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A review of diagnostic tools for screening individuals in suicidal crisis

Przegląd narzędzi diagnostycznych osób w kryzysie samobójczym

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Abstract

The objective of this paper is to present statistically validated diagnostic tools available in Poland for the clinical assessment of suicidal risk, tendencies, and inclinations. The conclusions drawn from scientific studies available in the Google Scholar database, as articulated by the authors of this article, allow for a tailored selection of tools based on the individual needs, preferences, and professional circumstances of the examiner. The described tools vary in terms of complexity and time requirements; it is important to note that some necessitate a psychology degree or the completion of specialised training, which has been indicated and elaborated upon. The choice of the assessment method remains at the discretion of the diagnostician. A comprehensive clinical assessment of individuals experiencing a mental health crisis requires exceptional attentiveness, as it often involves the need to consider and make decisions regarding the initiation, continuation, or cessation of hospitalisation. This decision can be quite challenging due to the subjective nature of the thoughts of the individual being examined, which may be difficult for the examiner to articulate. Familiarity with diagnostic tools is a key hard competency in the work of medical personnel, as their utilisation significantly facilitates the conduct of interviews, establishes a structured medical assessment, and provides the examiner with insights into the severity of the crisis or the patient's history of suicidal attempts. It is essential to acknowledge that the questionnaires described below constitute merely a component of the diagnostic process. A comprehensive and reliable assessment of an individual's mental state necessitates that the examiner first establishes a positive rapport with the participant, grounded in an understanding of the individual's current condition and sensitivity to their emotions, thoughts, and behaviours.

Keywords: suicide, tools for assisting the diagnosis of suicidal tendencies, suicide crisis

Streszczenie

Celem niniejszej pracy jest przedstawienie dostępnych w Polsce, rzetelnych statystycznie narzędzi diagnostycznych do klinicznej oceny ryzyka, skłonności i tendencji samobójczych. Przedstawione w artykule wnioski, oparte na dostępnych w bazie danych Google Scholar badaniach naukowych, dają – według autorów – możliwość swobodnego doboru narzędzi zgodnie z indywidualnymi potrzebami, preferencjami oraz uwarunkowaniami zawodowymi osoby przeprowadzającej badanie. Opisane narzędzia różnią się poziomem trudności oraz czasochłonnością. Należy zaznaczyć, że niektóre z nich wymagają posiadania dyplomu psychologa lub

ukończenia specjalistycznego szkolenia, co zostało wskazane i opisane w artykule. Wybór formy badania pozostaje w gestii diagnosty. Pełna ocena kliniczna osób będących w kryzysie psychicznym wymaga wyjątkowej uważności, gdyż niejednokrotnie wiąże się z potrzebą rozważenia i podjęcia decyzji o rozpoczęciu, utrzymaniu lub zakończeniu hospitalizacji. Decyzja ta bywa bardzo trudna ze względu na specyfikę subiektywnych myśli osoby badanej, które mogą być niemożliwe do zwerbalizowania. Znajomość narzędzi diagnostycznych jest jedną z kluczowych kompetencji twardych, niezwykle potrzebnych w pracy personelu medycznego, gdyż wykorzystanie ich w znacznym stopniu ułatwia prowadzenie wywiadu, nadaje strukturę rozmowie oraz dostarcza badaczowi wiedzy na temat stopnia kryzysu lub historii prób samobójczych pacjenta. Należy pamiętać, że opisane poniżej kwestionariusze są tylko częścią procesu diagnostycznego, gdyż pełna i rzetelna ocena stanu psychicznego wymaga od osoby badającej przede wszystkim nawiązania dobrej relacji z pacjentem, opartej na zrozumieniu jego stanu oraz wrażliwości na jego emocje, myśli i zachowania.

Słowa kluczowe: samobójstwo, narzędzia diagnostyczne do badania osób w kryzysie samobójczym, kryzys samobójczy

INTRODUCTION

According to the National Police Headquarters (Komenda Główna Policji), approximately 13 individuals in Poland die by suicide daily (11 of whom are male). It should be noted, however, that between 2023 and 2024 the most pronounced decline in suicide counts in Poland occurred, amounting to 7.4% – a reduction of 388 deaths. This represents the largest decrease observed in a decade. Statistics indicate that every completed suicide is preceded by more than 10 suicide attempts. Among individuals under the age of 19, this figure rises to over 16. Each suicide results in the suffering of approximately 20 individuals within the deceased's social circle (Ruczaj, 2025), and their grief has been classified as a form of trauma. Frank R. Campbell posits that suicide affects individuals who maintain 28 different types of relationships with the deceased, encompassing parents, siblings, friends, neighbours, and colleagues (Brągiel, 2022). Analyses conducted to date regarding the causes of suicide clearly indicate that singular factors do not unequivocally explain why individuals take their own lives. Over the past centuries, research has progressively sought to achieve a more comprehensive understanding of the complexities surrounding this phenomenon. Suicidology, due to its interdisciplinary nature, examines the act of suicide by considering cultural, religious, racial, ethnic, linguistic, socioeconomic, familial, and cognitive aspects. Furthermore, analysis within the field of suicidology also encompasses issues related to age, gender, political conditions, public health, and clinical aspects.

As stated by the World Health Organization (2014), in economically advanced countries the incidence of suicide is three times higher among men than among women. In contrast, in low- or middle-income countries, this ratio is significantly lower, with the rate of female suicides to male suicides being 1:1.5. On a global scale, suicide accounts for 50% of all cases of violent death among men and 71% among women. In nearly all regions of the world, when age is taken into account, suicide rates are highest among individuals aged 70 years or older, for both women and men. In certain countries, suicide rates are notably highest among the youth demographic. Globally, suicide represents the third leading cause of death among individuals aged 15–19 years, following road injury and interpersonal violence (Wasserman et al., 2021). A significant proportion of suicides are committed impulsively, facilitated by the relatively widespread availability of means to carry out such acts, including firearms. The use of firearms, alongside the consumption of pesticides and hanging, constitutes the most common methods of suicide worldwide (Bachmann, 2018). It is important to emphasise that the choice of method among the myriad of means employed to end one's life is also influenced by an individual's affiliation with a particular social group.

