Editorial

A Suicide-Specific Diagnosis – The Case For

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Suicide has been and continues to be a major concern, accounting for over 700,000 deaths worldwide in 2019 and being the fourth leading cause of death among people aged 15–29 (World Health Organization, 2021). In the United States, nearly 48,000 people died from suicide in 2019 (Centers for Disease Control and Prevention, 2019). Additionally, the US national suicide rate steadily increased from 1999 to 2019 (Hedegaard et al., 2021). To address this serious public health issue, an increasing number of experts in the field have argued for inclusion of a suicide-specific diagnosis in the *Diagnostic and Statistical Manual* (DSM) to improve suicide risk assessment and prevention (Fehling & Selby, 2021; Oquendo et al., 2008; Rogers et al., 2019; Sisti et al., 2020; Voros et al., 2021).

The DSM is an essential resource in the field of psychiatry, since it serves as a common nosographic system to group diagnostic criteria for mental disorders. Although most countries outside the United States rely on the World Health Organization's *International Classification of Diseases* (ICD) for psychiatric diagnosis, the ICD and DSM are mutually influential and changes in the DSM have significant impact beyond the United States. The DSM has undergone various iterations as knowledge expands. For example, the DSM-5 (American Psychiatric Association [APA], 2013) introduced the diagnosis of suicidal behavior disorder (SBD) as a "Condition for further study." The main diagnostic criterion of SBD was a suicide attempt within the previous 24 months. In the revised DSM-5 edition (DSM-5-TR; APA, 2022), suicidal behavior is also listed as a modifier of other diagnoses under "Other conditions that may be a focus of clinical attention." This welcome shift reflects the growing consensus that suicidal behaviors are not merely symptoms of depression and thus need to be assessed regardless of diagnosis. Indeed, as the National Violence Death Reporting System highlighted, 10%–54% of suicide deaths occur in individuals with no psychiatric diagnosis (Stone et al., 2018).

Although this change is welcome, we argue it will not provide clinicians with sufficient tools to assess imminent suicide risk or allow researchers to investigate the phenomenon. First and foremost, the code will only target patients who have already engaged in self-injurious behavior with intent to die *and* disclosed such behavior to their clinicians. Considering that a large percentage of suicide deaths, particularly those from firearms, occur on the first attempt (Anestis, 2016), flagging recent history of suicide attempts will not be sufficient. In the absence of recent suicidal behaviors, clinicians will inquire about patients' suicidal ideation (Ribeiro et al., 2016). As noted by many, this practice is very problematic; individuals at risk of suicide frequently conceal suicidal ideation (Høyen et al., 2021). In one study, more than 50% of patients who died by suicide explicitly denied suicidal ideation when questioned prior to their deaths (Berman, 2018). Additionally, the literature has described the fluctuating nature of suicidal ideation (Kleiman et al., 2017), such that some individuals may genuinely deny suicidal ideation and yet experience it soon after. In sum, while the inclusion of a suicidal behavior code in DSM-5-TR is a substantial advance, it will not provide a sufficient tool to guide clinicians' assessment of imminent suicidal risk.

In the absence of practical tools to identify individuals at imminent risk, assessing suicidal risk remains a highly stressful task for clinicians (Rothes et al., 2014). However, thanks to the growing body of research on short-term risk factors for suicidal behavior, new tools are now available. Over the past few years, two different research teams have described presuicidal states that are predictive of short-term suicidal thoughts and behaviors: the *suicide crisis syndrome* (SCS; Galynker, 2017) and *acute suicidal affective disturbance* (ASAD; Rogers et al., 2017). The SCS consists of five components grouped into two criteria: A and B. To be diagnosed with SCS, a patient must meet Criterion A, frantic hopelessness/entrapment, and have at least one symptom from all four subgroups within Criterion B:

Table 1. Proposed diagnostic criteria for the suicide crisis syndrome (SCS)

Criteria	Description
Criterion A	Entrapment/frantic hopelessness
	A persistent or recurring overwhelming feeling of urgency to escape or avoid an unacceptable life situation that is perceived to be impossible to escape, avoid, or endure
Criterion B (at least one symptom from each subgroup)	B1. Affective disturbance
	Manifested by at least one of the following:
	• Emotional pain
	• Depressive turmoil (rapid spikes of negative emotions or extreme mood swings)
	• Extreme anxiety (often accompanied by dissociation or sensory disturbances)
	• Acute anhedonia (i.e., a new or increased inability to experience or anticipate interest or pleasure)
	B2. Loss of cognitive control
	Manifested by at least one of the following:
	• Ruminations (intense or persistent rumination about one's own distress and the life events that brought on distress)
	• Cognitive rigidity (an inability to deviate from a repetitive negative pattern of thought)
	• Failed thought suppression (repeated unsuccessful attempts to suppress negative or disturbing thoughts)
	• Ruminative flooding (an experience of an overwhelming profusion of negative thoughts accompanied by a sensation of pressure or pain in one's head, impairing ability to process information or make a decision)
	B3. Disturbance in arousal
	Manifested by at least one of the following:
	• Agitation
	• Hypervigilance
	• Irritability
	• Global insomnia
	B4. Social withdrawal
	Manifested by at least one of the following:
	• Withdrawal from or reduction in scope of social activity
	• Evasive communication with close others

