Published in final edited form as:
*Prof Psychol Res Pr*. 2010 June 1; 41(3): 221–227. doi:10.1037/a0018712.

# The Problematic Label of Suicide Gesture: Alternatives for Clinical Research and Practice

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## Abstract

Historically, certain terms used to describe psychopathology have evolved over time due to changing social and political contexts. This paper explores the importance of a clear and consistent language for characterizing suicide-related behaviors with a particular focus on the commonly used label “suicide gesture.” The historical and contemporary uses of the term are explored, and clinical, research, and training implications are discussed. Clinicians and researchers are strongly encouraged to consider discontinuing the use of the term suicide gesture in light of its associated dismissive connotations and inconsistent application in clinical practice and research. In lieu of the term suicide gesture, recommendations are made regarding an increased emphasis by clinicians and researchers on more precise descriptions of suicidal behaviors and the functional assessment of suicide-related behaviors.

### Keywords

suicide gesture; suicide attempt; operational definitions; language for describing psychiatric symptoms; nomenclature; functional assessment

## The Problematic Label of Suicide Gesture: Alternatives for Clinical Research and Practice

Nomenclature for suicidal ideation and behavior has been the subject of considerable international attention and debate (DeLeo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006; Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007a, 2007b; O'Carroll et al., 1996). Clear and consistent terms are needed to guide research and clinical practice. Nonetheless, even in contemporary psychiatric diagnostic systems such as DSM-IV-TR (American

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Psychiatric Association, 2000), suicide-related terms are used in the diagnostic criteria for disorders such as major depressive disorder and borderline personality disorder (BPD) without being defined, either in the glossary of the technical terms or in the text. Indeed, "suicide gesture" is an example of a term that has been used in various ways with various implications, both in clinical work and in research.

The need for clear and consistent use of terms has provided the impetus for efforts to develop standard operational definitions and nomenclature to classify suicide and self-injurious thoughts and behaviors (e.g., Centers for Disease Control and Prevention [CDC], in preparation; DeLeo et al., 2006; Posner, Oquendo, Gould, Stanley, & Davies, 2007; Silverman et al., 2007a). Building on an earlier collaborative effort sponsored by the National Institute of Mental Health, the Center for Mental Health Services, and the American Association of Suicidology (O'Carroll et al., 1996), Silverman et al. (2007a) referred to the term suicide gesture as akin to a behavioral form of suicide threat, and they did not include the term in their recommended nomenclatures because of its imprecision and arguably dismissive connotations. Posner and colleagues (Posner et al., 2007) cited similar reasons for deciding against use of the term "suicide gesture" in the Columbia-Classification Algorithm for Suicide Assessment (C-CASA; Posner et al., 2007), developed for the Food and Drug Administration in response to the need for a consistent and appropriate means of classifying adverse suicidal events in pediatric clinical trials. In a forthcoming report published by the CDC (in preparation) describing uniform definitions to be used in suicide surveillance, the term suicide gesture similarly is not recommended because of the subjective and often negative nature of the term. Despite the fact that many current or proposed systems for describing self-harm behaviors do not recommend the use of suicide gesture as a label, the term has continued to be used widely in clinical practice and in research, as well as in training settings. The purposes of this paper are to briefly describe the history of the commonly used term suicide gesture, to provide an overview of the multiple and inconsistent ways in which this term has been used in the literature, to discuss the implications of the use of this term in clinical practice, research, and training, and to suggest alternatives to its use.

## The Historical Origins of the Term Suicide Gesture

The process of developing a shared language for characterizing psychopathology and implementing a standard nomenclature for clinical and research purposes has long been recognized to be a complex task (e.g., Wakefield, 1992; Wilson, 1993). For example, in developing nomenclature, there have been numerous controversies related to what constitutes mental disorder, the assumptions that are associated with these designations, and what is conceptualized as normal, healthy psychiatric functioning (see Wakefield, 1992 for review). Moreover, the evolution of terminology reflects changing social norms and values. In particular, because of concerns related to social stigma and the negative connotations associated with certain terms, terminology may fall out of favor and be replaced by more appropriate and respectful language. For instance, in an effort to be more sensitive to the issue of labels, the American Psychological Association (2001) has advised that written descriptions of individuals "put the person first," rather than highlighting the label or descriptive phrase. In an example, individuals diagnosed as having the psychiatric disorder schizophrenia may be designated as "meeting diagnostic criteria for schizophrenia" or "with diagnosis of schizophrenia," rather than as "schizophrenics."

