Parasuicide. *British Journal of Psychiatry*, *115*, 746–747.

LINEHAN, M. M. (1986). Suicidal people: One population or two? In J. J. Mann & M. Stanley (Eds.), *Psychobiology of suicidal behavior* (pp. 16–33). New York: Annals of the New York Academy of Sciences.

LINEHAN, M. M. (2000). Behavioral treatments of suicidal behavior: Definitional obfuscation and treatment outcomes. In R. W. Maris, S. S. Canetto, J. L. McIntosh, & M. M. Silverman (Eds.), *Review of suicidology* (pp. 84–111). New York: Guilford.

MARIS, R. W. (1992). How are suicides different? In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.), *Assessment and prediction of suicide* (pp. 65–87). New York: Guilford.

MARIS, R. W., BERMAN, A. L., & SILVERMAN, M. M. (2000). The theoretical component in suicidology. In *Comprehensive textbook of suicidology* (pp. 26–61). New York: Guilford.

MARUSIC, A. (2004). Toward a new definition of suicidality? Are we prone to Fregoli's illusion? *Crisis*, *25*(4), 145–146.

MAYO, D. J. (1992). What is being predicted? The definition of "suicide." In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.), *Assessment and prediction of suicide* (pp. 88–101). New York: Guilford.

MEEHAN, P. J., LAMB, J. A., SALTZMAN, L. E., & O'CARROLL, P. W. (1992). Attempted suicide among young adults: Progress toward a meaningful estimate of prevalence. *American Journal of Psychiatry*, *149*, 41–44.

MENNINGER, K. (1938). *Man against himself*. New York: Harcourt, Brace & World.

NATIONAL INSTITUTE OF MENTAL HEALTH. (1995). *Studies of suicide and suicidal behavior* [Program announcement]. Washington, DC: U.S. Government Printing Office.

NATIONAL STRATEGY FOR SUICIDE PREVENTION. (2001). *Goals and Objectives for Action*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.

O'CARROLL, P. W., BERMAN, A. L., MARIS, R. W., MOSCICKI, E. K., TANNEY, B. L., & SILVERMAN, M. M. (1996). Beyond the Tower of Babel:

A nomenclature for suicidology. *Suicide and Life-Threatening Behavior*, *26*, 237–252.

PEETERS, B. (2000). Lexical perspectives on transivity and ergativity: Causative constructions in English, by Maarten Lemmens [Book review]. *Studies in Language*, vol. 24, 683–694.

PLATT, S., BILLE-BRAHE, U., KERKHOF, A. D., SCHMIDTKE, A., BJERKE, T., CREPET, T., ET AL. (1992). Parasuicide in Europe: The WHO/Euro multicentre study on parasuicide. I: Introduction and preliminary analysis for 1989. *Acta Psychiatrica Scandinavica*, *85*, 97–104.

RETTERSTOL, N. (1993). *Suicide—A European perspective*. Cambridge: Cambridge University Press.

ROSENBERG, M. L., DAVIDSON, L. E., SMITH, J. C., BERMAN, A. L., BUZBEE, H., GANTNER, G., ET AL. (1988). Operational criteria for the determination of suicide. *Journal of Forensic Sciences*, *32*, 1445–1455.

RUDD, M. D. (1997). What's in a name. . . . *Suicide and Life-Threatening Behavior*, *27*, 326–327.

RUDD, M. D. (2000). Integrating science into the practice of clinical suicidology: A review of the psychotherapy literature and a research agenda for the future. In R. W. Maris, S. S. Canetto, J. L. McIntosh, & M. M. Silverman (Eds.), *Review of suicidology 2000* (pp. 49–83). New York: Guilford.

RUDD, M. D., & JOINER, T. E., JR. (1998). The assessment, management, and treatment of suicidality: Toward clinically informed and balanced standards of care. *Clinical Psychology: Science and Practice*, *5*, 135–150.

SCHMIDTKE, A., BILLE-BRAHE, U., DE LEO, D., & KERKHOF, A. D. (EDS.). (2004). Suicidal behavior in Europe: Results from the WHO/Euro multicentre study on suicidal behaviour. Gottingen, Germany: Hogrefe & Huber.

SHNEIDMAN, E. (1968). Classification of suicidal phenomena. *Bulletin of Suicidology*, *2*, 1–9.

SHNEIDMAN, E. S. (1985). *Definition of suicide*. New York: John Wiley & Sons.

SILVERMAN, M. M., & MARIS, R. W. (1995). The prevention of suicidal behaviors: An overview. *Suicide and Life-Threatening Behavior*, *25*, 10–21.

SIMON, R. I. (2006). Imminent suicide: The illusion of short-term prediction. *Suicide and Life-Threatening Behavior*, *36*, 296–301.

SOMMER-ROTENBERG, D. (1998). Suicide and language. *Canadian Medical Association Journal*, *159*, 239–240.

WAGNER, B. M., WONG, S. A., & JOBES, D. A. (2002). Mental health professionals' determinations of adolescent suicide attempts. *Suicide and Life-Threatening Behavior*, *32*, 284–300.

WINCHESTER, S. (1998). *The professor and the madman: A tale of murder, insanity, and the making of the Oxford English Dictionary*. New York: HarperCollins.

WORLD HEALTH ORGANIZATION. (1986). *Summary report: Working group in preventive practices in suicide and attempted suicide*. Copenhagen: WHO Regional Office for Europe.

WORLD HEALTH ORGANIZATION. (1998). *Primary prevention of mental, neurological and psychosocial disorders*. Suicide. Geneva: Author.

ZAHL, D. L., & HAWTON, K. (2004). Repetition of deliberate self-harm and subsequent suicide risk: Long-term follow-up study of 11,583 patients. *British Journal of Psychiatry*, *185*, 70–75.

Manuscript Received: August 15, 2005
Revision Accepted: October 31, 2005