affective disturbances, loss of cognitive control, disturbance in arousal, and social withdrawal. Overall, at least five of 15 symptoms must be present (see Table 1).

By contrast, the ASAD is characterized by an acute and sudden increase in suicidal intent over hours or days, marked social and/or self-alienation (e.g., self-disgust, perceived burdensomeness), the conviction that this condition is intractable, and two or more manifestations of overarousal (Rogers et al., 2017). The main difference between the SCS and ASAD stems from the role they assign to suicide ideation. Unlike ASAD, the SCS criteria do not include self-reported suicidal ideation, which allows for the identification of at-risk individuals who neither disclose nor are aware of suicidal intent.

A large body of research substantiates the validity, reliability, and clinical utility of the SCS. The SCS has demonstrated concurrent validity regarding both suicidal ideation (Barzilay et al., 2020; Otte et al., 2020; Yaseen et al., 2019) and suicide attempts (Bloch-Elkouby et al., 2021; Calati et al., 2020). Additionally, the SCS is predictive of 1-month postdischarge suicidal thoughts and behaviors (Bloch-Elkouby et al., 2021; Cohen et al., 2022) and suicide attempts (Barzilay et al., 2020; Yaseen et al., 2019). Further, the SCS demonstrated incremental predictive validity over suicidal ideation regarding suicidal attempts (Rogers et al., 2022). The SCS has been employed in numerous research and clinical settings, both in the United States and internationally (c.f., Høyen et al., 2022; Menon et al., 2022; Otte et al., 2020; Wu et al., 2022).

Although the data require replication, the SCS has demonstrated impressive evidence of predictive validity. A cut-point of 163 on the Suicide Crisis Inventory, version 2 (SCI-2), a measure of the SCS, yielded an area under the receiver operating characteristic curve (AUC) of .883 in

predicting suicide attempts 1–2 months postdischarge, with sensitivity/specificity of 1.0/.82. By contrast, suicidal ideation at baseline was not a significant predictor of postdischarge suicide attempts (Bloch-Elkouby et al., 2021). An earlier version of the SCI predicted post-discharge suicidal behavior with an AUC of .733 and an odds ratio of 8.62 (Barzilay et al., 2020).

In the context of this literature, a proposal for the SCS to be included as a discrete diagnosis is currently under review by the DSM-5 Scientific Review Committee. In addition to the main SCS criteria, self-reported suicidal ideation and ASAD are included as modifiers. This allows for the presence of self-reported suicidal ideation and the ASAD's criterion of intense alienation from self and/or others to be factored into clinical decision-making, addressing the concern noted by Berman and Silverman (2023) in this issue that the core SCS criteria do not incorporate self- and social alienation. The purpose of this editorial, therefore, will be to examine the arguments in favor of and against a new suicide-related diagnosis in the DSM, with a specific emphasis on the SCS. In particular, we will address the arguments presented by Silverman and Berman in their article "Feeling Ill at Ease With a New Disease" (2020), which covers a broad spectrum of concerns about the inclusion of a suicide-specific diagnosis in the diagnostic system.

Arguments Supporting a Suicide-Specific Diagnosis

The SCS Provides a Structured, Systematic Method to Assess Imminent Suicidal Risk

A suicide-specific diagnosis in the DSM would seek to address the growing rates of suicide nationally and globally by disseminating accurate predictive models for suicide (Fehling & Selby, 2021). As such, SCS provides a structured and systematic method to approach near-term suicidal risk (Galynker, 2017) that is immediately disseminable on a national and even global basis and can be promptly integrated into medical education (Foster et al., 2021). A nosological system (present/absent) provides highly actionable information, enhancing and simplifying clinical decision-making (Jablensky, 2016). This is in contrast to dimensional ratings, which, while able to capture subtle variations in severity, are far less actionable. Moreover, the SCS symptoms show strong discriminant validity (Bloch-Elkouby et al., 2021) and therefore do not overlap with other existing medical entities.

