

# Suicide Wrongful Death: Standard of Care Problems Involving the Inaccurate Discernment of Lethal Risk When Focusing on the Elicitation of Suicide Ideation

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## I. INTRODUCTION

**Abstract**—Suicide and wrongful death forensic cases are the fastest rising tort in mental health law. Most suicide-related personal injury claims fall into the legal category of “wrongful death.” Though mental health experts may be called on to address a range of forensic questions in wrongful death cases, the central consultation that most experts provide is about the negligence element—specifically, the issue of whether the clinician met the clinical standard of care in assessing, treating, and managing the deceased person’s mental health care. Standards of care, varying from US state to state, are broad and address what a reasonable clinician might do in a similar circumstance. This fact leaves the issue of the suicide standard of care, in each case, up to forensic experts to put forth a reasoned estimate of what the standard of care should have been in the specific case under litigation. Because the general state guidelines for standard of care are broad, forensic experts are readily retained to provide scientific and clinical opinions about whether or not a clinician met the standard of care in their suicide assessment, treatment, and management of the case. In the past and in much of current practice, the assessment of suicide has centered on the elicitation of verbalized suicide ideation. But suicide ideation, in the matter of suicide risk determination, may be a necessary but insufficient target of lethal suicide risk assessment. Assessment of near-term suicide risk—assessment that goes beyond verbalized suicide ideation and relates to acute crisis variables—is likely needed. Specifically, such other or additional suicide risk variable assessment may be required in the context of lethal suicide risk situations, as opposed to the discernment of general, nonlethal suicide behavior as a standard of practice (whether a patient is having suicidal thoughts or exhibiting an ambivalent suicide attempt potential). In the current study, verbalized suicide ideation information was unhelpful in the assessment of lethal risk. The Lethal Suicide Risk Assessment, Acute Model, and other dynamic, near-term risk models (such as the Acute Suicide Affective Disorder Model and the Suicide Crisis Syndrome Model)—going beyond elicited suicide ideation—need to be incorporated into current clinical suicide assessment training and become the legal standard of care for expected clinical behavior. Without this expanded clinical assessment perspective, the standard of care for suicide assessment is out of sync with current knowledge—an emerging dilemma for the forensic evaluation of suicide wrongful death cases.

**Keywords**—Forensic evaluation, standard of care, suicide, suicide assessment, wrongful death.

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### A. Suicide

**S**UICIDE is the principal fatal outcome associated with mental health care. It has been reported that since 2006, suicide-related cases have accounted for 15% of US malpractice claims [1]. Families and friends are often devastated by the death of a loved one and are searching for causes or persons who might have contributed to their loved one’s death. Clinicians, conversely, are often similarly traumatized by a patient’s death and fearful of legal action against them. Personal injury lawsuits are filed and attorneys for both plaintiff and defense often seek mental health experts to address the issues in each case.

### B. Wrongful Death

Suicide-related personal injury claims fall under the legal domain of “wrongful death.” A “wrongful death” action is a civil lawsuit, usually initiated by close family members or dependents, against individuals or entities they believe negligently caused the death of a loved one. In a wrongful death case, plaintiffs seek compensation for emotional and financial damages due to the recklessness or negligence of treating mental health clinician, agency, or hospital. There are four elements to a wrongful death case: 1) *Negligence* (the treating clinician behaved in a careless, reckless or negligent manner), 2) *Breach of Duty* (the deceased was a patient of the clinician and this clinician had a duty to protect and treat them), 3) *Causation* (the clinician’s negligence caused the patient’s death), and 4) *Damages* (the patient’s death is the central issue of damage but lost earnings and other losses may be asserted) [2].