With specific reference to the term suicide gesture, a review of the literature confirms that use of the term dates back decades. For example, Prudhomme (1938) described two types of suicidal behavior: "the hysterical (gestural) or relatively benign type in which attempts are made but rather rarely carried out . . . and the psychotic or annihilating type which is malignant; under this heading come the actual suicides of the depressives, praecoxes and

involutionals." Lewis (1933) similarly differentiated between "ineffective gestures and bids for attention" and what were considered to be "serious, genuine attempts" (p. 270). In psychoanalytic interpretations of self-destructive behaviors, Davidson (1941) suggested that suicidal behavior can be related to both the unconscious aspects of personality (e.g., when behavior has specific symbolic meaning), and to the conscious aspects of personality (e.g., in relation to feelings of guilt or unworthiness). As a specific example of the latter, he referred to suicidal behavior of "the psychopathic variety, as a *gesture* to one's ends" (p. 42, italics added). Wilson (1942) wrote specifically about "hysterical suicide" and contended that hysterical fugue states may arise when individuals initiate suicide behaviors. In these fugue states, an "altered personality" without suicidal intent can be "suddenly substituted" to protect the individual. The resulting self-destructive behaviors without full suicide intent were referred to as suicide gestures.

The term also has been used historically in military settings to characterize the behavior of military personnel who were thought to engage in self-harm behaviors for instrumental reasons (e.g., avoiding responsibility) and were therefore deemed to be malingering or not "genuinely suicidal" (e.g., Fisch, 1954; Tucker & Gorman, 1967). As Fisch (1954) noted, "One is soon struck by the transparent insincerity of these attempts, which in the majority of cases, are more aptly termed gestures" (p. 33). Tucker and Gorman (1967) went further when they said, "The suicide gesture is more frequently a communicative act directed at the patient's environment . . . .The person who makes a suicide gesture in the military can usually be typified as 'the man nobody likes'" (p. 854). Additional descriptions cited by Tucker and Gorman (1967) include 'transparent insincerity,' 'manipulative,' and 'emotional blackmail' (p. 854).

Among the earliest to point out difficulties in how we conceptualize suicidal behaviors, Eisenthal (1967) described common clinical practice, when he noted that:

> Among the first questions usually asked about the behavior of a suicidal patient is: 'Was his attempt genuine or a gesture? Did he really mean it when he threatened to kill himself? If the attempt was genuine, the implication is that the patient will continue to be a serious risk, but that if it was a gesture, suicide is unlikely. (p. 987)

However, he then suggested flaws with this practice insofar as there are situational determinants of suicidal behavior that are important and may change over time, and because he found in his study that "seriousness" of suicidal behavior was not predictive of later suicide outcomes.

The term suicide gesture continues to be used contemporarily both in clinical practice and in research. For example, in the National Comorbidity Study, suicide gestures were defined as "self-injury in which there is no intent to die, but instead an intent to give the appearance of a suicide attempt in order to communicate with others" (Nock & Kessler, 2006, p. 616). Suicide gestures were contrasted with suicide attempts, with the former being less common and evidenced more by females, and with fewer diagnoses of depression, less comorbidity, and less history of sexual or other physical abuse (Nock & Kessler, 2006). Using a similar definition, the concept was included in a recently developed assessment instrument, the Self-Injurious Thoughts and Behavior Interview (SITBI; Nock, Holmberg, Photos, & Michel, 2007). In this preliminary report on the SITBI measure, individuals never heard the term suicide gesture per se, but were asked "have you ever done something to lead others to believe you wanted to kill yourself when you really had no intention of doing so?" (Nock et al., 2007, p. 310). Although both of these studies provided clear and concise operational definitions of the term, it is interesting to note that psychometric analyses of the SITBI suggested that, despite high inter-rater reliability in classification of responses to this query, the responses to this question had poor test-retest reliability over six months (Nock et al.,

2007). This low test-retest reliability for the lifetime presence/absence of suicide gestures contrasted with strong test-retest reliability for lifetime presence/absence of suicide ideation, plans, and attempts. Nock and colleagues (2007) proposed several possible explanations for this finding, including the social undesirability of the construct and perhaps a lack of clarity regarding how participants interpreted the question. Velting, Rathus, and Asnis (1998) similarly found that confusion about the term gesture contributed to discrepant reporting of past suicidal behavior by adolescents.

