Can a New Diagnosis Help Prevent Suicide?

There is no established method of identifying patients in immediate danger of attempting suicide. Some researchers are trying to change this.

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ONE NIGHT in her Nashville apartment, Bre Banks read a comment from her boyfriend on Facebook. They were in a shaky spell, and his words seemed proof she would lose him. She put her laptop down on the couch and headed to the bedroom to cry. "My legs seized up, and I fell," she recalled. With her knees and forehead pressing into the carpet, she heard a voice that said, "Slit your wrists, slit your wrists." She saw herself in the bathtub with the blood flowing. She was terrified that if she moved she would die.

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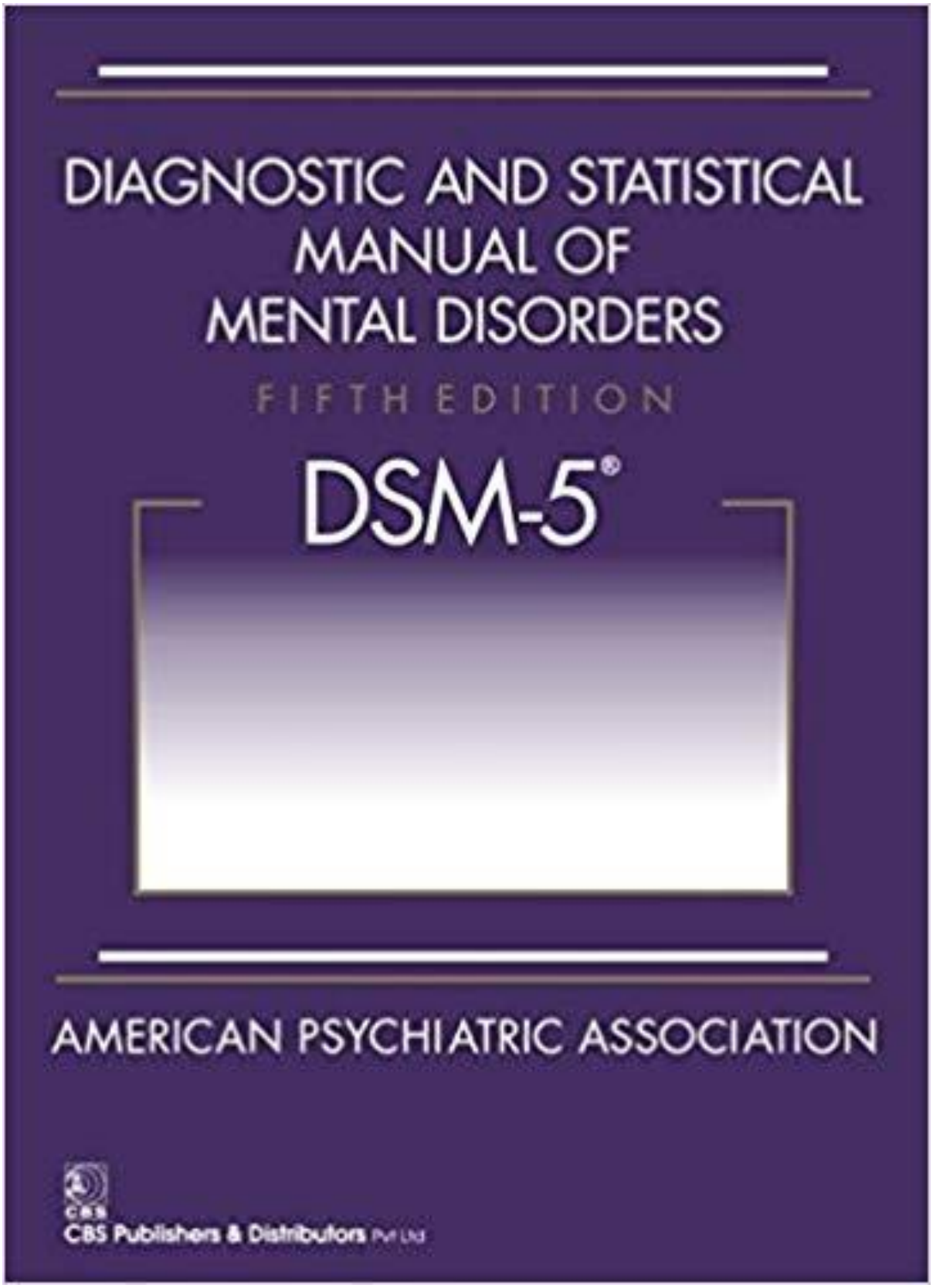
Banks, then 25, was a disciplined graduate student with a job and close friends and had no psychiatric history. "I had never considered suicide an option," she says. But for the next three days, she couldn't sleep while the voice and disturbing images persisted. After seeing a therapist, she decided to teach herself techniques from dialectical behavior therapy, one of the few treatments shown to reduce suicidality. The voices and images came back over the next few months, but eventually faded. Eight years later, Banks now evaluates suicide prevention programs across Tennessee as a manager at the large mental health provider Centerstone's research institute, and she and the same boyfriend just celebrated their 10th anniversary.