Psychological, health-related, social, cultural, and other factors can individually or collectively lead to suicidal behaviour. However, due to the stigma associated with mental disorders and suicide itself, many individuals lack the courage to seek help. Researchers studying this phenomenon ponder whether suicide is an act preceded by a conscious choice and an awareness of the consequences of the decision being made. Analyses indicate that the decision to attempt suicide is, to some extent, a choice between a situation in which the individual cannot, or does not know how to, meet the expectations and tasks (whether real or imagined) placed upon them, and a situation in which they are not compelled to make any efforts to engage with the surrounding world. Paradoxically, attempts to avoid decisiveness and the act of making choices are perceived as a process accompanying individuals throughout their lives (Hołyst, 2016). Despite widespread evidence indicating that many fatalities are preventable, acts of suicide continue to represent a significant and unresolved social issue that necessitates an appropriate approach aimed at reducing their incidence. Suicidal behaviour should be understood as a consequence of a complex process, rather than as an existential dilemma. The reduction of suicidal tendencies requires time, as they are influenced by a multitude of interrelated factors. The prevalent belief that one should refrain from discussing suicidal tendencies with an individual – due to the notion that such conversations may exacerbate these tendencies – often presents a formidable barrier that is difficult to overcome. It is essential to recognise that the suicidal thoughts of a suffering individual are independent of whether another person inquires about or discusses them, as these thoughts can manifest in any other circumstance. Furthermore, naming them explicitly serves to remove the veil of secrecy surrounding them.

This article endeavours to elucidate selected diagnostic tools that assist in the identification of a suicidal crisis, as the diagnosis of suicidal risk necessitates a multifaceted analysis and evaluation of various variables. Individuals with suicidal tendencies may convey their despair in indirect and subtle ways that can be challenging for those in their immediate environment to recognise. According to research (Kim et al., 2023), individuals who did not receive a psychiatric diagnosis during hospitalisation for deliberate self-harm exhibited the lowest survival rate, at 81.48%, whereas the group diagnosed with a psychiatric disorder in the Department of Psychiatry demonstrated the highest survival rate, at 93.4%. Nearly 83% of individuals who died by suicide had consulted their general practitioner within the year preceding their death, with as many as 66% having done so in the month prior. This form of silent plea for help demands exceptional vigilance from clinicians and often precludes the possibility of preventing tragedy.

Currently employed diagnostic methods, which are based on structured interviews, procedures, questionnaires, and risk assessment scales, provide multifaceted information. However, it is important to note that their diagnostic value is limited, as no single tool guarantees an accurate assessment of suicide risk. Familiarity with the available diagnostic instruments and their appropriate application facilitates clinicians in conducting presuicidal assessments, enabling quicker identification of threats and the determination of the patient's risk group. Consequently, this may ultimately help in preventing tragedy. The knowledge accumulated during the diagnostic process can prove invaluable, particularly when comprehensive information regarding the individual's history, as well as that of their family and close associates, is lacking. Such data is especially pertinent during the initial phase of treatment, in the event of a deterioration in the patient's condition, or during various forms of emotional crises.

In order to systematise knowledge regarding the tools described below, it has been assumed that suicide is a dynamic process. Consequently, the presentation of selected methods is based on Ringel's theory, which posits the existence of three components that precede suicidal actions. The Austrian psychiatrist and neurologist, in his publication "When Life Loses Its Meaning" (Ringel, 1987), demonstrates that suicidal behaviour does not occur suddenly; rather, it is a prolonged process during which traumas accumulate, ultimately distorting personality. In his view, an integral subject of suicide research is aggressive behaviour, with suicide regarded as the apex of neuroticism. This act is committed under the influence of a constriction of the emotional sphere and an increase in levels of aggression. Ringel argued that it is crucial to identify the presuicidal syndrome, which leads to the erosion of defensive mechanisms, potentially culminating in the decision to commit suicide.

The syndrome encompasses the following areas of psychopathology: narrowing, inhibited aggression, and self-aggression, and suicidal fantasies. Narrowing is characterised by a disruption in the balance between the external situation and the individual's subjective adaptive capabilities; it is a progressive process in which the individual grapples with intense thoughts regarding the act of suicide. Narrowing can be categorised into several types: dynamic narrowing, characterised by the predominance of negative emotions, particularly anxiety, alongside pessimistic thoughts, low self-esteem, feelings of helplessness, anticipation of misfortunes, and a focus on perceived subjective losses; situational narrowing, which involves an inability to perceive opportunities for altering one's circumstances, a sense of being trapped in a no-exit situation, and a lack of hope that undermines the sense of purpose and hinders the initiation of constructive actions; value system narrowing, which entails the devaluation of previously esteemed values, as well as the abandonment of interests and social connections; and interpersonal relationship narrowing, which manifests as social withdrawal, loneliness, and feelings of rejection. In summary, cognitive changes related to the perception and evaluation of reality, a reduction in social interactions, and the relinquishment of values previously regarded as significant to the individual are characteristic components of narrowing. Suppressed aggression, in its initial phase, is restrained, creating a specific tension that subsequently turns inward and is directed against the self.

Conversely, suicidal fantasies (suicidal ideation) may be perceived as a means of alleviating psychological tension. According to Ringel (1987), an individual expressing suicidal intentions is engaged in a cognitive process characterised by ambivalence, referring to the bipolarity of attitudes towards life and death ("I want to and I do not want to"). An increase in self-destructive fantasies may indicate a heightened risk, as the act of taking one's own life is erroneously perceived as a beneficial and desirable solution.

It is posited that personality predispositions play a significant role in the various components of the suicidal syndrome and may manifest with varying degrees of intensity. The absence of clearly articulated suicidal fantasies, in conjunction with escalating cognitive constriction and pronounced tendencies towards self-aggression, may be assessed as affective withdrawal within the context of depression, thereby necessitating the incorporation of pharmacotherapy. In such instances, failure to recognise the syndrome may establish conditions conducive to the individual's decision to end their life.

