Original Article

Standardization of Reasons for Living Inventory for adolescents: Diagnosis, appraisal, therapy and rehabilitation of people who attempt to suicide

Anahita khodabakhshi koolaee[1],PhD; Osman Mahmmodi;
Rahmanberdi Ozuoni Davaji
University Social welfare and Rehabilitation sciences, Tehran, Iran

Objectives: In this study, assessed the reliability, validity, and predictive power of a new version of the Reasons for Living Inventory for Adolescents (RFL–A; Osman et al., 1998) among Iranian Adolescents in the city of Kermanshah.

Methods: To examine this study A group of 400(189 males and 211 females) adolescents in high schools of Kermanshah and adolescents that had attempted to suicide and been cared in Emam Khomeini hospital selected to complete, the RFL–A, Beck Suicide Scale Ideation (BSSI; Beck et al., 1999), Beck Hopelessness Scale (BHS; Beck et al., 1974) And Oxford Happens Inventory (OHI). Additional information about the sample group including diagnosis and suicide status were obtained from their educational and medical records and documents.

Results: It was determined that the RFL–A is a valid and reliable measure of adolescent suicide risk potential. Additionally, the RFL–A possesses better predictive value than the Beck Hopelessness Scale (Beck, Weismann, Lester, & Trexler, 1974).

Conclusion: The results showed the clinical and research utility of the RFL–A Specially in the work with suicide is included along with suggestions for future research. In addition, we could use this scale for diagnosis, appraisal, therapy and rehabilitation of people with history of suicide attempt.

Keywords: Reasons for Living, Adolescents, reliability, validity.

Introduction:

The vast majority of research on suicide risk focuses on negative factors that increase the chances of an individual engaging in intentional self-harm (1; 2).

The different approach to assessment suicide risk arose with the product and development of the Reasons for Living Inventory (3). Linehan and colleagues chose to examine the cognitive factors that allow individuals desire to live in the face of hardship and adversity. They say that suicidal individuals lack coping characteristics possessed by normal individuals and have important role in understanding suicide risk. Their new scale allowed to therapist differentiated suicidal and normal individuals to be based on the content of their belief systems. This scale has a 48-item and six valid and reliable subscales: Survival and Coping Beliefs (SCB), Responsibility to Family (RF), Child Related Concerns (CRC), Fear of Suicide (FS), Fear of Social Disapproval (FSD), and Moral Objections (MO).

The RFL and its psychometric properties have been examined and supported in several studies (4; 5; 6; 7). Findings on sex differences with the RFL have varied. One study found no dif-

1.correspondenc Email: anna_khodabakhshi@yahoo.com

ferences in scores across subscales (7), whereas women scored higher than men on some subscales, such as FS, RF, and MO, in others (8; 5; 9; 7).

The RFL has been used in a variety of studies with college students in the countries like United States and Australia as a means of examining protective factors (8). Results of Dyck et al (1991) showed weak but significant negative correlations between total RFL score and hopelessness, and they belief that the RFL have a distinct construct have supported. In addition, Hirsch and Ellis (1996) found that suicide Ideators could be distinguished from normal based on their scores on the RFL. Connell and Meyer (1991) grouped college students into categories based on reported history of suicidality and found that the SCB, RF, and MO subscales adequately discriminated between groups. The clinical utility of the RFL has been demonstrated with both adult outpatient (Dyck, 1991) and psychiatric inpatient samples (9). Dyck concluded that the RFL is less influenced by depression than a commonly used measure of hopelessness and may therefore be a better measure of suicide risk with depressed patients.

Strosahl and colleagues (1992) found that the SCB subscale of the RFL was the best at discriminating across of desire to suicide in a group of patients with a history of suicide. Range, Hall, and Meyers (1993) examined the factor structure, reliability, and validity of the RFL when used with adolescents. Their sample included 128 high school students between the ages of 14 and 17, plus a comparison sample of 153 college students under the age of 20. Their confirmatory factor analysis (CFA) failed to fit the data from either sample to the original RFL six-factor structure or to a five-factor solution (deleting CRC items).

However, Range et al. (1993) were able to derive two unique six-factor solutions accounting for 53.6% of the variance in high school student data and 49.8% of variance in college student data. The researchers determined internal consistency reliability of all original RFL subscales except MO to be adequate in both samples (range of Cronbach = .77 to .91).