In the public imagination, suicide is often understood as the end of a torturous decline caused by depression or another mental illness. But clinicians and researchers know that suicidal crises frequently come on rapidly, escalating from impulse to action within a day, hours, or just minutes. Many also point to the fact that they may strike people like Banks, who are otherwise in good mental health.

That understanding is one reason a movement is building to define suicidality as a condition in its own right. Most recently, researchers from Mount Sinai Beth Israel and Florida State University have agreed to collaborate on a joint proposal for a new diagnosis in the next Diagnostic Statistical Manual of Mental Disorders (DSM), a handbook published by the American Psychiatric Association. The criteria include familiar symptoms of depression, but these symptoms occur in an acute state that is not currently obvious to clinicians. Proponents say it could spur more research and make it easier for suicidal patients to get the care they need.



Researchers are collaborating to include a new diagnosis for suicidality in the next edition of the Diagnostic and Statistical Manual of Mental Disorders, a handbook published by the American Psychiatric Association.

Some have expressed skepticism. “Far too many diagnoses in psychiatry come and go,” said George Makari, a Weill Cornell Medicine psychiatrist and historian of psychiatry. The idea that suicidality may not be a symptom of something else — a mood or personality disorder — is novel. “If they’re making the claim that we’ve been seeing this upside down for a long time,” he said, “that’s fascinating.”

Suicide rates have been rising sharply since 1999, figures from the Centers for Disease Control and Prevention (CDC) show. More than half of those who take their lives do not have a known mental health condition. There is also no established way to pinpoint when a patient is in immediate danger. “You cannot rely on people telling you when they are or are not suicidal,” said Igor Galynker, a professor of psychiatry at Icahn School of Medicine in New York.

Research backs that up: A 2019 meta-analysis of 71 studies conducted around the globe found that about 60 percent of people who died by suicide had denied having suicidal thoughts when asked by a psychiatrist or general practitioner. Here in the U.S., a 2016 study examined data from four health systems that use standardized questionnaires in primary care and specialty clinics. (The questionnaires ask whether the patient has experienced “thoughts that you would be better off dead or of hurting yourself in some way.”) Although the answers did predict future suicide attempts to some extent, there were plenty of false negatives. Thirty-nine percent of the suicide attempts and 36 percent of the suicide deaths occurred among patients who had responded “not at all” to the key question. In another study, about a quarter of the suicide attempts were made by people who reported zero suicidal thoughts.

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It’s easy to assume they were lying, but that’s not quite true. Greg Simon, a psychiatrist and investigator at Kaiser Permanente Washington in Seattle, who led the 2016 study, was involved in a follow-up study based on interviews with 26 people who had made attempts after denying any suicidal thoughts on the standard questionnaire. The interviews revealed that some people had lied, he said. But they also revealed people who had provided “aspirational” responses — they were *trying* not to have suicidal thoughts — and people who had experienced no suicidal thinking whatsoever. (Among the latter group, alcohol often factored into their attempts.) None of them woke up that morning with a plan to die that day.

For his part, Galynker determined long ago — after he lost a patient who took him by surprise — that he couldn’t rely on patient reports. In 2007, he set out to develop a set of symptoms that would help pinpoint imminent suicide — even if the patient didn’t report suicidal thinking. “We hypothesized that the pre-suicidal state leading to suicidal action was short-lived, kind of like pulling a gun trigger,” he said. In 2009, he called it “suicide trigger state.” Over dozens of research papers, he explored various symptoms as predictors, developing checklists and then testing how well they predicted future behavior. While these checklists are still new, they are being used to screen for suicidal risk among high school students in Moscow, Russia, and among hospital patients in Chicago.

In 2017, Galynker coined the term "suicide crisis syndrome." People with this syndrome feel trapped, though they might not think of death per se. They may be flooded with misery and unable to think clearly. Certain thoughts, like Banks' images and voices, return repeatedly, no matter how much they are resisted. They may experience mood swings or overwhelming emotional pain.

At Florida State University, Thomas Joiner, the author of several books on suicide and the editor of a suicide journal, outlined his own criteria for a quick-onset suicide crisis, which he calls "acute suicidal affective disturbance." This describes rapidly escalating plans for suicide over hours or days — faster than clinicians may expect. The key difference is that Joiner includes reports of suicidal thinking as an essential criterion.

The pair teamed up more than two years ago when the first paper describing both of their diagnoses appeared. Together, the two researchers envision a new DSM suicide diagnosis with two sub-types, one with thoughts of suicide, and one without. Before this diagnosis is approved for the DSM, however, the researchers may need to show more conclusively that the phenomenon they describe isn't a symptom of depression or another mental illness, and that their methods of screening for it are effective.

Psychiatrist Michael First at Columbia University, who presided over earlier revisions of the DSM, sees a suicide-specific diagnosis as an "appealing idea." If the melding of Galynker's and Joiner's formulations worked well and proved to be accurate, First said, "then it would clearly be very useful to have it."