Findings from these and other studies raise questions about the subjectivity or clarity of the concept of suicide gesture, even when there are apparent unambiguous operational definitions. These studies also raise questions about the degree to which the negative connotations or social undesirability of the construct are recognized even by non-clinician respondents. Moreover, the possibility that respondents lack clarity in how to interpret the question of engaging in suicidal behaviors in the absence of suicide intent also may reflect the term's lack of consistency across studies.

## Overview of Definitional Issues: Multiple Meanings and Lack of Clarity

As noted above, the term suicide gesture continues to be used in the literature and with few notable exceptions (e.g., Nock et al., 2007), its definition has evolved into a vague category with multiple and often overlapping connotations. The multiple uses of this term have contributed to a lack of precision in the field and to misconceptions about suicidal behavior. Importantly, the seemingly arbitrary distinction drawn between a “genuine” suicide attempt and a suicide gesture ignores the fact that suicidal behavior is often characterized by mixed motives and considerable ambivalence about life and death (Shneidman, 1996). The various uses of the term are described in greater detail below.

**Low medical lethality—**Although the term suicide gesture is sometimes used interchangeably with suicide attempt in medical journals, the term often refers to suicidal behavior of low medical lethality (i.e., little chance of resulting in death). For example, in a study of suicidal thoughts and behaviors in youth, Apter et al. (2006) defined suicide gesture as “a suicidal threat accompanied by a suicidal act (that the patient believes) is of low lethality” (p. 81). In another example, Grossman, Milligan, and Deyo (1991) noted that unreported suicide attempts were assumed to be “gestures or . . . [suicidal behaviors that resulted in] minor injuries” (p. 873). This latter use of the term is particularly common in studies of the effects of drug overdoses (e.g., Bebarta, Heard, & Nadelson, 2004; Nagle & Schunk, 1995). Indeed, there are numerous reports of behaviors deemed to be gestures because they resulted in little or no significant medical sequelae or required minimal medical intervention (Clarke & Ramoska, 1988; Poff & Rose, 1992; Zahn, Brinton & Norton, 1981).

**Low or no intent to die—**The term suicide gesture has been used routinely to refer to suicide attempts characterized by little or no intent to die with the implication being that such behaviors are necessarily less serious than those with clear intent to die (e.g., Deykin, Perlow, & McNamarra, 1985; Drew, 1999; Ryser, 1983). For instance, in a longitudinal study, Prinstein et al. (2008) considered suicide threats and gestures to comprise a single category of behaviors in a continuum of severity; these behaviors “were assessed by asking adolescents to report ‘if they tried to make someone believe that you might end your life, but didn't do it’” (p. 95). This perspective is exemplified in a paper describing the use of film in teaching psychiatry residents about aspects of suicide (Hyler & Moore, 1996). A clear distinction is drawn between suicidal behaviors that are “actually suicide gestures” and those that are “genuine suicide attempts” by comparing characters in popular films. They discuss the behavior demonstrated by Glenn Close's character in the movie “Fatal Attraction” as

having all of the ingredients to distinguish a suicide gesture from a suicide attempt, including “a dramatic presentation, the impulsive nature of the act, the choice of method (superficial wrist cuts, being less lethal than firearms, jumping, or hanging), readily available assistance, and clear-cut secondary gain” (p. 214).

**Intention to communicate to others—**Suicidal behavior often is labeled as a gesture when the perceived purpose of the behavior is to communicate to others, or demonstrate the extent to which individuals are suffering. Communication is often the suspected function of suicidal behavior when the method chosen has low medical lethality. Many articles report that individuals make suicide gestures to signal to others that something is wrong (Perry & Albee, 1994), or as a “cry for help” (Widiger & Rinaldi, 1983). In this vein, in a recent *JAMA* article (Kessler, Berglund, Borges, Nock, & Wang, 2005), individuals who endorsed the item “My attempt was a cry for help. I did not intend to die,” were classified as having made a suicide gesture (a contrast to those who endorsed either “I made a serious attempt to kill myself and it was only luck that I did not succeed” or “I tried to kill myself, but I knew my plan was not foolproof”).