### C. Negligence and The Standard of Care

Though mental health experts may be called on to address any of these four elements of wrongful death, the central consultation that most experts provide is about the negligence element—specifically, the issue of whether the clinician met the clinical standard of care in assessing, treating, and managing the deceased person’s mental health care. There are no well-defined, specifically-outlined standards of care for suicide put forth by professional mental health associations in the US, but most states have general medical standards of care, as in this

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example from the US state of Missouri, which states: [the clinical standard of care includes] “that degree of skill and learning ordinarily used under the same or similar [medical] circumstances” [3]. The suicide management and treatment standard of care is not evidence-based care or superlative care; it is what most reasonable clinicians would do. This fact leaves the issue of the suicide standard of care, in each case, up to forensic experts to put forth a scientifically-grounded, clinical opinion of what the standard of care should have been in the specific case under litigation.

Psychologist Joseph Obegi [4] has proposed a framework for the evaluation of the standard of care in suicide wrongful death cases. To summarize, he outlines six elements in suicide assessment and management:

1. Gathering information from the patient (the suicide risk assessment).
2. Gathering data from other sources.
3. Estimating suicide risk (the suicide risk formulation).
4. Treatment planning (initiation of treatment with multiple interventions).
5. Documentation (writing down clinical thinking about the assessment and treatment strategy, along with continual updates).
6. Monitoring (ongoing monitoring of fluctuating symptoms and clinical needs).

Each of these clinical elements warrants careful review by the forensic expert. The suicide assessment process and suicide risk formulation, along with the determination of an appropriate level of risk and intervention, are typically central to the forensic assessment process.

#### D. Suicide Ideation and Lethal Risk

In the past and in much of current practice, the assessment of suicide has centered on the elicitation of verbalized suicide ideation. In recent years, however, research has indicated that the elicitation of verbalized suicide ideation may be helpful in predicting some suicide behavior and even ambivalent suicide attempts but not as helpful in identifying persons who have a lethal risk potential [5], [6].

Berman [6] asserts that the most widely used suicide screen instruments--the Columbia-Suicide Severity Rating Scale (C-SSRS), Ask Suicide-Screening Questionnaire (ASQ) and Patient Health Questionnaire-9 (PHQ-9--rely heavily on “the self-report of SI, in spite of the fact that expressed SI has only weak evidence as a predictor of death [i.e., predictor of lethal risk vs risk of general suicidal behavior], especially in the near term” (p.341). He asserts that in 15 different studies, 70-80% of the time, persons who end their lives in suicide do not reveal their suicidal ideation to health care or mental health personnel at their last professional contacts.

Other investigations have supported this finding that persons who are lethally at risk often do not verbalize suicide risk at their last medical or psychiatric contact, perhaps 50-80% of the time [7]. Tragically, then, lethally at-risk patients tend to hide their risk—perhaps having gotten to a place where no help seems relevant and there is a determined unwillingness to reveal lethal ideation [8].

#### E. Getting Closer to “Lethal” Suicide Risk

Other recent research [6] has suggested that the practice of suicide assessment should not only include screening about suicide ideation (with the C-SSRS, ASQ, and PHQ-9) but also the use of dynamic, actionable risk variables that are predictive of acute suicidal crises. Berman [6] argues for research on “near-term” suicide risk factors and advocates that actionable risk variables should be emphasized (i.e., risk variables that be acted on rapidly). He points to near-term suicide risk variables such as 1) overarousal symptoms (anxiety, agitation, insomnia, etc.), 2) interpersonal dysfunction (not fitting in, withdrawal, isolation, etc.), 3) negative thought patterns (thwarted belonging, hopelessness, catastrophic thinking, etc.), 4) comorbid psychiatric problems, 5) substance abuse and 6) immediate life stressors (intimate partner problems, work stress, etc.). He concludes: “A prudent suicide risk assessment must go well beyond questions about suicidal ideation—and the denial of suicide ideation is insufficient to formulate no or low risk.” In our research [9], we have investigated the specific issue of novel, actionable, near-term risk factor variables and their association with lethal risk (patients who report a suicide attempt where they meant to die, corroborated by chart review). The following is a discussion of this research.

