Child–Adolescent Suicidal Potential Index (CASPI): A Screen for Risk for Early Onset Suicidal Behavior

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This study’s purpose was to develop a reliable and valid self-report questionnaire, the Child–Adolescent Suicidal Potential Index (CASPI), to screen for risk for suicidal behavior in children and adolescents. Four hundred twenty-five child and adolescent psychiatric patients and nonpatients completed the CASPI and other research instruments to rate suicidal and assaultive behavior and symptoms of depression, anxiety, and hopelessness. The 30-item CASPI involves 3 factors (anxious–impulsive depression, suicidal ideation or acts, family distress) that contributed to a unidimensional 2nd-order factor accounting for 59% of the total variance. Internal consistency (alpha) for the total score was .70, and test–retest reliability (ICC) for the total score was .76. Total score distinguished between children and adolescents with different severity of psychopathology and different levels of suicidal and assaultive behavior. Each of the 3 factors had different contributions to discriminating between levels of suicidal status. CASPI total score of 11 distinguished suicidal ideation or acts from nonsuicidal behavior, with sensitivity 70% and specificity 65%. CASPI total score positively correlated with symptom severity of depression, anxiety, and hopelessness.

Rates of youth suicide are high despite dissemination of research results on youth suicidal behavior and the premise that identification of youth at risk will facilitate prevention of youth suicidal acts (Alcohol, Drug Abuse, and Mental Health Administration, 1989; Pfeffer, 1989). An important issue not sufficiently addressed is the development and utilization of screening strategies that reliably detect youth who are at risk for suicidal behavior. Empirical research suggests that risk factors for youth suicidal behavior can be classified as (a) psychiatric symptoms and psychiatric disorders, especially impulsivity, mood, anxiety, disrup­tive behavior, substance abuse, and personality disorders (Brent et al., 1988, 1993; Harrington et al., 1994; Kovacs, Goldston, & Gatsu­onis, 1993; Ohring et al., 1996; Pfeffer, 1986; Pfeffer, Plutchik, Mizruchi, & Lipkins, 1986; Pfeffer et al., 1993; Rao, Weissman, Martin, & Hammond, 1993; Shaffer, 1988; Shaffer et al., 1996); (b) family discord and psychopathology, including violence, depression, substance abuse, and personality disorders (Myers, Burke, & McCauley, 1982; Pfeffer, Normandin, & Kakuma, 1994); (c) stressful experiences, particularly abuse and losses of emotionally important people (Cohen-Sandler, Berman, & King, 1982; Deykin, Alpert, & McNamara, 1985; Gould, Fisher, Parides, Florý, & Shaffer, 1996; Pfeffer et al., 1993); and (d) cognitive factors involving competence in academic and social activities and perceptions of hopelessness (Asarnow, Carlson, & Guthrie, 1987; Cotton & Range, 1993; Marciano & Kazdin, 1994; Pfeffer, Hurt, Peskin, & Sieffker, 1995; Rotheram-Borus & Trautman, 1990; Spirito, Overholser, & Hart, 1991).

Widely used clinician-rated instruments, such as the Beck Scale for Suicide Ideation (Beck, Kovacs, & Weissman, 1979; Steer, Kumar, & Beck, 1993) and the Suicide Intent Scale (Beck, Schuyler, & Herman, 1974), and self-report instruments, such as the Scale for Suicide Ideation (Beck, Steer, & Ranieri, 1988), the Suicide Probability Scale (Cull & Gill, 1982), the Suicide Behaviors Questionnaire (Linehan, 1981), the Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974); and the Reasons for Living Inventory (Cole, 1989; Linehan, Goodstein, Nielsen, & Chiles, 1983), were developed for adults to measure aspects of suicidal risk. However, few reliable and valid clinician-rated or self-report instruments have been developed for the measurement of suicidal risk in children and adolescents (Eymon, Mikawa, & Eymon, 1990; Garrow, Lewinsohn, Marsteller, Langhinrichsen, & Lann, 1991; Range & Kroat, 1997). Notably, instruments developed for adults may not have the necessary developmental specificity to measure suicidal risk in children and adolescents.

Interview techniques, such as the Kiddie–SADS (Ambrosini & Dixon, 1996) and the Diagnostic Interview Schedule for Children (King et al., 1997), primarily rate severity of symptoms of psychiatric disorders and include measures of suicidal ideation and suicidal acts. However, such techniques do not measure multifactorial elements of suicidal risk.

The Child Suicide Potential Scales (CSPS), administered as a semi-structured interview to children and adolescents, is among