CLINICIANS currently struggle with little guidance on how to identify imminent risk or make sense of suicides that seem to come out of the blue.

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Nearly once a week, attending psychiatrist Dmitriy Gekhman at Mount Sinai Beth Israel sees a patient who has attempted suicide and is hard to classify, though he must find a relevant code for each patient's chart. "You kind of go through the history and everything, and they're not depressed. They don't meet the criteria for depression, they don't meet criteria for bipolar disorder, and they don't have a personality disorder," he said. "We just discharged somebody this week who that happened to, and we still have somebody on the unit now."

If a diagnosis based on Galynker's and Joiner's research were put in place, it would put the patient's doctors on notice that the patient is a risk for suicide with rapid onset. Over time, it's possible that clinicians and even teachers and parents would become better at seeing the signs. The diagnosis, Joiner explained, is a "warning sign for the future."

Detroit's Henry Ford Health System provides a glimpse of how suicide prevention might evolve. At Henry Ford, suicide is considered its own mental health category, not primarily a symptom of depression. In 2002, the health system began a series of initiatives, and reduced patient suicide rates a dramatic 80 percent over the next seven years.

The staff at Henry Ford discovered that from 2000 to 2010, only half of patients who died by suicide had received a mental health diagnosis, closely matching current national statistics. This could be undiagnosed illness, "but I think a lot of people don't meet the criteria," said Brian Ahmedani, who directs the health system's Center for Health Policy & Health Services Research.

Henry Ford screens everyone with questionnaires asking about suicidal thoughts, a practice the Joint Commission, which certifies health care organizations, started recommending in 2016. But in its behavioral health units, the risk assessment focuses on triggers, such as a job loss. Ahmedani says that patients in the highest risk percentile usually have a number of triggers: chronic pain, opioid use, and insomnia, for example. Because assessing the many possible combinations can be difficult, Henry Ford uses artificial intelligence to analyze electronic medical records, helping clinicians who may not have time to catch a perfect storm before it's already too late. Veterans are a high-risk group, so the Veterans Affairs (VA) has begun using these algorithms too.

Currently, suicidal people are often prescribed antidepressants. However, other than lithium, most often used to treat people with bipolar disorder, there's little evidence that medication prevents suicide, Ahmedani observed. New VA clinical guidelines also support short-term infusions of a drug called ketamine.

Henry Ford offers treatments specific to suicide: identifying triggers and coping mechanisms, for example. It also offers cognitive behavioral therapy and dialectical behavior therapy, the treatment that helped Banks. Patients are encouraged to develop a safety plan that includes removing guns or painkillers from the home, and an idea of who they might call under duress.

David Covington, a suicide prevention activist, said, "we used to think that if you treat addiction, the mental health will get better, and the other side thought if you treat mental health, the addiction will get better. Now we say you have to treat both." Similarly, a person might need treatment for both suicide and depression.

The new diagnosis, more fundamentally, could change who we think might be driven to the extreme of a suicide attempt. Psychiatrists still refer to suicide attempts with a short buildup as "impulsive," but Joiner's team disputes that these are impulsive people. Megan Rogers, a Ph.D. candidate who works with Joiner, sees outpatients at the university clinic. She recalls one who "within hours would go from no risk to high risk" but had what she describes as a "conscientious and vigilant," rather than impulsive, personality.

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Still, some question whether a new diagnosis would actually benefit patients. For one thing, it isn't clear how such a diagnosis would influence treatment — or whether it would save lives. "There is simply no value in a prediction that cannot lead to an effective preventative measure," writes psychiatrist Matthew Large in a 2018 paper evaluating suicide assessment approaches generally. More people could land in hospital psychiatric care, or be kept longer than they desire, he said. And "while it is generally assumed that hospitalization can prevent suicide, this has never been demonstrated empirically." In fact, suicide rates are high among recently discharged patients and some say hospitalization can make things worse.

Galynker agrees that hospitalization is not necessarily the answer and is looking at new treatment methods. In the meantime, the diagnosis might communicate the higher risk to insurance companies, explained Lisa Cohen, a professor of psychiatry at Icahn School of Medicine and co-author with Galynker, giving patients better access to treatment options.

Psychiatrists who make decisions about hospitalization say they would appreciate more science to guide them. "It would be incredibly helpful to have a very clear indication that someone is at higher risk," observed Julie Holland, who once presided over a psychiatric emergency room at Bellevue Hospital in New York. A close look at the buildup to a crisis would be invaluable. "We do that when somebody's heart stops, or when somebody's heart is imminently stopping," said Chicago psychiatrist Leo Weinstein, who teaches at Northwestern University. "Making the unstable state a diagnostic entity in its own right," like ventricular fibrillation or congestive heart failure, he says, "is crucially important."

Temma Ehrenfeld is a writer and ghostwriter in New York drawn to philosophy and psychiatry. Her most recent book is "Morgan: The Wizard of Kew Gardens."