## II. EXPLORATORY PATTERNS OF ACUTE SUICIDE RISK: THE LETHAL SUICIDE RISK PATTERN MODEL

### A. The LSRP Model: Methods and Results

Previously, we conducted a Structural Equation Model (SEM) analysis targeting seriously mentally ill adults [9]. In our model construction, we used eight negative thought patterns (feeling like a burden on others, hopelessness, self-hatred, etc.) mediated by nine transdiagnostic clinical factors (mental torment, insomnia, substance abuse, PTSD intrusions, etc.) to predict acute lethal suicide risk. In this previous paper [9], we addressed both acute and lifetime lethal risk contexts. In the current paper, we are only comparing the LSRP Acute Model with a model, where Acute Suicide Ideation (Ideation in the Last Several Days) is added to the LSRP Acute Model.

### B. Variables and Acute Risk

The original LSRP Acute Model had excellent fit ( $\chi^2(df) = 94.25(47)***$ , with a Comparative Fit Index (CFI) = .98, Root Mean Square Error of Approximation (RMSEA) = .05, 90 Confidence Interval = .03-.06,  $p(RMSEA) = .05 = .63$ , and Akaike Information Criteria (AIC) = 340.25,  $***p < .001$ ). All paths were significant. Every construct or its error term was significantly correlated with at least one other construct or its error term, indicating that all constructs contributed meaningfully to the LSRP model, even if that construct did not have a direct relationship with that model’s outcome measure. There were four risk factor pattern configurations in the LSRP Acute Model. These four patterns are outlined below.

*Acute Pattern 1: Direct thought pattern configuration:* In the first acute risk pattern, negative thought patterns involving Self-Hatred and a Sense of Failure were observed to have direct relationships with Acute Suicide Behavior Severity (acute

lethal suicide risk).

*Acute Pattern 2: Thought Pattern-Tortured Mentation configuration:* This risk pattern involved indirect associations of five different thought patterns (Demoralized Distress, Hopelessness, Self-Hatred, a Sense of Failure, and Burdensomeness) with Acute Suicide Behavior Severity mediated by Tortured Mentation. The Tortured Mentation construct appears to be a phenomenologically useful summary construct for the activating dimensions of clinical overarousal and mental overload, which may include depressive rumination, bipolar acceleration, intense anxiety, panic, rage outbursts, prolonged insomnia, and even chronic physical pain. Note: It is speculated that the empirically derived construct of Tortured Mentation corresponds to Shneidman's [10] construct of "Perturbation." And it is further noted that the construct of Tortured Mentation has broad similarity to the "overarousal" component of Tucker and colleague's ASAD criteria [11].

*Acute Pattern 3: Thought Pattern-Command Hallucination pattern configuration:* The thought pattern-clinical factor configuration suggested by this pathway to Acute Suicide Behavior Severity (Hopelessness or a Sense of Failure mediated by Command Hallucinations to kill oneself) constitutes highly useful clinical information in populations of persons with severe mental illness.

*Acute Pattern 4: Interpersonal Theory of Suicide configuration:* The contemporary theory of suicide with the strongest empirical basis is Thomas Joiner's Interpersonal Theory of Suicide (ITS) [12]. The central elements of this theory (Burdensomeness, Thwarted Belonging, and Capability for Suicide) are evident in this configuration. Additionally, the negative thought constructs of Self-Hatred and Suicide Ambivalence are also part of this configuration.

### III. CURRENT PROJECT: ADDING ACUTE SUICIDE IDEATION TO THE LSRP ACUTE MODEL

As noted, the current paper is a comparison of the LSRP Acute Model in our prior project [9] and the outcome that results when a measure of acute suicide ideation (ideation in the last several days) is added to this previous LSRP Acute Model. Given the findings of a number of research reviews [6], [7] that persons who are in a state of lethal risk often refrain from verbalizing suicide ideation, we hypothesized that when the construct of Acute Suicide Ideation was added to the LSRP Acute Model; this new model would have poorer goodness-of-fit than the model without suicide ideation as a predictor, i.e., the LSRP Acute Model without suicide ideation as a predictor.