THE CLINICAL DIAGNOSTIC CRITERIA FOR SUICIDAL ATTEMPTS

According to the classification established by the American Psychiatric Association (APA) in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), suicide is understood as the deliberate act by which an individual brings about their own death. In contrast, a suicide attempt is characterised as an effort to take one's own life, which may result in death. Suicidal ideation, from a clinical

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perspective, encompasses thoughts of self-directed harm that involve deliberate contemplation or planning of methods that could result in one's death. Furthermore, the DSM-5™ includes a chapter "Conditions for Further Study", which encompasses suicidal behaviour disorders (SBD). Gmitrowicz (2014) suggests considering an alternative term for the assessment of suicide risk within a specified timeframe, proposing the concept of an elevated suicide risk syndrome.
In the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) (World Health Organization, 1997), suicide is classified as an external cause of death encompassing a variety of behaviours, specifically intentional actions directed against oneself, and is designated under the numerical codes X60–X84 (intentional self-harm). In the International Statistical Classification of Diseases and Related Health Problems, Eleventh Revision (ICD-11) (World Health Organization, 2019), suicide is addressed within the chapters pertaining to mood disorders (block L1 – 6A6) and depressive disorders (block L2 – 6A7).

METHOD

The analysis of the available literature was conducted using the Google Scholar database, with the aim of identifying diagnostic tools for the assessment of suicidal tendencies that have a Polish-language version. Articles written in Polish and English were considered. A limitation of the review is the lack of data from additional academic platforms. The search terms used included "suicide" and "diagnostic tools". In the first stage, titles were screened to identify publications relevant to the aims of the review. In the second stage, abstracts of the selected papers were analysed to identify questionnaires used to assess factors associated with suicide (e.g. suicidal thoughts, behaviours, intentions, attitudes, hopelessness, and their severity) that are applicable in Polish clinical or research contexts. The search covered the period from 2010 to 2025. Only publications appearing as articles in peer-reviewed scientific journals were included.
Inclusion criteria comprised: (1) availability of a Polish-language version of a diagnostic tool or evidence of its use in Polish samples, (2) empirical validation published in at least one peer-reviewed journal, and (3) relevance to the assessment of suicidal tendencies or suicide-related constructs.
Exclusion criteria included: (1) studies assessing self-harm without suicidal intent, (2) tools focused primarily on depression, suicide stigma, or general mental health, (3) non-validated instruments, and (4) reviews, monographs, or conference reports. A total of 29 articles met the inclusion criteria, enabling the identification of nine diagnostic tools used in the assessment of suicidal tendencies.
Evaluation of the quality of the questionnaires: the tools identified in the literature were assessed with regard to evidence of reliability reported in at least one empirical study. In addition, the practical utility of each tool and the specific domains of suicidal tendencies that they assess were reviewed.

TOOLS FOR ASSISTING THE DIAGNOSIS OF SUICIDAL TENDENCIES

The Minnesota Multiphasic Personality Inventory (MMPI-2)

The Minnesota Multiphasic Personality Inventory (versions MMPI, MMPI-2, and MMPI-2-RF) is a widely used diagnostic tool employed by qualified psychologists to assess personality traits and levels of psychopathology. It is one of the most frequently utilised psychometric measures for evaluating psychopathological conditions. The questionnaire can be applied in hospital settings, outpatient facilities, correctional institutions, and in the recruitment process for military services. In the MMPI-2 version available on the Polish market, respondents are required to provide answers to 567 statements. Despite subsequent refinements, the MMPI-2 remains the most widely used version and has been translated into over 40 languages.
The MMPI-2-RF version (Minnesota Multiphasic Personality Inventory-2 Revised Form), which is not available in Poland, includes the SUI scale (Suicidal Ideation Scale), characterised by elevated scores in individuals reporting suicidal thoughts and past attempts. An analysis conducted using the Google Scholar database revealed over 302 scholarly articles discussing research employing the SUI scale.
It is noteworthy that all questionnaires within the MMPI group demonstrate high reliability in identifying suicidal tendencies, particularly suicidal ideation. However, the MMPI-2 does not possess a singular scale that encapsulates the multifaceted nature of suicidal tendencies. The literature indicates that the MMPI-2 includes two scales specifically addressing suicide: the Suicidal Thoughts Scale (DEP4), which comprises five items and functions as a subscale of the primary depression scale (DEP), and the Suicide Potential Scale (SPS), which contains six items: 150, 303, 506, 520, 524, and 530, that directly pertain to suicidal behaviours (notably, items 506 and 520 exhibit explicit suicidal content). It is important to note that item 454, which is part of the DEP4 scale, is not included in the SPS. The Suicidal Thoughts Scale demonstrates a robust correlation with suicidal ideation and behaviours (Barreto and Greene, 2017; Gajewski and Kucharska, 2023; Glassmire et al., 2001).
In the absence of Polish validation and normative data for the aforementioned scale, it would be advisable for future researchers to undertake such procedures. The advantage of the questionnaire lies in its capacity to assess a broad spectrum of personality traits and psychopathology. By contrast, its drawback is that, for administration and interpretation, access to the platform (or a paper form) must be purchased, and the assessment can only be conducted by a qualified psychologist.

The Columbia-Suicide Severity Rating Scale (C-SSRS)

The Columbia-Suicide Severity Rating Scale (C-SSRS) is a tool that is particularly prevalent in scientific research and recommended for clinical practice in the United States. Studies affirm its reliability, as well as its ease and speed of use in assessing suicidal risk. Developed at Columbia University (Posner et al., 2011) the scale is applicable for evaluating patients aged 12 and older. Gmitrowicz (2014) notes that the scale has received endorsement from the U.S. Food and Drug Administration. Koweszko et al. (2018) state that the tool is intended for use in various settings, including psychiatric facilities, general hospitals, outpatient clinics, rehabilitation centres, schools, uniformed service institutions, crisis intervention centres, social care services, and clinical research.