SCS Represents State-Based Risk Factors and Improves Diagnostic Precision

The proposed SCS diagnosis would focus attention on current state-based risk factors, reducing dependence on self-reported suicidal ideation, which has been shown to lead to a high number of both false negatives and false positives (Berman, 2018). A state-like diagnosis would guide and support time-sensitive clinical judgment (Chu et al., 2015; Ribeiro et al., 2013), thereby improving and clarifying safety and discharge planning (Bryan et al., 2017). Importantly, the improved precision of risk assessment with a suicide-specific diagnosis would reduce unnecessary health-care expenses while simultaneously improving identification of patients truly in need of intensified care.

Suicidal ideation has various limitations when it comes to predicting suicidal behavior, and the SCS may be a more effective method at detecting risk. In a sample of psychiatric patients, suicidal behavior (Rogers et al., 2022) and suicide attempts (Bloch-Elkouby et al., 2021), were more frequent in patients reporting both suicidal ideation and SCS versus suicidal ideation alone when assessed at 1-month follow-up. Thus, many individuals hospitalized with suicidal ideation will likely not attempt suicide (especially in a short timeframe), and therefore may be exposed to excessive and unnecessary treatment, often for medical–legal reasons, which can be traumatic and harmful for the patient (Hall & Hall, 2013), particularly when the treatments are delivered with coercive modalities (Paksarian et al., 2014).

As such, the SCS diagnosis would help identify the portion of the population who would actually benefit from hospitalizations and lead to narrower and more targeted interventions. In a recent study of hospital admission practices after the introduction of a novel tool incorporating both the SCS and the Columbia Suicide Severity Rating Scale (C-SSRS; Posner, 2011), the SCS diagnosis dominated admission/discharge decisions while the association with suicidal ideation was random. Further, over 90% of patients with suicidal ideation but not SCS were discharged from the emergency department (Karsen et al., 2023). Although these data are preliminary and await replication in a randomized controlled trial, they provide initial evidence that the emergency room staff felt the SCS improves precision in identifying patients at actual near-term risk for suicide and provided a valuable tool in suicide risk assessment.

SCS Improves Communication Between Health-Care Professionals

A diagnosable syndrome provides clinicians with clear objective criteria to guide suicide risk assessment and decision-

making. Ultimately, having a diagnosis grounded in clinical evidence should promote and simplify communication among health workers and prevent information loss. Likewise, a DSM diagnosis requires a diagnostic code to be entered into the medical record, on insurance claim forms, and other clinical documents. This will promote standardization of record keeping, which will in turn facilitate communication among health-care professionals both within and across clinical settings (Fehling & Selby, 2021). While widespread education in the SCS is critical for effective implementation, this has already been done quickly and efficiently in hospital settings. These include four community emergency departments in a hospital system in Chicago, Illinois in the United States (Karsen et al., 2023) and a catchment-based inpatient hospital in Trondheim, Norway (Prestmo et al., 2023).

SCS Diagnostic Criteria Can Be Integrated Into Patient Psychoeducation

The SCS criteria can be integrated into patient psychoeducation, such that patients can learn to recognize the warning signs of the suicide crisis, in order to seek assistance before taking suicidal action (Foster et al., 2021). This will support the demystification and de-stigmatization of suicidal crises, as has been shown with other psychiatric disorders (Uchino et al., 2012), potentially increasing patients' readiness to disclose their suicidal ideation to clinicians (Ammerman et al., 2022). Understanding that the SCS represents a short-lived condition should relieve some of the burden associated with long-term diagnostic stigma. Also, by increasing diagnostic precision around suicide-related phenomena, a suicide-specific diagnosis could reduce misdiagnosis, particularly of stigmatized long-term disorders (e.g., borderline personality disorder).

Finally, we believe that stigmatization primarily derives from misinformation, fear, and uncertainty (Klin & Lemish, 2008). Thus, the dissemination of and education about a clear and treatable suicide-related diagnosis may be one effective strategy to undermine the stigma surrounding suicidality.

The SCS Diagnosis Will Promote Data Collection and Research

A DSM diagnosis will serve to standardize record keeping and in so doing provide vastly increased opportunities for research using electronic medical records (Sisti et al., 2020). Hence, inclusion of the SCS (2023) in the DSM should improve the quality of information in data registries. While new technologies such as machine learning can process vast numbers of data, as noted by Berman and Silverman (2023) in this issue findings are limited by the data entered into the medical records. A DSM diagnosis will ensure that suicide-specific and state-based information will be systematically entered into the medical records, something that does not occur now. In turn, available clinical and research data will allow for the development of empirically testable hypotheses and experimental paradigms to scrutinize the biological substrates of the SCS and to develop both psychological and pharmacological treatments for it. Furthermore, the introduction of a new diagnosis may increase interest in the topic by stakeholders (e.g., pharmaceutical companies, health-care organizations), thus promoting research efforts and broadening the horizons of investigation.