Westfield, Cardin, and Deaton (1992) based on original RFL scale produced an RFL-type measure specifically for the college student population. Similar original RFL scale they derived a six-factor solution. But they put college-related concerns factor in new scale and remove child-related concerns factor for a specific, increased importance placed on friends in addition to family. College Student Reasons for Living inventory included: SCB, College and Future-Related Concerns, MO, Responsibility to Friends and Family, FS, and FSD (10). The psychometric properties of the College Student Reasons for Living inventory examined and accepted in the several studies (11; 12).

Utility of the RFL with the adolescent population in the several studies examined. Cole (1989) based on five subscale (CRC was dropped) of six subscale RFL compared high school students and adolescences delinquents. They results were consistent with Linehan et al. (1983) but MO failed to significantly correlate with depression, hopelessness, or suicidality in the delinquent adolescences (13). In the other hand, the high school sample Ideators were distinguished from attempters based on their MO scores.

Results study of Pinto, Weismann, and Conwell (1998) Instead, exploratory components analysis yielded a five-factor solution accounting for 66.5% of the variance failed to replicate the original RFL factor structure with adolescent psychiatric inpatients.

Based on the available data, it appears that the theoretical base of RFL is adequate to adolescents. However, the results of past studies when the RFL is used with adolescents and college students suggested the need for a unique measure for adolescents (14).Therefore decided to develop a new measure, based on the underlying theory of the RFL, specifically for adolescents.

Improved ways of assessing the level of suicide risk in the Iranian adolescents is necessary. Based on annual data for 2006 collected from

Social Welfare organization, from 5 attempt for suicide three of them are adolescents between age 12 to 24 (15). In the all cities and state of Iran, Kermanshah have upper rate of suicide. The rate of completed suicides in the 15- to 24-year-old age group has deviated from a mean of 6.1 (per100, 000 population) for the 2008 year in Kermanshah (Imam Khomeini hospital of treatment suicide). These data suggest that intentional self-harmful behavior and the potential for engaging in such behaviors are a serious concern for young people, parents, teachers and counselors and overall society in Kermanshah.

The RFL–A is a 32-item self-report measure designed specifically to assess adolescents' adaptive reasons for not committing suicide. It is comprised of five factors: Future Optimism (FO), Suicide-Related Concerns (SRC), Family Alliance (FA), Peer Acceptance and Support (PAS), and Self-Acceptance (SA). Less relevant items (e.g., relating to concerns about the effects of suicide on one's children) are not included in the RFL–A. The factor structure of the RFL–A is consistent with the multifaceted nature of adolescent suicidality (16). The authors also found support for convergent and construct validity. Important group differences on the RFL–A were identified. Specifically, boys had significantly higher SA scores, adolescents in the normal group scored higher on all subscales than a suicidal group, and a psychiatric no suicidal group scored higher than a psychiatric attempter group. The main purpose of this study was to confirm the factor structure of the RFL–A derived by Osman et al. (1998) in the Iranian adolescents (Kermanshah city).and we tested the hypothesis that: 1) the RFL–A can distinguish adolescent on suicide group from normal. 2) Finally, we hypothesized that the RFL–A would discriminate between suicide attempters and no attempters better than the Beck Hopelessness Scale (17).

Method:

Participants

Participants (189 males and 211 females) were recruited from all Kermanshah high schools and patients between age 15 to 24 that because attempt to suicide be care in Farabi hospital. Boys (M age = 15.42, SD = .88) and girls (M age = 15.86, SD = 1.04) did not differ significantly in age, t (221) = .21, p = .83. Most of the participants were Kurd (94.4%), 3.1% were Lack, and 2.5% were Fars. Data collected from the total sample of participants were used to assess the factor structure of the RFL–A. To explore additional psychometric properties of the RFL–A, we collected complete data on the measures used in this study on a subsample (n = 96; 54 males and 42 females) of participants (see Measures and Procedure section). We assigned these participants to two groups based on information obtained by author and a review of the medical records. In addition, to the semi structured (i.e., clinical interviews). Participants in the group suicide (13 males and 25 females) with a history of multiple suicide attempts who were admitted because of a recent suicide attempt within 1–2 weeks prior to admission and self-harm or injury with established intent to die were assigned to the attempter group (n = 14). The method of attempts identified included drug or medication overdoses (n = 5), self-inflicted lacerations (n = 3), hanging (n = 8), attempts to use a gun (n = 3), car accidents (n= 2), and jumping from heights (n =3). Participants in the normal group (176 boys and 186 girls) who had no previous history of suicide attempts.