The C-SSRS has also faced critical opinions regarding its effectiveness. Mokros et al. (2025) report the development of a condensed screening instrument intended for rapid assessment in acute clinical settings, the construct validity and predictive utility of which have been empirically corroborated. Accordingly, the instrument comprises a screening version (Polish validation) and an expanded form, i.e. a partially structured interview that allows for the exploration of suicidal thoughts. These thoughts are categorised into: a desire for death; active suicidal ideation that is unspecified in terms of methods but lacks a plan and actual intent; the intention to commit suicide without a plan; and finally, the intention with a specific plan.

Another area for exploration is the intensity of these thoughts, understood in terms of frequency, duration, and controllability. In this section, the examiner also inquires about protective factors, defined as "things", or "someone or something", that may or may not influence the suppression of the desire for death or actions associated with suicidal thoughts. Subsequently, it is essential to ascertain the reasons behind these thoughts.

The next section examines all forms of suicidal behaviour, including actual attempts, thwarted attempts, aborted attempts, as well as preparatory actions and behaviours. The authors of the questionnaire provide instructions prior to each of these categories of questions, guiding the examiner on how to interpret the terminology used. Finally, it is essential to inquire specifically about actual attempts, which are defined as those necessitating medical attention and having the potential for fatal outcomes.

The C-SSRS screening version comprises six categories. Confirmation of any of these categories within the past month or since the last consultation indicates a significant risk of suicidal behaviour that necessitates in-depth screening. The colours used in the questionnaire, ranging from yellow to red, are intended to facilitate decision-making for the examiner. These categories are as follows:

1. desire for death;
2. current suicidal ideation (if the response is affirmative, the examiner proceeds to items 3, 4, 5, and 6; if negative, the examiner moves directly to item 6);
3. thoughts regarding methods of suicide;
4. suicidal behaviour tendencies;
5. willingness to enact a suicide plan;
6. history of suicidal behaviour.

It is noteworthy that the instrument in the screening version has a Polish adaptation and validation (Mokros et al., 2025), with the authors indicating that the Polish version of the C-SSRS demonstrates robust psychometric properties and high internal consistency, as evidenced by a Cronbach's alpha coefficient of 0.891. Two components of the questionnaire have been identified by the authors: 1) "Suicidal Thoughts, Intentions, and Plans" and 2) "History of Suicide Attempts". In the study under discussion, both factors were found to be significantly correlated, despite the fact that, in the relevant literature, they are considered distinct yet sequential elements of the suicidal process. A positive history of suicide attempts is regarded as one of the most critical risk factors for completed suicide. The authors assert that the tool can be employed to assess suicide risk among psychiatric inpatients.

It is also worth mentioning that the C-SSRS has been translated into over 100 languages, does not require specialised knowledge for its application, and offers a free online training course, culminating in an examination and a certificate. The Assessment version (an interview expanded to include psychosocial resources) has the advantage of conducting a detailed examination of an individual in crisis, whereas the screening version possesses Polish validation. Availability: authors grant permission for free use, and online training is provided by the author. Its principal drawback is that the Assessment version requires specialised knowledge of suicidal crises. Furthermore, completion of the online training and receipt of the dedicated certificate are prerequisites for conducting the assessment. The evaluation itself may take approximately 30 minutes. Intended users include psychiatric facilities, general hospitals, substance-use treatment and outpatient centres, crisis intervention and social care services, educational institutions, law enforcement and uniformed services, and participants in clinical research.

Toll for Assessment of Suicide Risk (TASR)

The instrument published in 2006 by Chehil and Kutcher, known as the Tool for Assessment of Suicide Risk (TASR), is available in a Polish version. It comprises three sections, each containing nine questions to which the patient responds with "yes" or "no". The first section addresses the individual risk profile, encompassing variables such as age, gender, health status, social support, and experiences of abuse. The second section focuses on risk symptoms, including depressive, psychotic, and anxiety symptoms, as well as impulsivity. The final section examines risk factors derived from the clinical interview, which includes

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the use of psychoactive substances, suicidal thoughts, intentions, and plans, previous suicide attempts, imperatives that may encourage such actions, intractable problems, and access to means that facilitate the execution of a suicide plan. In the modified version released in 2011 (TASRm), the nature of certain questions was altered, and three additional questions regarding protective factors were introduced. These questions pertain to reasons for living and the internal and external resources available to the individual for managing suicide risk. The authors emphasise that the instrument cannot predict whether an individual will commit suicide; however, it can be employed to gather all necessary information for assessing risk, which is categorised as low, medium, or high (Chehil and Kutcher, 2012).

The TASR comprises three distinct components:

- individual risk profile – includes variables such as gender, age, familial history of suicide, chronic medical conditions, psychiatric disorders, perceived social support deficits, substance misuse, and experiences of physical or sexual violence (each factor contributing one point);
- risk-related symptomatology – encompasses depressive symptoms, positive psychotic symptoms, feelings of hopelessness, worthlessness, anhedonia, anxiety or agitation, panic attacks, irritability, and impulsivity (each factor contributing two points);
- risk factors from history – predominantly reflect the current psychiatric presentation and include recent substance use (within the past week), suicidal ideation, intent, planning, command hallucinations related to suicidal or homicidal acts, previous suicide attempts, perceived insurmountability of current problems, and access to lethal means (each factor contributing three points).

Higher total scores are indicative of an increased risk of suicidal behaviour; however, the authors do not specify particular scoring thresholds for risk stratification. Additionally, the TASR incorporates the clinician's subjective risk assessment, which is independent of the numerical score and categorised as high SR (A), moderate (B), or low (C).

In Poland, Nowak and Pawełczyk (2023) conducted a case-control study to determine the utility of the TASR in the emergency department of a psychiatric hospital among patients experiencing suicidal crises. Based on their findings, it was concluded that the scale can be applied in the assessment of suicide risk in patients in crisis; however, a comprehensive evaluation of the patient's overall condition is considered more critical than focusing solely on individual risk factors, including suicidal thoughts and tendencies. Nevertheless, the instrument demonstrates low discriminative power. Another disadvantage is that the instrument lacks Polish validation and normative data.