Arguments Opposing a Suicide-Specific Diagnosis

Silverman and Berman (2020) have argued against the introduction of new diagnostic categories pertaining to suicide and its related behaviors. We will now address many of the arguments proposed by these authors:

A Diagnosis Serves to Classify Disease and SCS Is Not a Disease

With this argument Silverman and Berman (2020) questioned the appropriateness of a suicide-specific diagnosis since suicide-related behavior is not a disease, a health problem or a disorder of structure or function. The authors used Sartorius's (2015, p. 242) definition of a disease as "a condition for which we (a) have discovered its causes, (b) understand its pathogenesis, (c) can comprehensively describe its clinical manifestations and reactions to treatment, and (d) can measure its history." Although this definition may be appropriate for several organic diseases, it is poorly applicable in psychiatry. In fact, the majority of DSM-5 disorders fail to meet this definition's requirements, for their causes are unknown (a, b), their clinical manifestations and reactions to treatment are nonspecific (c), and, in the absence of objective diagnostic tools, measures remain faulty and outcome difficult to predict (d). Typically, in psychiatry, we observe and identify internally cohesive disease entities resulting from the clustering of symptoms; then we try, rarely succeeding, to hypothesize the etiology (Jablensky, 2016; Oquendo & Baca-Garcia, 2014). In this vein, the SCS is no exception; it describes a syndrome characterized by a cohesive combination of interdependent symptoms (Bloch-Elkouby et al., 2020) that responds to medical treatment but, if left untreated, exposes the patient to a serious and

even life-threatening condition (Galynker, 2017). In this regard, the SCS does not differ from other "state-like" disorders, such as panic attacks or depressive episodes. It is worth noting that our effort is directed toward the evaluation, specifically, of the SCS, an acute mental state. Therefore, our arguments may not be pertinent to other associated phenomena (e.g., suicide, suicidal ideation, or suicidal behavior).

A Suicide-Specific Diagnosis Overmedicalizes Suicide-Related Behaviors

Medicalization is the attribution of medical connotations to an event previously considered of another nature (Maturo, 2012). Silverman and Berman (2020) argued that a new suicide-specific diagnosis would lead to an overmedicalization of a condition in which "biology is only part of the story." We agree that introducing a suicide-specific diagnosis into DSM will medicalize the presuicidal mental state. However, we believe the benefits of this outweigh the risks. Moreover, we argue that suicide is *already* medicalized since suicide-related behavior is (a) listed as a criterion for a psychiatric diagnosis (borderline personality disorder) and (b) one of the most frequent reasons for psychiatric admissions (Høyen et al., 2021). Contrary to what is claimed by the authors, medicalization of a condition does not imply a physical or biological malfunction, but rather the need for medical intervention. Thereby, people diagnosed with the SCS, who do not manifest an evident organic dysfunction but still suffer from a mental disorder, would greatly benefit from medical treatment. Similar to other acute medical conditions (e.g., myocardial infarction or panic attacks), SCS needs to be diagnosed and promptly treated. Importantly, "medicalizing" the SCS does not obviate the need for psychotherapy for suicide prevention; rather, an SCS diagnosis is likely to *improve* psychotherapy effectiveness, as effective treatment of SCS will render the patient calmer and with greater cognitive flexibility and thus more receptive to verbal interventions (Bloch-Elkouby et al., 2021). Although clinical trials for the SCS are needed and in preparation, treatment as usual within an inpatient population led to significant and clinically meaningful reductions in SCS symptomatology between admission and discharge, with a 52% reduction in SCI scores (Galynker et al., 2017).

A Suicide-Specific Diagnosis Increases Clinicians' Legal Exposure

The topic of clinician liability in the context of a suicide-specific diagnosis has been heavily debated. Joiner et al. (2018) consider a suicide-specific diagnosis as a protective element against charges, while Wortzel et al. (2018) feel it is neither sufficient nor necessary for moderating legal medical

disputes. Silverman and Berman (2020) maintain that having a suicide-related diagnosis would not ease medical liability.