Measures and Procedure

Each participant completed a brief demographic questionnaire, the RFL–A, the Beck Suicide Scale Ideation (BSSI), and Oxford Happiness Inventory (18).

Reasons for living inventory for adolescents (16). The RFL–A is a 32-item self-report measure designed specifically to assess adolescents' adaptive reasons for not committing suicide. It is comprised of five factors: Future Optimism (FO), Suicide-Related Concerns (SRC), Family Alliance (FA), Peer Acceptance and Support (PAS), and Self-Acceptance (SA). Less relevant

items (e.g., relating to concerns about the effects of suicide on one's children) are not included in the RFL–A. The factor structure of the RFL–A is consistent with the multifaceted nature of adolescent suicidality (16). The authors also found support for convergent and construct validity.
Beck Suicide Scale Ideation (17): This 19-item scale is designed to assess prior suicide ideation and behavior, frequency of suicide ideation, threats of suicide, and likelihood of attempting Suicide someday. The BSSI has been used in several investigations with adolescents and young adults. The BSSI was used as a measure of self-reported suicide likelihood in validating the RFL–A scales. In this study we use from BSSI to assess divergent validation.

Oxford Happiness Inventory (18): The OHI contains 29 items designed to assess happens. It also assesses four dimensions of suicidality: happens, hope and positive expectations about future events. Each OHI item is rated on a 4-point scale ranging from 1 (none or a little of the time) to 4 (most or all of the time). The SPSS has good reliability and concurrent validity (Tatman, Greene, & Karr, 1993). We used this scale as a measure to assess convergent validation
Beck Hopelessness Scale (17).The BHS is a 20-item self-report instrument with a true–false response format. As in previous investigations, this scale has been used in several investigations to assess the extent of negative expectations about future events (see Joiner & Rudd, 1996; Marano, Cisler, & Lemuroid, 1993).
We collected data from each participant within 4 weeks of admission. Participation in the study was voluntary. During data collection, the second author or a practicum student in psychology (all trained in the administration of the research package) approached and asked each potential participant to volunteer to participate in the study. Next, the study was briefly explained, informed consent was obtained, and the questionnaire package was administered individually. Approval for conducting the study was obtained from the hospital administrator and the Medical Sciences University of Kermanshah. The protocol also included obtaining adolescent assent and significant other (legal guardians and parents) written informed consent before administering the questionnaire packet and reviewing the medical records.

Data analyses:
Based goals of study used from below data analyses:
For analyses material of scales used from classic test model
Statically features of material of scales assess by descriptive statistics
Reliability of items each scale assess by kornbakh coefficient and retest
For assess factor validation and determine number factors of scale used from pc style
For calculation divergent validation correlation between RFL-A and BSSI assessed.
For calculation convergent validation correlation between RFL-A and OHI assessed.
For calculation relationship between RFL-A and other variables like age, gender and education used from T-test and correlation.
For calculation discriminate validation and comparison mean of two group (suicide and normal) used from T-test.

Reliability Analysis
We examined the internal consistency reliability of the RFL–A total and scales for the combined sample before evaluating the validity of this new instrument. The alpha coefficients for the RFL–A scales were as
Follows: FA = .88, SRC = .92, SA = .91, PAS = .89, and FO = .90. The corrected item-total correlation for each scale was greater than .40. The alpha index for the RFL–A total scale was .93. These findings are consistent with those reported by Osman et al. (16). And result of retest after 2 weeks on subsample (n=50) was .87. in the table 1 we can see mean, std. deviation, Corrected Item-Total Correlation and Cronbach's Alpha if Item Deleted all question of RFL-A.

table1: mean, std. deviation, Corrected Item-Total Correlation and Cronbach's Alpha if Item Deleted RFL-A