SAD PERSONS

The tool developed by Patterson et al. (1983) for assessing the likelihood of suicidal behaviour serves as a memorable diagnostic instrument, primarily due to its use of a concise acronym comprising ten English words: SAD PERSONS. This tool is grounded in key risk factors, articulated as follows: Sex – Male gender; Age – Adolescent and elderly age groups; Depression; Previous attempts; Ethanol abuse; Rational thinking loss; Social support lacking; Organised plan for suicide; No spouse or not living with a relation; Sickness. This framework provides a structured approach to identifying individuals at heightened risk for suicidal ideation and behaviour. The scale was standardised, assigning a score of 0–1 to each item, thereby enabling the categorisation of risk levels as follows: low – 0–2; moderate – 3–4; high – 5–6; very high – 7–10. In cases of moderate risk, hospitalisation is recommended, whereas in instances of high risk, it is deemed absolutely necessary.

Nowak and Pawełczyk (2018) report the existence of a modified version of the SAD PERSONS scale, abbreviated as MSPS (Modified Sad Persons Scale), which incorporates a final item pertaining to expressed suicidal intent (Stated Intent). This modification assigns double weight to four risk factors. A score of six points or above indicates the necessity for psychiatric hospitalisation. The negative predictive value is 100%, with sensitivity ranging from 94% to 100%, and specificity between 60% and 70%. Sensitivity increases when a lower cut-off score of five points is employed (Nowak and Pawełczyk, 2018). The MSPS retains the original mnemonic of SAD PERSONS, with the exception of the letter "P", which in this context denotes "psychiatric care", and the final letter "S", which signifies "stated intent for the future". The MSPS encompasses both objective elements (e.g. age and gender) and subjective factors (depression, loss of rational thought, a structured plan, and stated future intent). Overall scores range from 0 to 14, with subjective elements weighted accordingly.

Changchien et al. (2015) examined the correlations between 13 items of the MSPS and the corresponding items of the original SAD PERSONS Scale in a sample of individuals diagnosed with mental disorders. An additional risk factor identified was "current life stressor". The methodology involved a retrospective selection of 210 hospital medical records of patients who were classified according to the "severity" of suicidal ideation into three groups: (A) without suicidal thoughts, (B) with suicidal thoughts, and (C) with a history of suicide attempts. The study found seven factors – age, depression, previous attempts, loss of rational thinking, a structured plan, stated future intentions, and current life stressor – to be statistically significant, suggesting that they are particularly relevant within these groups. Further analyses of intergroup relationships revealed that "the proportion of individuals with suicidal ideation or those who had attempted suicide was consistently significantly higher than that of individuals without suicidal thoughts" across most variables, except for correlations with "age" and "loss of rational thought". The researchers drew the following conclusions: five factors – depression ($p < 0.05$), previous attempts ($p < 0.01$), organised plans ($p < 0.01$), stated future intentions ($p < 0.01$), and current life stressors ($p < 0.01$) –

exhibited a significantly strong correlation with suicide. Among these, "organised plans" and "previous attempts" emerged as the most robust predictors. Thus, "depression", "organised plans", "specific future intentions", and "current life stressors" demonstrated a consistently significant relationship with suicide within the study. Furthermore, the factor of "organised planning" exhibited the strongest correlation with the "severity" of suicidal behaviour. The factor of "age" also differed significantly across the three examined groups. The group with suicidal ideation included the highest proportion of men over 45 years of age and women over 55 years. However, this difference was found to have weak statistical significance and was subsequently excluded from consideration. The researchers also indicated that the components of the questionnaires employed in the study may be useful in assessing both medium-term and long-term suicide risk. Additionally, they noted that aspects including emotions experienced and the patient's level of cognitive awareness should also be taken into account during the assessment process.

It is important to note that there are also reports advising against the use of the SAD PERSONS scale as a screening tool for suicide risk in general hospital settings. These studies argue that clinicians should employ a comprehensive clinical assessment that takes into account individual risk factors as well as relevant biopsychosocial elements. They emphasise that vigilance should be heightened in the presence of depressive symptoms and current or future-oriented thoughts of self-harm or suicide. Researchers highlight that, particularly during the initial consultation with the patient, it is crucial to evaluate their mental state, as the aforementioned factors are associated with a significantly elevated risk of suicidal behaviour. The authors further indicate that the psychometric properties of the SAD PERSONS scale may be insufficient for the identification of patients at risk of suicide; however, the tool can be utilised for structured interviews. They suggest that for the purposes of further research, it is essential to employ the modified version of the MSPS instead of the SAD PERSONS scale for evaluating current suicide risk. Additionally, they recommend implementing a follow-up for individuals being examined to predict subsequent suicidal thoughts or attempts. They also assert that the modified version of the SAD PERSONS scale should be evaluated with respect to its sensitivity and specificity, and compared with other instruments that assess self-harm. The authors advocate for research across various medical professional groups to ensure that the tool can be reliably administered by all medical personnel. The findings indicate that the cut-off score for the SAD PERSONS scale was 2/3, which corresponded to a high current risk of suicide with a sensitivity of 79.0% and a specificity of 35.0%. In contrast, while specificity at a cut-off score of 4/5 exceeded 90.0%, sensitivity was only 27.0%. The parameters that correlated with a high risk of suicide were limited to depression and the presence of future suicidal intentions. The authors of the study concluded that screening tools with high sensitivity are essential for suicide prevention. The SAD PERSONS scale failed to identify the majority of individuals requiring intensive psychological intervention, despite demonstrating high specificity for suicide risk. Consequently, this tool should not be utilised as a screening measure for self-harming patients presenting to general hospitals.

