

SUICIDE-SPECIFIC DIAGNOSIS: THE CURRENT PERSPECTIVE AND THE WAY FORWARD

Tathagata Biswas

Department of Psychiatry, All India Institute of Medical Sciences-Bhubaneswar, Odisha, India

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Dear Sir,

Suicide, a major public health concern, has a global prevalence of 9.0/lakh population (Ilic & Ilic 2022). Despite its catastrophic nature, suicide has received little attention in the major psychiatry nomenclatures, merely complementing the diagnosis of other disorders (depression and borderline personality), while missing a mention in anorexia nervosa and schizophrenia, where it is a leading cause of death (Rogers et al. 2019). Moreover, at times suicides may not be related to a mental illness (Fehling & Selby 2021). Thus, a suicide-specific diagnosis can help a) improve and standardise suicide assessment in clinical settings, b) increase preventive measures in vulnerable patients, c) provide a universal language for researchers and healthcare providers, and d) reduce personal, legal and social burden (Fehling & Selby 2021, Rogers et al. 2017).

Three acute suicidal diagnoses have been recently proposed:

i) Suicidal behaviour syndrome (SBS) is an inclusion under DSM-5 ‘conditions for further study’. It recognises patients attempting suicide in the preceding two years, acknowledging the higher risk for future attempts in them. However, the retrospective nature of the diagnostic criteria fails to identify the risks in first attempters. Furthermore, the non-inclusion of ‘previous suicidal ideations’ is debatable, given the strong association between contemplation and behaviour (Harmer et al., 2023). It also overlooks the lifetime suicide risks in people with a history of attempt(s) prior to two years (Fehling & Selby 2021).

ii) Suicide crisis syndrome (SCS) is a pre-suicidal mental state characterised by negative affect, loss of cognitive control, hyperarousal and social withdrawal associated with recurrent feelings of entrapment with/without suicidal ideations. Recent evidence showed high predictive validity of SCS for near-future suicide attempts. However, further studies are needed to establish its ‘time

course’, delimitation from other mental illnesses and usefulness in the paediatric populations (Schuck et al. 2019).

iii) Acute suicidal affective disturbance (ASAD) represents drastic spikes in suicidality, characterised by intense suicidal intent (over hours/days), social alienation, hopelessness and overarousal. However, differentiating sudden spikes of suicidal intent from impulsivity is clinically challenging. Studies exploring the onset, course, sociocultural influences, and biological underpinnings of ASAD are currently limited (Rogers et al. 2019).

Conceptual differences exist between the constructs. While SBS screens the recent past to identify suicide risks in the present, the other two rely on the current symptoms. Despite overlapping components (Figure 1), SCS captures the cognitive/executive breakdown leading to suicide, while ASAD assesses the rising suicidal intent during such a crisis. Thus, SCS and ASAD belong to the same illness spectrum, with ASAD representing the end stage (Rogers et al. 2017). Theoretically, the construct of SBS is founded on the significant predictability of a past attempt for future suicidal behaviour (SB) (Di Napoli & Della Rosa 2015, Fehling & Selby 2021), SCS on the narrative-crisis model for suicide (Schuck et al. 2019), and ASAD on Schneidman’s psychache and Beck’s hopelessness models (Rogers et al. 2019).

Several studies have confirmed the construct validity of the diagnoses (Rogers et al. 2017; Voros et al. 2021). Additionally, SBS has shown 64% sensitivity and 88% specificity in predicting short-term SB (Galynker et al. 2017). However, data on the predictive validity of SBS and ASAD are limited. The relevant assessment scales, the Suicide Crisis Inventory (SCI) and the ASAD inventory lifetime (ASADI-L), require further validation (Galynker et al. 2017, Oh et al. 2022). Future study is necessary to identify the symptoms with the most predictive value and if combining the three constructs is more advantageous than using them individually (Rogers et al. 2019, Voros et al. 2021). Again, the influence of comorbid psychiatric