**Behaviors preparatory to suicide attempts—**Interestingly, the term suicide gesture also has been used, albeit less frequently, to refer to behavior preparatory to, or in anticipation of suicide attempts. For example, Bridge and colleagues (2005) rated suicidality on a 5-point scale (0 to 4) of severity. On this scale, a three denoted a suicide gesture, which was defined as an “episode in which a subject had suicide intent and means at hand but did not attempt suicide” (Bridge, Barbe, Birmaher, Kolko, & Brent, 2005, p. 2174). Hence, not following through with an attempt despite engaging in actions such as holding a bottle of pills, firearm, or knife, presumably would be considered a gesture.

**To manipulate others or the situation—**As was noted in the review of the history of the term, the construct suicide gesture often has been used to refer to behaviors that are often judged as deliberate, instrumental attempts to control or manipulate others or the environment by coercive means. Nock et al. (2007), for instance, noted that “suicide gesture(s) may be construed as being manipulative of another person's feelings and behaviors” (p. 315). The use of the term in this way also was seen in the aforementioned description of the movie Fatal Attraction, in which the antagonist engaged in suicidal behavior with very clear secondary gain (Hyler & Moore, 1996). Similarly, Fisch (1954) noted that “the person who makes a gesture still has his attention focused primarily on the external world. He is using his body principally as a vehicle with which to express anger and protest against an environment, with the object of injuring or altering the environment, rather than removing himself permanently from it” (p. 36).

**Interchangeable with the term suicide attempt—**There are many clinicians and researchers who use the term suicide gesture as a synonym for suicide attempt. In other words, suicide gesture is merely used descriptively to indicate that the person engaged in suicidal behavior. This appears to occur across cultures (e.g., USA, Thailand, France) and medical specialties (e.g., psychiatry, genetics, emergency medicine, molecular psychiatry, substance abuse, highway safety) (e.g., Baud, 2005; Campi-Azevedo, Boson, De Marco, Romano-Silva & Correa, 2003; Dire & Kuhns, 1988; Havanond, 2003; Le Heuzey, Isnard, Badoual, & Dugas, 1995; Reynolds & Eaton, 1986).

## Implications for Clinical Practice

The implications of terminology to describe suicidal or self-injurious behaviors that is pejorative or inconsistently used are far-reaching in clinical practice. Several key areas of concern are detailed below.

**Clinical assessment and communication regarding level of risk—**As noted above, the term suicide gesture has been used to describe behaviors that clinicians often assume can be taken less seriously or with less urgency than “genuine” suicide attempts. There are several flaws to this reasoning in clinical assessment and communication of level of risk. For example, it is important to recognize that intent and lethality are not unitary or even necessarily highly correlated constructs. In children and adolescents in particular, there have been inconsistencies across studies in the degree to which intent and lethality are correlated (DeMaso, Ross, & Beardslee, 1994; Lewinsohn, Rohde, & Seeley, 1996; Nasser & Overholser, 1999; Plutchik, Van Praag, Picard, Conte, & Korn, 1989) and even self-injurious behavior without suicidal intent can result in serious medical injury. Additionally, it has been observed that most suicidal behavior is associated with mixed motives and varying degrees of ambivalence about life and death (Shneidman, 1996), making it difficult to neatly dichotomize suicidal behavior into genuine suicide attempts and suicidal behavior that can be taken less seriously. Taken together, the perception that such behaviors are less serious may compromise clinical assessment in several ways, including the possibility that clinicians could be less inclined to conduct a thorough assessment of other factors contributing to risk for suicidal behavior. Labeling of an individual's behaviors as gestures to family members also may communicate a dismissive stance that may lead to a false sense of security regarding the individual's safety and needs for monitoring.

**Clinical decision-making and level of care—**The use of the term suicide gesture and/or the dichotomizing of serious suicide attempt and suicide gesture also may muddy clinical decision making regarding the level of clinical care needed to maintain an individual's safety. Particularly in emergency department settings, quick assessments of an individual's suicide risk or potential often are needed in order to make clinical care decisions to ensure the individual's safety and to arrange appropriate aftercare. At present, there is recognition that many suicide attempts may not require hospitalization and that some individuals with suicide attempts can be managed safely on an outpatient basis. Indeed, some suicide researchers (e.g., Linehan, 1993; Miller, Rathus, & Linehan, 2007) have suggested the possibility of iatrogenic effects of hospitalization for some individuals with suicide attempts. There are multiple factors that should be considered in decisions to hospitalize a person (e.g., level of immediate intent, ability to participate in a safety plan, access to means), but use of dismissive language to label self-injurious behavior may bias decisions about level of clinical care needed, or color the perceptions of the urgency with which follow-up care is needed following a crisis.