#### A. Data Collection and Descriptives

The data collection and descriptives for this current comparison project are the same as in the previous structural equation project [9]. Data collection for the original structural equal model analyses was done in an urban mental health center setting, and included subjects from an outpatient mental center, emergency setting, inpatient setting and a mental health agency serving a primarily Hispanic/Latin population. The SEMs were constructed based on 458 subjects. The diversity of subjects was notable with 43.8% white, 35.1% black, 3.8% Hispanic/

Latin and 17.3% identifying as another ethnic background. Regarding gender, 51.1% identified as male and 48.9% as female. This urban population was a high-risk sample in terms of reported suicide history with 34.7% of subjects reporting a suicide attempt some time in their lives.

#### B. Ethical Review

This research was approved by the University of Missouri—Kansas City Institutional Review Board, the Missouri Department of Health, and the Truman Medical Center research committee. Complete data collection information, measure selection of clinical factors and thought patterns and analytic procedures employed to construct the acute and lifetime SEM's are detailed in [9].

#### C. Thought Patterns Variables

Thought pattern variables were selected from scales available from prominent cognitive behavior therapists. These cognitive-behavioral thought patterns, directly associated with suicidal risk, were selected based on theoretical rigor, prominence within the field of suicide research, and scientific and psychometric development [13], [14]. After factor analyses, these negative thought pattern constructs consisted of Hopelessness, Suicide Ambivalence, Self-Hatred, Sense of Failure, Demoralized Distress, Unbearable Pain, Thwarted Belonging and Burdensomeness.

#### D. Clinical Variables

Clinical items were selected from a range of inventories and transdiagnostic clinical factors relating to posttraumatic stress, emotional, physical and sexual trauma, neglect, insomnia, depression, anxiety, overarousal symptoms substance abuse, psychotic symptoms, etc. These clinical variables produced nine reliable clinical factors (Insomnia, Mental Torment, Developmental Trauma, Posttraumatic Intrusions, Substance Abuse, Dissociation, Command Hallucinations, Dehumanization and Capacity for Suicide).

#### E. The Acute Suicide Ideation Measure

The suicide ideation measure for this project was obtained from Linehan's *Parasuicide History Interview*, which assesses a range of suicide behaviors from no ideation ever to making a suicide attempt [15]. For this project, we employed a scale pertaining to suicide ideation in the past several days. This scale was organized into five ordinal choices based on the participant's estimate of the frequency of their suicide ideation within the past few days: 1) Not at all, 2) Rarely, 1-2 times, 3) Sometimes, 3-5 times, 4) Often, 6-10 times, 5) Very Often, > 10 times. Because the typical suicide screening process involves an inquiry for any suicide ideation, this measure was selected to assess acute intensity of suicide ideation. The Acute Suicide Ideation measure (Ideation in the Last Several Days) was added as a mediating variable between the thought pattern variables and the outcome variable and is described below.

#### F. The Dependent Variable

The dependent measure in our studies was also adopted from The Parasuicidal History Interview [15]. This dependent

variable was comprised of the following distribution in our studies: 1) subjects reporting no ideation or just suicide ideation alone (53.9%), 2) subjects reporting suicide ideation and a plan (8.8%), 3) subjects reporting having made a suicide attempt but not meaning to die (16.6%), and 4) subjects reporting having made a suicide attempt and meaning to kill themselves (18.1%). Confirmation of the seriousness of this latter category was corroborated by a chart review.

### G. Approach to the Statistical Analysis

Survey information was entered into an electronic database and double-checked for accuracy. If information was missing from two or more items within a construct, the case was excluded. Internal reliability for the 16 constructs was then evaluated for the 458 cases that met this criterion. Alpha coefficients  $\geq .700$  were deemed reliable. All constructs met this criterion, with four to six items per construct.