In the scientific report derived from a study conducted in a hospital emergency department, the MPSP was utilised to evaluate the credibility of patients following a suicide attempt, thereby informing decisions regarding their admission or discharge. Researchers noted that this type of assessment presents a significant dilemma for physicians working in the department. They also emphasised the necessity for an objective evaluation of such patients. The conclusion drawn from their research is that, although the MSPS does not meet all established criteria, it can be effectively employed in the emergency department setting. Furthermore, the study concluded that the MSPS is a scale that can be safely used in the assessment of patients presenting after suicide attempts and in the identification of those who do not require hospitalisation. Disadvantage: neither instrument has undergone validation or standardisation within the Polish population. Furthermore, there are empirical reports advising against the use of the tool for screening purposes, particularly among individuals presenting with self-injury. Advantage: the use of mnemonic devices facilitates the retention of key thematic domains related to suicidal crisis, thereby enhancing cognitive accessibility and recall.

Reasons for Leaving Inventory (RFL-48)

A component of the narrowing observed in the pre-suicidal syndrome is the alteration or diminishment of the values that an individual holds. For the purpose of psychological diagnostics aimed at exploring the extent of meaning change in the life of a potential suicide victim, a tool known as the Reasons for Living Inventory (RFL) may be employed. This inventory, developed by Marsha M. Linehan et al. at the University of Washington (Linehan et al., 1983), enhances psychological interviews by providing insights into the respondent's psychological resources and their reasons for living, which serve as protective factors. It is pertinent to note that Linehan is the originator of dialectical behaviour therapy (DBT), which is specifically designed for working with individuals experiencing suicidal ideation, including those with borderline personality disorder. The researcher has observed that the emergence of suicidal thoughts correlates with a reduction in the number of reasons for living.

Research conducted by the author indicates that individuals with suicidal tendencies attribute less significance to various domains of life that are considered important by those without such tendencies. This pattern is observed both in the general population and psychiatric cohorts. The RFL comprises 48 items spanning six areas which may serve as deterrents to suicide. These areas include belief in coping

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abilities, responsibility towards family, concerns for children, fear of suicide, fear of social disapproval, and moral norms. The task of the individual being examined is to identify which of these areas would serve as a deterrent to suicide in the event that thoughts of death were to arise. The inventory has been developed for various age groups. In addition to the general version, supplementary versions exist for adolescents and older adults. Alternative methods take into account different categories of reasons for living, indicating varying motivations depending on age. Only one of the versions (RTL-48) has undergone a Polish adaptation. The Polish adaptation (Siewierska and Chodkiewicz, 2022) of the instrument demonstrates psychometric properties comparable to the original version, with a Cronbach's alpha coefficient of 0.89. Its factor structure is identical to that of the original and the versions validated in subsequent years; all versions comprise six factors characterised by analogous test items, with factor loadings exceeding 0.5. Consequently, the Polish adaptation can be utilised for the assessment of specific factors. The Polish version also exhibits satisfactory theoretical validity. The authors assert that, despite certain limitations, the Polish adaptation of the tool developed by Linehan et al. is valuable for clinical research and screening therapeutic interventions focused on identifying personal motivations that protect against suicide in adults. Disadvantage: lack of Polish adaptation and validation for adolescents and seniors. Advantage: the instrument has Polish adaptation and validation. Useful in clinical and screening research (for identification of adult individuals' psychological resources).

Suicidal Behaviours Questionnaire-Revised (SBQ-R)

Suicidal thoughts can be explored using the Suicidal Behaviours Questionnaire-Revised (SBQ-R), which consists of four items designed for self-report assessment of the intensity of suicidal tendencies, including suicidal behaviours such as ideation and attempts. The SBQ-R was developed based on a 34-item questionnaire created by Marsha M. Linehan et al. for suicidal thoughts and behaviours. The method was modified and abbreviated by the original authors, and later revised and psychometrically refined by Osman et al. (2001). The questionnaire has been validated in multiple languages, including a Polish version (Chodkiewicz and Gruszczyńska, 2020). The scoring system ranges from 1 to 3 for items 1 to 3, and from 0 to 6 for item 4. The questionnaire comprises three questions regarding the past occurrence of suicidal thoughts and behaviours, as well as one question pertaining to the likelihood of such behaviours occurring in the future.

It facilitates the determination of an overall score, which serves as an indicator of suicidal risk, with a cut-off point for the psychiatric patient group set at a score of 8 or higher (Osman et al., 2001). Exploratory and confirmatory factor analyses conducted by Polish researchers have confirmed the tool's unidimensional nature, with internal consistency, assessed using Cronbach's alpha coefficient, of 0.83. As for validity, factor analysis yielded a single factor accounting for 68.6% of the variance in outcomes; confirmatory factor analysis demonstrated satisfactory model fit ($\chi^2 = 4.91$; degrees of freedom, df = 2; $p = 0.08$; comparative fit index, CFI = 0.99; Tucker–Lewis index, TLI = 0.98; root-mean-square error of approximation, RMSEA = 0.07; standardised root-mean-square residual, SRMR = 0.01). The results of the questionnaire correlate significantly positively with levels of depression and psychological distress, and negatively with the sense of meaning in life. Individuals who have previously engaged in suicidal behaviours or experienced suicidal thoughts, as well as those with a family history of suicide attempts or alcohol dependence, exhibited significantly higher scores on the SBQ-R. The authors assert that the Polish version of this instrument is useful in clinical research, screening, and suicide risk assessment within therapeutic practice, particularly among young adults. Moreover, the authors highlight that a notable advantage of the tool is its high reliability, achieved within a brief measurement timeframe, alongside its strong discriminative power and the inability to reduce results solely to the evaluation of depressive symptoms. Disadvantage: study sample included only younger adults. Advantage: the instrument has Polish adaptation and validation. It does not merely explore clinical symptoms of depression. Useful in clinical, screening, and diagnostic contexts of an individual's resources. Short item count: 4.

