

DR. ALAN L. BERMAN (LANNY)



Dr. Berman is President of the International Association of Suicide Prevention (IASP). Previous to this, he held elected positions in IASP as both treasurer and vice president.

Since 1995, he has been the Executive Director of the American Association of Suicidology (AAS). He is a Past-President of the AAS (1984-1985), their 1982 Shneidman Award recipient (for Outstanding Contributions in Research in Suicidology), and their 2006 Louis I. Dublin Award winner (for outstanding service and contributions to the field of suicide prevention).

Dr. Berman holds a B.A. degree from the Johns Hopkins University and a Ph.D. from the Catholic University of America. From 1969 to 1991 he taught at the American University where he attained the rank of tenured full professor. In 1991 Dr. Berman changed his appointment to that of Distinguished Adjunct Professor when he was named Director of the newly established National Center for the Study and Prevention of Suicide at the Washington School of Psychiatry, a position he held until accepting his current role with the AAS in January, 1995. Diplomate in Clinical Psychology (American Board of Professional Psychology) and a Fellow of the American Psychological Association and the International Academy of Suicide Research, Dr. Berman maintains a part-time private practice of psychological and forensic consultation in Washington, D.C. Dr. Berman is board certified as a forensic Suicidologist. He is a past-president of the APA's Section VII, Div. 12 (Behavioral Emergencies). He has published over 100 professional articles and book chapters and authored/edited seven (7) books in Suicidology. He serves as consulting editor for three peer-reviewed journals: *Suicide and Life Threatening Behavior*, *Crisis*, and *Archives of Suicide Research*.

Assessing and Formulating Risk for Suicide: New Thoughts on Old Approaches, New Strategies

Suicide risk assessment is the most important standard of care behavior demanded of the clinical practitioner. A systematic assessment, first and foremost, leads to a level of risk formulation that informs management activities designed to safeguard a patient from self-harm or death and to decision-making regarding discharge of a patient from the most secure of safeguarded environments. Secondary to this, risk formulation serves to identify modifiable risk and protective factors that target treatment planning to reduce the former and increase the latter. No formulation of suicide risk can reliably identify those who will act on suicidal urges (i.e. sensitivity) or those who will not (specificity). Compounding this problem, however, is the concept of imminent risk, the most severe of level of risk formulations, for which there exist no reasonable clinical criteria or guidelines. Moreover, risk assessment guidelines must recognize the dynamic nature of suicide risk, capable of changing rapidly in response to shifting external conditions of stress and/or internal conditions of distress and vulnerability. Hence, both a reasonable understanding of what variables best inform judgments of risk and the need for a testable model for reasonably formulating levels of risk for suicide and suicidal behaviours are essential.

To date, there has been scant attention to developing new understandings of suicide risk and to discerning the relative significance of chronic versus acute risk factors to the development of reasonable judgments of levels of risk. Long-held and in vogue models of suicide risk formulation depend first and foremost on the identification of

patients with suicide ideation, with greater risk attendant to presence of active ideation with intent and/or plan. Tragically, most practitioners fail to engage further consideration of suicide risk if ideation is absent or denied. This traditional thinking about the cardinal risk factor that triggers a suicide risk formulation must change. This presentation will challenge that clinical mindset and offer a model for risk formulation, based on empirically-defined risk factors, that does not require the presence of communicated suicidal thoughts to initiate a formulation of risk. Clinical examples will be offered.