A mean for each item was calculated for the 16 constructs. Then, using AMOS 23.0 [16], the SEMs were evaluated using a maximum likelihood estimation of the covariance, testing goodness-of-fit for each model. The causal model framework of the eight negative thought pattern constructs and the nine clinical constructs plus the construct for Acute Suicide Ideation were constructed as noted above and statistically evaluated.

In the SEM analysis, the criteria of goodness-of-fit followed standard statistical recommendations [16], [17]. The “ideal value” of a model’s Chi Square/df is deemed to be  $< 2.00$ , a “very good fit” is  $< 3.00$  and an “adequate” fit is  $< 5.00$ . For the Confirmatory Fit Index (CFI), an “ideal value” is deemed to be  $\geq .95$ , “very good”  $\geq .92$  and “adequate”  $\geq .90$ . Finally, the Root Mean Square Error of Approximation (RMSEA) produces an “ideal value” that is  $\leq .05$ , a “very good fit” as  $\leq .08$  and an “acceptable fit” as  $< .10$ . We adopted a  $p$ -value of  $\leq .05$  as our index of statistical significance for this analysis including all coefficients (regression or correlation), Chi Square tests of independence, F-tests, and t-tests of differences.

### H. Results

A graphic of the SEM model of the thought and clinical factor prediction of Acute Suicide Behavior Severity, with Acute Suicide Ideation added is depicted in Fig. 1. The results of this SEM analysis affirmed our hypothesis that adding a measure of Acute Suicide Ideation would have a poorer goodness-of-fit than the LSRP Acute Model of fit previously identified. Addition of the Acute Suicide Ideation measure to the existing Acute LSRP Model produced a “short of an adequate fit” in the comparison of the constructed model to the observed data from our sample. The goodness-of-fit statistics for this current analysis are as follows: Chi Square,  $DF (71) = 3.571$ ,  $CFI > .953$ ,  $(NFI = .938, TLI = .876)$ ,  $RMSEA = .075$ ,  $90\% CI (.065 \text{ to } .085)$ ,  $P(\text{Close}) < .001$ ,  $AIC = 529.550$ . All direct lines in Fig. 1 depict a significant coefficient of relationship, with a  $p < .05$ . Coefficients in the model with a  $p > .05$  value were eliminated (i.e., trimmed from the figure).

As one can observe in Fig. 1, there is a nonsignificant relationship between Ideation in the Last Several Days and Acute Suicide Behavior Severity, the outcome measure. Adding

current suicide ideation to the LSRP Acute Model was unhelpful and led to a nonsignificant outcome for the new prediction model.

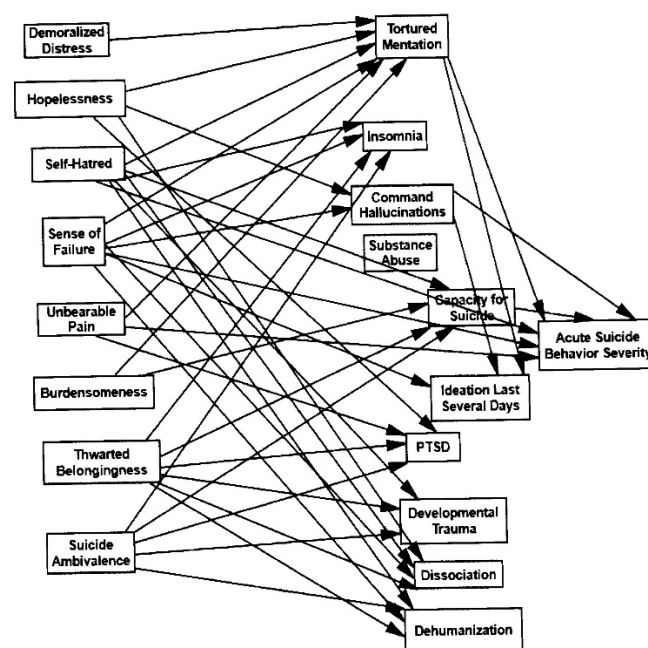


Fig. 1 SEM of eight thought pattern variables with nine clinical factors combined with Acute Suicide Ideation (ideation in last several days) predicting lethal suicide risk (Acute Suicide Behavior Severity)