Suicidal Acute Risk Scale (SARS)

The preliminary version of the scale (Skala Aktualnego Ryzyka Samobójczego), developed at the Department of Psychiatry, Physiotherapy Division of the Medical University of Warsaw (Klinika Psychiatrii Oddziału Fizjoterapii Warszawskiego Uniwersytetu Medycznego) (Łoza and Polikowska, 2016), was presented at the Polish Psychiatric Association (Polskie Towarzystwo Psychiatryczne, PTP) Congress in Lublin in 2013. The primary objective of the authors in constructing this tool was to assist psychiatrists and other professionals in making medical and legal decisions during psychiatric hospitalisations. The scale focuses exclusively on current phenomena, defined as those which have occurred no later than within the previous two weeks. It facilitates the assessment of the risk of suicidal behaviour in two ways: quantitatively (determined by the sum of points) and qualitatively (defined by high-risk criteria). The establishment of high-risk criteria supports the decision regarding the necessity of treatment and occurs in two instances: when criterion A is met (either independently or in conjunction with criteria B, C, and D) or when the triad of criteria B, C, and D is present. The Suicidal Acute Risk Scale (SARS) demonstrates satisfactory psychometric parameters (Cronbach's alpha coefficient of 0.82, kappa of 0.78). Disadvantage: lack of testing in other treatment, medical, and therapeutic centres.

Advantage: a quick diagnostic method for assessing individuals in suicidal crisis.

Suicide Risk Assessment Procedure (PORS)

It is important to note that, within the Polish clinical context, attempts have been made to develop a structured assessment for patients at risk of suicide, resulting in the creation of the Suicide Risk Assessment Procedure – "PORS" (Procedura Oceny Ryzyka Samobójczego) (Lubas and Rode, 2022). As reported by the authors, this tool is designed for use in psychiatric wards and systematically categorises risk factors, while also outlining the appropriate course of action in the event of a potential suicide attempt. The tool comprises an initial assessment, a monitoring phase, and a final stage referred to as the "exit" phase. The procedure incorporates previously described instruments, namely the C-SSRS and the Ask Suicide-Screening Questions (ASQ) (Horowitz et al., 2020). In the process of developing the PORS procedure, the translation of the instrument into Polish was undertaken. Pilot testing was conducted employing a test–retest methodology with a sample size of N = 30 participants (mean age = 37.7 years; standard deviation = 12.56) to evaluate the comprehensibility and unambiguity of individual items. No items were reported as problematic by the participants. Additionally, bilingual individuals (N = 10; mean age = 37.2 years; standard deviation = 15.65) participated in equivalence studies to assess linguistic equivalence between the original and translated versions.

The ASQ is a four-item screening tool for assessing suicide risk among adult patients in medical facilities. All questions pertain to key risk factors associated with suicidal behaviour, with three specifically addressing recent suicidal thoughts and a desire for death. The ASQ demonstrates robust psychometric properties (with correlation coefficient ranging from 0.87 to 0.96), and a high three-month predictive validity has been established for this tool within a cohort of individuals presenting to emergency departments following a suicide attempt.

For each question, patients respond with either "yes" or "no". In the event of an affirmative response to question 4, an additional inquiry regarding current suicidal thoughts and intentions should be posed (question 5 in the ASQ). Disadvantage: absence of studies across a broader range of treatment, medical, and therapeutic settings. Advantage: complete procedural protocol for managing patients in suicidal crisis within the context of inpatient psychiatric care.

Verbal Suicide Scale (WSS)

The Verbal Suicide Scale (Werbalna Skala Samobójstwa, WSS) is a Polish diagnostic tool designed to assess attitudes towards suicide (Koweszko et al., 2017). The scale is based on a modified mechanism employed in the free association technique. According to its premises, the psychic apparatus dissociates conflicting contents, specifically the conflict between drives and internalised aggression. This methodology seeks to reduce psychological resistance during the assessment process. Individuals engage with the scale by selecting from a curated list of 27 words that are thematically related to suicide. The scale facilitates the calculation of an overall score as well as scores across three subscales: suffering avoidance, internalised aggression, and hopelessness. The interpretation of the scale pertains to personality traits as well as risk and protective factors associated with suicide. In order to facilitate the practical application of the WSS instrument within clinical settings, the researchers established sten norms (ranging from 0 to 10) for each of the three subscales and for the overall score (from 0 to 27). The primary purpose of the test is to differentiate functioning within the normative range. The scale comprises ten units, ranging from 1 to 10. Raw scores were transformed using the formula: $S = 5.5 + 2 \times Z$, where Z represents the standardised score (Z-score). Scores of 7 to 10 are considered high, with normative data enabling assessment along a continuum from low to high. Validity: correlations of the WSS subscales with other measures of suicide risk (C-SSRS; NGASR – Nurses' Global Assessment of Suicide Risk) and with individual dimensions of perceived coherence. Normative sten scale values developed on a sample of 157 psychiatrically admitted patients. Conclusions: The obtained results suggest that suicidal behaviour operates independently of conscious attitudinal states. The findings from the Verbal Suicide Scale most notably pertain to patients with substance misuse or dependence on psychoactive substances. The instrument is suitable for individual assessment of suicidal attitudes and may be employed by a range of research and public health organisations upon prior authorisation from the author. Commercial use of the WSS is prohibited. Disadvantage: absence of studies conducted in other treatment, medical, and therapeutic settings. Advantage: individual assessment, potential for repeatable measurement, with no time constraints; typical assessment duration is approximately 5 minutes. Subject to the author's consent, the instrument along with its administration guidelines may be shared with clinicians, researchers, and students, for both diagnostic and research purposes.

DISCUSSION

The phenomenon of a suicidal crisis, when viewed through a psychological lens, extends far beyond mere statistics or theoretical constructs; it embodies a deeply intricate process that engages the full spectrum of an individual's personality. This critical juncture arises when adaptive mechanisms become overwhelmed by experiences that are perceived as "unbearable". Given the complexity of such circumstances, it becomes evident that superficial evaluations of symptoms or the assignment of a diagnosis alone fall short of addressing the underlying issues.