As an example of the problems potentially inherent in this approach, individuals diagnosed with BPD often are considered to make suicide gestures, but they also are at much higher risk of dying by suicide relative to individuals diagnosed with many other psychiatric disorders (Linehan, Rizvi, Shaw-Welch, & Page, 2000; Paris & Zwieg-Frank, 2001), especially in the presence of comorbid depression (e.g., Soloff & Fabio, 2008; Yen et al., 2003). In this context, it would be a serious clinical error to overlook or take an unconcerned stance toward the self-destructive behaviors and associated clinical needs of this population.

It is acknowledged that some health professionals, particularly in emergency department settings, have negative attitude towards patients that engage in suicidal and self-harm behaviors (e.g., McAllister, Creedy, Moyle, & Farrugia, 2002). Moreover, it has been suggested that negative attitudes toward patients admitted in emergency settings for perceived inappropriate reasons may affect the type of care that these patients receive (Sanders, 2000). Clearly, assigning a different name to self-injurious behaviors may not in and of itself result in better staff attitudes and more responsive or sympathetic patient care. Nonetheless, it is a central tenet of cognitive therapy that cognitions (or in this case, interpretations or labels) affect feelings and behaviors.

**Communication regarding seriousness of distress—**In the treatment of chronically suicidal individuals, including those diagnosed with BPD, there is considerable emphasis on the importance of establishing an environment that does not invalidate an individual's private experience (e.g., Linehan, 1987, 1993). By definition, providing the label suicide gesture to behavior reported to be a suicide attempt highlights the discrepancy between the individual's privately experienced distress and the distress perceived by others. This practice may function to invalidate the experiences of the suicidal and highly distressed individual. This could then have a deleterious effect on clinical relationships and reduce the likelihood that individuals will follow through with recommended aftercare. Moreover, the label suicide gesture may be a source of stigma for those who have survived suicide attempts (Sudak, Maxim, & Carpenter, 2008).

**Liability—**Over and above communication and clinical decision-making issues, there also is a practical issue regarding liability and the use of the term suicide gesture. Unfortunately, it is the case that a significant proportion of mental health clinicians (i.e., 20% of doctoral-level psychologists and 50% of psychiatrists) will have at least one client who dies by suicide during their careers (Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988). In such cases, there often are questions raised by distraught family members regarding the appropriateness of care and foreseeability of the tragic outcome (Berman, Jobes, & Silverman, 2006). From a liability perspective, the term suicide gesture in clinical documentation may convey a dismissive attitude toward the suicidal behavior (even if this was not the intent). Other actions taken by clinicians, upon review, may then be interpreted in light of this presumed negative stance, contributing to perceptions of negligence in actions.

## Recommendations & Conclusions

To summarize, across studies and settings, the term suicide gesture has been used inconsistently and in various ways, some of which may negatively impact the quality of care provided to patients. As pointed out by O'Carroll and colleagues (1996), a lack of consistent usage of terms for suicidal behaviors also creates confusion and makes it difficult for clinicians to communicate clearly with each other. Moreover, inconsistent terminology impedes efforts to summarize data (e.g., in surveillance efforts) and ultimately prevent suicidal behavior insofar as the definitions of terms affect our ability to synthesize findings and measure outcomes consistently across studies. Finally, although these arguments do not presume that individual clinicians who currently use the term gesture in practice necessarily see the term as having pejorative connotations, it is the case that the term emerged from a history of often negative attributions about individuals who “gesture” suicide. In light of these multiple difficulties, it is recommended that the term suicide gesture no longer be used.

It is important to note that although various suicide-related terms (e.g., suicidal ideation, suicide attempt) in addition to suicide gesture have sometimes been used inconsistently in research and clinical practice, it is notable that these terms did not emerge from a history of negative attributions about individuals who engage in the behaviors. Efforts to improve the nosology (e.g., CDC, in preparation; Posner et al., 2007; Silverman et al., 2007a, 2007b) and evidence-based assessment of suicide-related thoughts and behaviors (e.g., Nock et al., 2007) are constructively advancing the field. Importantly, the CDC (in preparation), Posner et al. (2007) in an effort sponsored by the FDA, and Silverman et al. (2007a, 2007b) have all recommended against use of the term suicide gesture because of its inconsistent usage and history of negative connotations, while retaining use of terms such as suicide ideation and suicide attempts.