Item	Mean	Std. Deviation	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted	Item	Mean	Std. Deviation	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Q1	3.3595	1.11172	.453	.961	Q17	3.8658	1.44078	.453	.960
Q2	4.0177	1.42216	.607	.960	Q18	1.2380	1.67819	.127	.959
Q3	3.8506	1.32353	.455	.960	Q19	3.6076	1.49464	.680	.959
Q4	4.0658	1.35396	.635	.960	Q20	3.7722	1.67657	.685	.960
Q5	3.9747	1.42115	.170	.960	Q21	3.6608	1.71921	.723	.960
Q6	2.5215	1.72807	.339	.961	Q22	3.7899	1.44226	.697	.959
Q8	3.7722	1.61331	.519	.961	Q23	3.4810	1.62047	.332	.961
Q9	3.3772	1.02109	.393	.961	Q24	3.9316	1.39720	.793	.959
Q10	3.5696	1.80160	.433	.960	Q25	3.4025	1.99173	.521	.959
Q11	3.5266	1.59032	.620	.960	Q26	1.8582	1.89580	.418	.959
Q12	3.3443	1.77774	.687	.960	Q27	3.6076	1.64962	.387	.960
Q13	3.5595	1.68402	.601	.961	Q28	3.4709	1.67121	.700	.959
Q14	3.3696	1.69205	.601	.961	Q29	3.6025	1.63605	.745	.959
Q15	2.0937	1.76941	.409	.959	Q30	3.3392	1.11808	.605	.960
Q16	3.3873	.78004	.375	.959	Q31	2.0532	1.75526	.303	.960
Q17	3.8658	1.44078	.453	.960	Q32	3.8177	1.52881	.746	.959

PC

Because we can use PC model and achieve this note that data correlation is not zero we should applied Bartlett Test Of Sphericity before PC model and then used PC to examine the five – factor oblique model reported by Osman et al(16). However we see in the table 2 KMO is .92 and significant (.0001) and therefore we can do factor analysis in the sample group.Because extraction factors fit with social and cultural structure of sample group , in the section explorative factor analysis we examine the one – factor, two – factor, three – factor, four – factor and five – factor solution model. In the end of this section appears that factor solution model have better and equated with data and were able to derive unique five-factor solutions accounting for 57.8% of the variance in adolescents data(Table 3).

Table2: .KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.927
Bartlett's Test of Sphericity	**Approx. Chi-Square**	1.193E4
	df	1134
	Sig.	.000

Table 3: Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	11.497	35.928	35.928	11.497	35.928	35.928
2	3.127	9.772	45.700	3.127	9.772	45.700
3	1.365	4.267	49.967	1.365	4.267	49.967
4	1.286	4.018	53.984	1.286	4.018	53.984
5	1.253	3.915	57.899	1.253	3.915	57.899

In addition, we specified and evaluated the fit of 5 competing models, a one- factor, two- factor, three- factor, four- factor and five factors for select best solution way in factor analyses. After do this models it is appears that best solution way for factor analyses is five factors. Table 4 present the RFL-An items internal consistency (alpha coefficients) and descriptive statistics (skewness and kurtosis) for each factor.

Table 4: Reasons for living inventory for adolescents, internal consistency and descriptive statistics

Factor	alpha coefficients	skewness	kurtosis
1.Family Alliance (FA)	.88	- 0.91	- 0.21
2. Suicide-Related Concerns (SRC)	.92	- 0.59	- 1.08
3. Self-Acceptance (SA)	.91	- 0.86	- 0.16
4. Peer Acceptance and Support (PAS)	.89	- 1.06	0.53
5. Future Optimism(FO)	.90	- 1.32	1.17

Based on results PC model of factor analysis material of scale, number factors of RFL-A in the Iranian population was five factors. Because this scale for first time used in this population lower limit of load factors .35 determined (19). Factors Structure, coefficient reliability and standard error of measurement each factor presented in Table 5 and in the Table 6 we can see Principal Component Analysis with Promax Rotation Method.

Table 5: Factors Structure, coefficient reliability and standard error of measurement five factor

Factors	Number of questions	coefficient reliability	Std. error of measurement
Family Alliance	7	.88	23/04
Suicide-Related Concerns	6	.92	10/92
Self-Acceptance	6	.91	8/64
Peer Acceptance and Support	6	.89	7/98
Future Optimism	7	.90	6/49
Total	32	.93	12/85

Table 6. Principal component analysis Structure Matrix

	Component				
	1	2	3	4	5
Q24RFL	.833				
Q25RFL	.722				
Q30RFL	.716				
Q17RFL	.712				
Q7RFL	.706				
Q12RFL	.575				
Q1RFL	.472				
Q13RFL		.747			
Q20RFL		.746			
Q15RFL		.624			
Q4RFL		.524			
Q11RFL		.486			
Q28RFL		.485			
Q26RFL		.406			
Q3RFL			.750		
Q9RFL			.724		
Q29RFL			.686		
Q14RFL			.634		
Q18RFL			.612		
Q31RFL			.501		
Q10RFL				.755	
Q16RFL				.648	
Q5RFL				.612	
Q27RFL				.579	
Q23RFL				.558	
Q6RFL				.434	
Q32RFL					.670
Q22RFL					.604
Q19RFL					.555
Q21RFL					.548
Q8RFL					.514
Q2RFL					.488