### I. LSRP Conclusions

The findings of this study offer practical suicide risk assessment information. It is important to go beyond a primary focus on the elicitation of acute suicide ideation information in a suicide assessment. Clinically, every risk variable in the LSRP Acute Model is actionable (i.e., targetable for specific clinical intervention). These near-term suicide risk variables should be considered for a standard assessment insofar as they are related to a suicidal crisis. Then, clinical action should be taken immediately to reduce these drives of crisis. Given the difficulty in meaningfully triaging the level of suicidal risk, the LSRP Model supports enhanced determination of acute risk, along with information for rapid crisis intervention.

## IV. OTHER NEAR-TERM RISK MODELS AND IMPLICATIONS FOR THE SUICIDE ASSESSMENT STANDARD OF CARE IN FORENSIC EXPERT CONSULTATIONS

### A. The Standard of Care Problem

As noted in the introduction, the hypothetical standard of care in most jurisdictions relates to what a reasonable clinician does to implement “that degree of skill and learning ordinarily used under the same or similar [medical] circumstances.” Currently, most clinicians, in their assessment of suicide risk, focus primarily on verbalization of suicide ideation by their patients [5]. This may be the current practice, but it should not be the standard of care. Training is needed to improve clinicians’ skill and methods in assessing acute, “lethal” suicide risk as opposed to general suicidal behavior alone.

### B. Near-Term Suicide Risk Models

In addition to our research, Tucker et al. [11] have outlined the Acute Suicidal Affective Disturbance (ASAD). This approach was proposed as a DSM-V diagnosis and constitutes a near-term suicide risk model, with components of 1) rising suicide intention, 2) social dysregulation, 3) two types of overarousal, and 4) hopelessness. Similarly, Yaseen et al. [18] have proposed the Suicide Crisis Syndrome (SCS). This dynamic-variable approach emphasizes five components: 1) the negative thought pattern of entrapment, 2) an affective disturbance (emotional pain, mood swings, anxiety, etc.), 3) loss of cognitive control (rumination, negative thoughts, etc.), 4) a disturbance of arousal (agitation, hypervigilance, irritability, insomnia, etc.), and 5) social withdrawal. The SCS near-risk suicide assessment model does not use suicide ideation as a risk factor at all, whereas the ASAD model includes rapidly escalating intention to die as one of its variables.

### C. The Importance of Training to Improve the Standard of Care

Our research, along with near-term suicide risk variables highlighted in the Acute Suicidal Affective Disorder and Suicide Crisis Syndrome, points to the need to upgrade clinician skills to move beyond focusing primarily on suicide ideation to determine a patients' lethal risk potential. Such a training has been proposed by [19]. This training--Brief Dynamic Suicide Risk Assessment and Rapid Suicide Reduction--emphasizes novel, actionable, near-term risk variables, and a process to rapidly prioritize and intervene with patients in suicidal crisis.

## V. CONCLUSION

The problem discussed in this paper highlights an interesting aspect of what constitutes the psychiatric standard of care for suicide assessment in many jurisdictions. The way in which a clinician employs a clinical procedure (suicide assessment) may be "consistent with other clinicians practicing with similar skill" but be out of synch with what research indicates is an important and valid practice. In the forensic situation, how can we hold defendant clinicians liable, if the methods that are customary and widely used in detecting lethal risk are unreliable? Much training is needed to improve the practice of suicide assessment to include greater awareness of suicide crisis factors and near-term suicide risk variables in gauging the most important suicide behavior--lethal suicide risk behavior.

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