One alternative to the current inconsistent use of the term suicide gesture is to adopt more precise use of language. For example, Nock et al. (2007) clearly operationally defined the term suicide gesture as referring to behaviors intended to give the appearance of suicidal behavior, in the absence of true suicidal intent. However, as noted previously, the term already has been used in multiple ways and acquired a history of negative, dismissive connotations, and its use has been recommended against by various groups and organizations because of these connotations. Given this context, widespread adoption of this precise use of the term suicide gesture might be difficult to achieve.

Another strategy for increasing precision in our language would be to more clearly differentiate suicidal and non-suicidal self-harm behaviors. For example, we would suggest that to prevent confusion, the term suicidal only be used to refer to behaviors in which there is at least some intent to kill oneself. While acknowledging that there are sometimes cases in which it may be difficult to establish intent (Freedenthal, 2007; Posner et al., 2007; Silverman et al., 2007a, 2007b), other terms such as non-suicidal self-injury can be adopted to refer to self-harm behaviors without any reported intent to die. Self-harm behaviors that are not associated with intent to die but are meant to give the appearance of being suicidal could potentially be considered a specific subset of non-suicidal self-injury. The clinical characteristics of suicidal behavior such as degree of subjective intent, medical lethality, and form could be noted separately from the label of suicide attempt itself (e.g., a suicide attempt by overdose with high reported intent, but low medical lethality). In this way, noting intent and medical lethality routinely with suicide attempts would be analogous to noting the clinical characteristics or features of diagnostic categories in DSM-IV-TR, e.g., clinical course specifiers and melancholic features for major depressive disorder. In addition, Posner and colleagues (2007) included a category of behaviors referred to as “Preparatory acts toward imminent suicidal behaviors,” which could be used to refer to behaviors leading up to a suicide attempt. This purpose of this article is not to propose a specific nomenclature, particularly given the fact that several groups have already been involved in such efforts (CDC, in preparation; DeLeo et al., 2006; Posner et al., 2007; Silverman et al., 2007a). Rather, we cite these examples to illustrate the fact that greater precision in our language for describing these behaviors is indeed possible. The use of more precise descriptors is consistent with the overarching goals of performing more competent suicide risk assessments and more clearly communicating the results to inform treatment planning, which are critical components of effective and ethical care for suicidal individuals (e.g., Jobes, Rudd, Overholser, & Joiner, 2008).

Another alternative is to place greater emphasis on the functional assessment of suicidal and non-suicidal behaviors. Functional approaches emphasize the importance of classifying and treating behaviors based on the antecedent and consequent conditions that are thought to trigger and maintain the behaviors in question. As such, a functional approach to assessment moves beyond simply focusing on the topographical features of the suicidal behaviors and instead centers on the underlying functional processes. In this regard, it has been noted that non-suicidal self-injury may have both negative reinforcing functions (e.g., to relieve negative affect or distress) as well as positive reinforcing functions (e.g., attention) (see Nock & Prinstein, 2004). Hence, if an individual is reportedly engaging in non-suicidal self-injurious behavior to make other people believe that he or she is at risk for suicide, an understanding of the functions of the behavior may lead the clinician to choose or focus on different clinical strategies. For example, treatment planning may focus on other approaches that the individual can take to elicit validating responses from others, and alternative methods for resolving difficulties or relieving or communicating distress. In considering functional assessments, it also is important to note that contextual issues regarding the precipitants, functions, and consequences of suicidal behaviors may differ depending upon

gender and culture (Goldston et al., 2008) and should be taken into consideration in conceptualizations of suicidal and non-suicidal behaviors and treatment planning.

In sum, the term suicide gesture has a long history of being applied in various and inconsistent ways in both clinical and research settings and continues to be part of our current professional vocabulary. In spite of its persistent usage, there is a clear and compelling rationale for discarding the term. Specifically, removing the term suicide gesture from usage will improve clarity of communication and promote respectful language among clinicians and researchers. Support of more precise language for describing suicidal and self-harm behaviors and greater emphasis on the functional assessment of suicidal behavior will provide an important foundation for improved treatment planning by increasing the consistencies in our use of terms, shifting attention away from dismissive labeling, and enhancing our ability to understand the context within which suicidal behavior is occurring.

## Acknowledgments

This research was supported in part by grants from the National Institute of Mental Health (K24-MH066252) awarded to the fourth author, and a postdoctoral fellowship from the American Foundation for Suicide Prevention awarded to the first author.

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