We argue that a suicide-specific diagnosis will likely reduce litigation risk by clarifying what is expected of clinicians and making it easier to follow clinical guidelines (Joiner et al., 2018; Oquendo & Baca-Garcia, 2014). Currently, suicide risk assessment leaves many questions unsolved, which makes it challenging, demanding, and impractical to provide an effective safety plan. Clinicians lack effective diagnostic tools and usually rely on patients' self-reported suicidal ideation, which exposes them to the risk of both under- and over-reporting. When patients conceal suicidal ideation, clinicians are hindered from adequately exploring suicide risk. On the other hand, patients can falsely report suicidal ideation for secondary gain, a particular risk in emergency or inpatient settings where seeking admission solely for food and shelter is not uncommon (Lebourgeois, 2007). Additionally, suicidal ideation can be chronic or long-lasting and therefore not indicate imminent risk. Consequently, clinicians typically rely on a combination of several implicit and explicit clues (i.e., gut feeling, experience, symptoms; Barzilay et al., 2018) to decide when and whether to initiate or intensify treatment. While, as noted by Berman and Silverman (2023) in this issue such judgments can be informative (Barzilay et al., 2018), they are influenced by the clinicians' own personality traits and emotion regulation abilities (Barzilay et al., 2021) and, by definition, are neither objective nor standardized.

Likewise, clinicians' negative emotional reactions toward suicidal patients can unconsciously drive clinicians' actions (Yaseen et al., 2017). Moreover, clinicians' subjective judgment and "gut feelings" are not recorded into medical records and hence provide little legal protection for the clinician. In sum, current risk assessment processes are subjectively driven, emotionally challenging, and ultimately inadequate for assessing near-term suicide risk (Barzilay et al., 2021). In this way, the absence of meaningful and actionable guidelines creates a level of clinical ambiguity that can only increase legal exposure.

Although it is difficult to predict what exactly would occur, it is reasonable to assume that by clarifying standards of care, providing actionable and evidence-based guidelines, and improving sensitivity to near-term suicidal risk, the SCS, as a suicide-specific DSM diagnosis, will not raise litigation risk and may even reduce it.

A Suicide-Specific Evaluation Should Be an Extension of the Mental Status Examination (MSE)

Silverman and Berman (2020) propose that a suicide-specific examination should be an extension of the MSE

as opposed to an independent diagnosis. This would uphold the benefits of a structured risk assessment without the drawbacks of a new diagnosis. We believe this solution does not have the broader cultural and institutional impact of a formal diagnosis and may, in fact, *increase* the complexity and ambiguity of suicide risk assessment. The SCS consists of 15 symptoms grouped into five criteria: one Criterion A and four Criteria B. Only five of these symptoms, one from each criterion, are needed to make the SCS diagnosis (Bafna et al., 2022; Bloch-Elkouby et al., 2021). Having all 15 SCS symptoms in the MSE without being grouped into criteria will create confusion regarding the presence and the severity of SCS. Additionally, the diagnostic code would not be used in the medical record, removing a key mode of communication between providers. What decision will the clinician make if four SCS symptoms are present? Or six? Or eight? Would it matter which symptoms are present and which are not?

Including SCS symptoms in the MSE would require clinicians to gather additional information about patients at risk without providing clear indications of how to proceed, inevitably increasing clinician burden. Furthermore, having diagnostic criteria would not preclude clinicians from considering other aspects of suicide risk assessment. As stated earlier, medicine in general and psychiatry, in particular, rely upon a categorical system of classification, which provides professionals with information about the course of illness and facilitates the decision-making process, ultimately reducing work-related stress (Frances, 2016; Jablensky, 2016).

Conclusion

Including a suicide-specific diagnosis in the DSM should be based on the need for a specific diagnosis, its accuracy, and its potential benefits (Fehling & Selby, 2021). From our perspective, SCS will improve suicide risk assessment and overcome the limitations of existing diagnostic tools to identify at-risk individuals. We anticipate it will aid decision-making when encountering patients with suicidal risk; reduce misdiagnosis and unnecessary treatment; and enhance communication among clinicians, staff, and families about suicide risk. Additionally, such a diagnosis should reduce clinicians' stress resulting from the evaluation of ambiguous circumstances (e.g., malingering, chronic or long-lasting suicidal ideation in patients suffering from personality disorders). Furthermore, the SCS could lead to clinical trials to develop more specific pharmacological and psychological treatments for this presuicidal state.

The objective of this editorial was to provide a thorough analysis of the "pros and cons" of including the SCS diagnosis in the DSM. Although there are arguments against the inclusion of the SCS or any suicide-specific diagnosis in the DSM, we believe the benefits of a presuicidal diagnosis far outweigh the drawbacks. Ultimately, our shared goal is to prevent suicide deaths.

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