Because of the confirmation number factors and explorative factor analysis we used the confirmatory factor analysis and following indexes to evaluate the fit of each model:
A relative robust chi-square of 2 or less.
Bentler and Bonett normed fit index(NFI) of .90 or greater,
Bentler and bonnet non-normed fit index (NNFI) of .90 or greater, robust comparative fit index(R-CFI) of .90 or greater.
Root mean squared residual index (RMSR) of .05 or less (20; 21; 22).
Results for the one, two, three, four and five factor solution model tested are presented in the Table 3. The five-factor model provided the best solution way model fit to the data. The Satorra-Bentler index (1.34) was less than 2, and NFI, NNFI, and R-CFI values were greater than .90. Also, the RMSR index was less than .05. These results suggest that the five factor solution way model can be reliably replicated in an adolescent sample.

Table7: Confirmatory Factor Analysis of the Reasons for Living Inventory for Adolescents for five models

Model	c2	d_i^1	$d_i^1$1c2	GFI	AGFI	CFI	RMSR
Five –Factor	32/2041	1012	859/1	94/.	89/.	92/.	032/.
Four –Factor	15/3468	1024	452/3	87/.	83/.	90/.	075/.
Three –Factor	05/3858	1057	734/3	84/.	84/.	89/.	093/.
Two –Factor	00/2056	1069	151/2	86/.	81/.	88/.	04/1
One-Factor	21/1834	1069	954/2	85/.	79/.	89/.	09/.

Discriminate, divergent and convergent validity
We conducted planned comparisons to determine divergent and convergent validity of scale and determine whether the RFL–A scales can distinguish adolescent based on suicide status. Results for achieve divergent and convergent validity in the Table 8 showed there was a positive correlation between, RFL–A and Oxford Happiness Inventory (18) and negative correlation between this scale and Beck Suicide Scale Ideation (17).

Table 8: Correlations between the RFL–A and Concurrent Validity Measures

	RFL–A Scales					
Measures	FA	SRC	SA	PAS	FO	RFL–A
Oxford Happiness Inventory	31*	.37*	39*	30*	.35*	.39*
Beck Suicide Scale Ideation	–.50*	–.44*	–.51*	–.52*	–.61*	–.48*
Beck Hopelessness Scale	–.60*	–.53*	–.57*	–.63*	–.66*	–.61*

Note: RFL–A = Reasons for Living Inventory for Adolescents; FA = Family Alliance; SRC = Suicide-Related Concerns; SA = Self-Acceptance; PAS = Peer Acceptance and Support; FO = Future Optimism;.
*p < .001, **p < .005
For comparisons between the suicide (n = 38) and normal (n = 40) groups, the overall t-test was

significant, t = .78, F (5, 168) = 26.04, p < .001; η2= .44. The normal group scored significantly higher than did the attempter group on all five RFL–A scales (all p values < .001). (See the Table 9 and 10).

Pearson product–moment correlations were computed between the RFL–A total and scales, and the con-current validity measures (the BSSI, BHS and OHI scales). The results are presented in Table 8 for the total sample. The analyses showed that all of the RFL–A total and scale scores were negatively and significantly correlated with scores on BSSI items (range = –.44 to –.61). Similarly, negative and significant correlations were obtained between scores on the RFL–A total and scales and scores on the BHS. And also positive and significant correlations were obtained between scores on the RFL–A total and scales and scores on the OHI. These results showed that RFL-A have good discriminate, divergent and convergent validity and specially can discriminate Suicide Attempters from normal Adolescents.