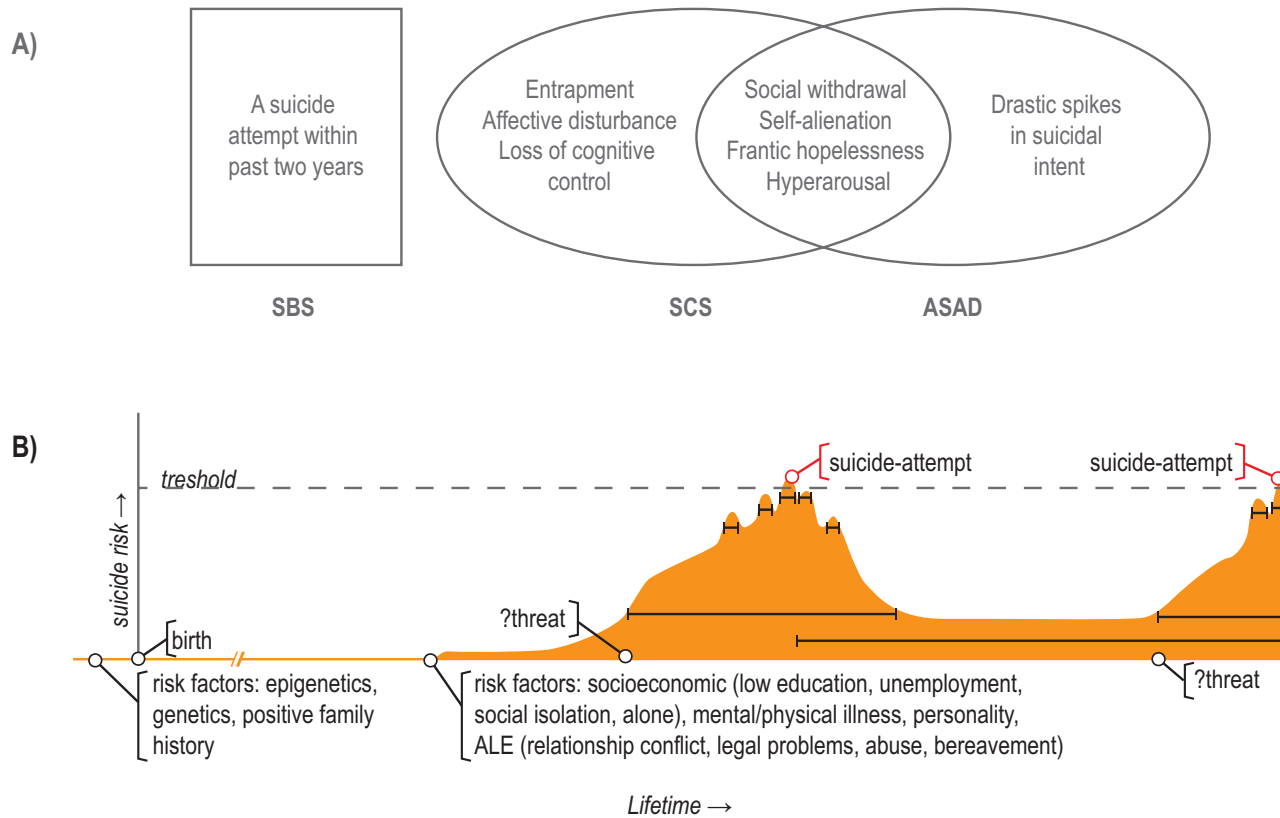


Figure 1: Concept diagrams for the suicide-specific diagnoses: SBS, SCS and ASAD.

A) The differences and overlapping components in the diagnostic criteria.

B) An illustrative case to understand suicide risks across the lifetime, and the possible suicide-specific diagnoses.

The dashed line represents an arbitrary threshold above which a suicide intent is acted upon resulting in suicidal behaviour/attempt. Some important risk factors for suicide (Favril et al., 2022) are mentioned at their probable time of emergence. A diagnosis of SCS (during the time periods marked 1) represents a pre-suicidal mental state characterised by entrapment and urgency to escape from a real or perceived threat (Schuck et al., 2019). ASAD (marked 2) represents an end-stage drastic spike in suicidal intent (Rogers et al., 2019). SBS (marked 3) is a period of high suicide risk for two years following a suicide attempt.

SBS: suicidal behaviour syndrome, SCS: suicide crisis syndrome, ASAD: acute suicidal affective disturbance, ALE: adverse life event, ?: real or perceived.

disorders on the symptoms of ACS and ASAD needs investigation. Future research may aim to identify the neurobiological correlates and integrate the concepts within the ambits of the Research Domain Criteria (RDoC). Furthermore, modern techniques like digital phenotyping, machine learning or computerised adaptive testing can help better understand the constructs (Voros et al. 2021).

Given the acuteness of the conditions, their diagnostic stability is doubtful in the long term. Also, the changes in the symptom severity with time may require a dimensional approach than a strictly categorical assessment. Again,

all three entities do not include the underlying factors classically used to assess suicide risks (Figure 1) (Erić et al. 2017, Favril et al. 2022). Perhaps a model integrating the background vulnerabilities of the patient alongside the acute crisis symptoms would be more useful in predicting SB. Additionally, a suicide-related diagnosis may risk stigmatisation (Kučkalić & Kučkalić 2017) and have major ethical and legal implications (Schuck et al. 2019). For how long a patient with an acute suicide diagnosis may be subjected to observations and unwarranted assessments need clarification. Finally, any predictive model is

futile without an efficient suicide intervention strategy in place by the appropriate institutions of the state.

To conclude, the recently proposed suicide-specific diagnoses (SBS, SCS and ASAD) are positive steps towards suicide prevention. However, substantial work is needed to understand the multifactorial complexities behind suicidal behaviours.

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Correspondence:

Dr. Tathagata Biswas. MBBS, MD
Department of Psychiatry, All India Institute
of Medical Sciences-Bhubaneswar, Odisha, India,
drtatz92@gmail.com, +91 9735177798