A comprehensive assessment of suicide risk requires methodologies that intricately capture not only the patient's cognitive processes but also the nuanced interplay between their emotional, psychological, and social dimensions. Diagnostic tools

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such as the MMPI-2, C-SSRS, SAD PERSONS, TASR, SARS, RTL-48, and SBQ-R, which are widely used in clinical settings, represent only a fragment of the broader solution needed to navigate these profound challenges. In the realm of mental health assessment, particularly in relation to suicidal crises, the effectiveness of existing diagnostic tools remains an underresearched though critically important area of inquiry. There is an imperative for comprehensive research that considers the unique characteristics of Polish society, the intricacies of its healthcare system, and the cultural factors that shape the understanding of mental health issues. It is essential to recognise that variations in symptom interpretation and the subjective experience of psychological distress can profoundly influence the precision of these diagnostic instruments. While international literature is replete with studies examining the application of such tools, there is a notable deficiency in domestic analyses, especially regarding the phenomenon of suicidal crises within Poland's specific cultural and systemic context. To enhance the precision and applicability of diagnostic instruments for evaluating suicide risk among Polish patients, it is essential to undertake comprehensive empirical research. Such investigations will enable the adaptation of these tools to the distinct psychological and sociocultural frameworks inherent to this population, thereby augmenting the accuracy of risk evaluation and fostering the development of more effective prevention strategies. A myriad of factors – including familial vulnerability to mental health disorders, socio-economic variables, and prevailing societal attitudes towards suicide – represent critical dimensions that warrant meticulous examination when interpreting assessment outcomes. Failure to account for these contextual elements may yield diagnostic instruments that, despite their technical validity, do not adequately reflect the lived experiences of individuals within the Polish context. Therefore, it is evident that conducting rigorous empirical studies to assess the efficacy of these diagnostic tools in Poland is not merely beneficial but fundamentally essential for the advancement of mental health interventions and the enhancement of suicide prevention initiatives.

From this perspective, the investigation of suicidal crises can be framed as fulfilling a dual purpose: a cognitive function that seeks to deepen understanding of the fundamental nature of the phenomenon itself, and a practical function that emphasises the adaptation of assessment instruments to meet the unique needs of Polish patients. It is essential to recognise that the application of psychometric tools within a statistical paradigm represents merely one aspect of the critical endeavours undertaken by researchers. Equally important is the consideration of these instruments in terms of their capacity to capture and illuminate the more profound dimensions of human suffering, which often transcend the boundaries of conscious awareness. By synthesising these perspectives, the evaluation of suicidal crises can attain a greater level of comprehensiveness, supporting the formulation of more effective intervention strategies.

It should be noted that a range of diagnostic instruments are employed in clinical practice by medical professionals, which include individual items addressing broadly conceived suicidal crisis. These encompass, for example, self-report tools designed to measure the intensity of depressive symptoms or perceptions of hopelessness, such as the Beck Depression Inventory (BDI) and the Beck Hopelessness Scale (BHS), as well as the Edinburgh Postnatal Depression Scale. One of the more frequently utilised scales for assessing suicide risk is the BHS (Rueda-Jaimes et al., 2018). The value of this scale lies, among other factors, in its inclusion of questions assessing both positive and negative coping styles. The Hamilton Depression Rating Scale (HDRS) is administered by clinical personnel during a direct interview. In this context, it should be borne in mind that the presence of symptoms characteristic of depressive disorder does not automatically imply suicidal ideation. Individuals in suicidal crisis frequently report experiences of psychic pain, as described by Shneidman in 1993 (Yöyen and Keleş, 2024). This represents an alternative concept to that formulated by Ringel, presented at the outset of the article. In this context, psychic pain is assessed by the Holden et al. (2001) Scale of Psychache (Skala Bólu Psychicznego) the sole instrument with a Polish adaptation (Chodkiewicz et al., 2017). It is worth noting that those at high risk predominantly include patients whose health status necessitates inpatient treatment. It is widely recognised that patients with schizophrenia, mood disorders, substance use disorders, and personality disorders constitute a particularly suicide-prone demographic. There are scales for evaluating suicidal thoughts and ideation in schizophrenia and schizoaffective disorders (InterSePT Scale for Suicidal Thinking, ISST) and for suicide risk (Schizophrenia Suicide Risk Scale, SSRS). However, these instruments have been criticised for omitting questions addressing spiritual/religious dimensions, an aspect relevant to psychological and psychotherapeutic support. The scales previously employed among individuals with schizophrenia were largely tailored to affective mood disorders and did not incorporate, for example, the influence of auditory hallucinations and self-harm delusions. The authors note that the ISST remains, at present, the most reliable, valid, and schizophrenia-specific instrument for assessing the severity of suicidal thoughts. A Polish version of the scale has also been developed, with reliability and validity demonstrated in a study of 218 patients with schizophrenia and schizoaffective disorders. Also, the authors report that a pilot study monitoring suicidal behaviours among psychiatric inpatients was implemented at the Institute of Psychiatry and Neurology using a brief questionnaire entitled "Monitoring of Suicidal Behaviours"; however, a search of available databases did not yield articles describing this questionnaire or its broader research applications.

It is also worth mentioning that the Suicide Risk Assessment based on the structured MINI tool (Mini International Neuropsychiatric Interview) is also available; however, it is based on the diagnostic criteria derived from DSM-IV and ICD-10. This assessment categorises suicide risk as low, intermediate, or high and is conducted by an examiner. It requires expertise in recognising the stages of suicidal

crisis and conducting clinical interviews, because asking the question "Do you have suicidal thoughts?" does not precisely delineate the level of risk.

CONCLUSIONS

The diagnostic tools most commonly referenced in the assessment of suicidal tendencies in Poland include the MMPI-2, C-SSRS, WSS, SARS and TASR. These instruments are valued for their linguistic accessibility and strong psychometric properties, which enhance their utility in clinical practice. A limitation of the article is that the review was restricted to one platform database only. Nevertheless, there exists a notable deficiency in comprehensive research conducted in Poland that evaluates both the psychometric characteristics of these suicide risk assessment tools and their applicability across diverse clinical scenarios.

Conflict of interest

The authors do not report any financial or personal connections with other persons or organisations which might negatively affect the content of this publication and/or claim authorship rights to this publication.

Author contribution

Original concept of study; collection, recording and/or compilation of data; analysis and interpretation of data; writing of manuscript: DTC. Critical review of manuscript: PD, PG. Final approval of manuscript: PD, MG, PG.

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