Table 9: Independent Samples Test For comparisons between the suicide and normal group

		F	t	df	Sig. (2-tailed)
Suicide-normal groups	Equal variances assumed	19.589	4.280	76	.000
	Equal variances not assumed		4.330	65.313	.000

Table 10: Means and Standard Deviations on the Reasons for Living Inventory for Adolescents for normal and suicide attempters

RFL–A Scale	Suicide Attempters		Normal group	
	M	SD	M	SD
1. FA	3.23	1.34	4.88	1.10
2. SRC	3.11	1.51	4.68	1.29
3. SA	3.34	1.28	5.05	0.66
4. PAS	4.02	1.39	5.41	0.84
5. FO	3.73	1.37	5.38	0.75

Note: RFL–A = Reasons for Living Inventory for Adolescents; FA = Family Alliance; SRC = Suicide-Related Concerns; SA = Self-Acceptance; PAS = Peer Acceptance and Support; FO = Future Optimism.

Conclusions:

The purpose of this study was to assess the reliability, validity, and standardization of the Reasons for Living Inventory for Adolescents (RFL–A; 16) among Iranian Adolescents (Kermanshah city). Several tools have been developed to help counselors and psychologists in determining which adolescents are most likely to committed suicide and which group is at the greatest risk. The majority of research and existing measures in the felid of adolescents' suicide focus on negative predictors of risk like depression, hopelessness and history of prior attempt for suicidal behavior. A major character of Linehan's RFL (3) is opposite the negative predictor approach that assesses potential-

ly life-threatening crises, this approach allows for the assessment of adaptive reasons for living. Although this measure has been used with varying degrees of success with young adults and adolescents, it has certain limitations (24; 8; 14; 25). Because these limitations Osman et al. (1998) created a psychometrically sound measure for adolescents based on the theoretical constructs underlying the RFL.

The results of this study add support to existing data (16) on the reliability and validity of the RFL–A. Our study also provides preliminary normative data for non suicide (normal) and suicide attempter adolescents in the Kurdish adolescents. Although no differences were found on subscale scores within the suicide attempter adolescents, females in the attempter group scored lower on FA, PAS and SRC, suggesting a pattern of suicide and decrease reasons for living in Kermanshah that opposite with world pattern (women 3 times more men have successful suicide). Perhaps females who engage in serious suicidal behavior have lost their connections to family and friends, and may these lower scores indicate increase tolerance of pain (as one components of suicide). It is unclear why boys who have made an attempt would get higher scores in these subscales in the same group. This finding will need to be explored in future

The total RFL–A score was very useful in distinguishing between the non suicidal (normal), and suicide attempter groups. As was expected, adolescents in the non suicidal group had the highest total scores, and suicide attempter groups' scored lowest. A significant amount of variance in scores on suicide probability were explained by the RFL–A. Low levels reasons for living appear to be indicators of greatest suicide risk. Scores on the RFL–A were also predictors of achieve scores in suicide ideation. Our analyses indicated that more hopeless and more suicide ideation of adolescents have limited optimism about the future, low levels of peer acceptance and support, and a weak sense of alliance with their families. These findings were congruent with prior studies (16; 26).

In the several areas the RFL–A appears relate to adolescent suicide risk. For example, the SA subscale predicts depression, anger, alienation, and family problems (26). The RFL–A can provide specific guidance to clinicians and counselors on where and when do interventions and assessment for improvement desire to life and decrease suicide in adolescents.

Additional support for the discriminative ability of the RFL–A comes from the results of the t scores and discriminate validity analyses. The RFL–A was found to be a significantly better than other scales that widely used tool for this purpose (2) can predicate suicide like hood. Results showed that the RFL–A and the theory underlying measures of adaptive functioning (3;14;10) is useful in assessing suicide risk and this scale more than original RFL (3) have sensitivity, specificity, and predictive value to suicide adolescents. However, the developmentally appropriate RFL–A in the Iran especially in the Kermanshah because higher static's of suicide is superior for use with adolescents.

A few limitations of this study must be discussed. The majority of participants were Kurdish, making it difficult to determine the racial and ethnic generalizability of the findings. Future studies should attempt to utilize more ethnically and racially diverse Participants like Turkmen, Fars, Lor and Turk people.

It has long been accepted that adolescent suicide risk is multiply determined (27; 28). Much of the existing literature focuses on negative risk factors (17). Only focus on risk factors in the assess suicide is incomplete and inadequate. We are believed that an accurate picture of risk can only be constructed from protocols that include both measures of negative factors and protective elements. The results of our study showed that RFL–A as a reliable, valid, and clinically useful tool for assessing adolescent suicide risk in the Kermanshah.

This scale could use to diagnosis, appraisal, therapy and rehabilitation for people who attempt to suicide and helpful for counseling and therapist to screen persons who risky for suicide.

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