Suicide Risk Assessment: A Diagnostic Perspective

Authors: Hou Xiangqing, Yang Ying, Zhang Qianqian, Yang Li, Yang Li

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Abstract

The assessment of suicide risk constitutes a prerequisite and foundation for intervention; however, its standardization and accuracy have remained principal challenges in the field of suicidology. In recent years, a growing body of research has demonstrated that suicide is not confined to the diagnostic categories of specific mental disorders, but rather represents a transdiagnostic clinical syndrome. Consequently, establishing independent diagnostic categories for suicide to enhance clinical risk assessment has emerged as a novel research direction. Diagnostic proposals such as suicidal behavior disorder, suicidal crisis syndrome, and acute suicidal affective disorder have achieved progress in empirical research and clinical application. Nevertheless, existing diagnostic frameworks remain immature, and their practical implementation entails potential risks. Future endeavors must focus on refinement and validation through connotation delineation, diagnostic differentiation, and research design.

Full Text

Preamble

Suicide Risk Assessment: A Diagnostic Perspective

HOU Xiangqing[1,2,3], YANG Ying[2,3], ZHANG Qianqian[1,2,3], YANG Li[2,3]
(1 School of Education, Tianjin University, Tianjin 300350, China)
(2 Institute of Applied Psychology, Tianjin University, Tianjin 300350, China)
(3 Laboratory of Suicidal Behavior Research, Tianjin University, Tianjin 300350, China)

Abstract: Suicide risk assessment is fundamental to effective intervention, yet its standardization and accuracy remain major challenges in suicide research. Recent studies increasingly demonstrate that suicide is not confined to specific mental disorder diagnoses but represents a transdiagnostic clinical syndrome. Consequently, establishing a separate suicide-specific diagnosis has emerged as

a novel research direction to improve clinical suicide risk assessment. Diagnostic proposals such as suicidal behavior disorder, suicide crisis syndrome, and acute suicidal affective disturbance have shown progress in empirical research and clinical application. However, existing diagnostic frameworks remain immature and carry potential risks in practical implementation. Future work must refine and validate these models through conceptual clarification, diagnostic differentiation, and improved research design.

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Corresponding Author: YANG Li, E-mail: yangli@tju.edu.cn

Suicide is defined as the act of deliberately killing oneself (WHO, 2014). According to global statistics, over 800,000 people die by suicide each year (WHO, 2021). Suicide risk assessment constitutes a critical component of suicide prevention efforts (肖水源, 2001). This process involves identifying factors that may increase or decrease risk to determine an individual's suicide risk level (Oquendo & Bernanke, 2017). Suicide is widely regarded as resulting from the interaction of multiple factors spanning biological, psychological, social, and environmental domains (杜睿, 江光荣, 2015), and this complexity poses significant challenges for assessment. The effectiveness of suicide risk assessment and its associated tools has long been questioned (Campos et al., 2023; Runeson et al., 2017). Consequently, improving suicide risk assessment has become an urgent priority in the field.

Currently, suicide risk assessment relies primarily on questionnaire measures (e.g., Beck Scale for Suicide Ideation, Suicidal Intent Scale, Depression Severity Scale) and/or interviews (e.g., Columbia-Suicide Severity Rating Scale, Mini International Neuropsychiatric Interview, Structured Clinical Interview for DSM) (Bolton et al., 2015). Given the numerous factors influencing suicide risk, assessment tools continue to proliferate. However, clinical practice lacks consistent protocols for assessment procedures and instruments, and variability in clinicians' knowledge and skills regarding suicide contributes to divergent risk assessment results that are difficult to compare or share across settings (Andreotti et al., 2020; Regehr et al., 2022). Furthermore, clinicians are expected to predict future suicide risk—whether an individual might attempt suicide within hours, days, or weeks—to enable preventive action (肖水源, 2019). Yet most existing risk factors represent distal predictors (e.g., mental disorders, history of suicide attempts) that help identify high-risk populations but provide limited information about the psychological processes or states preceding suicide, and thus cannot adequately explain how and why an individual's suicide risk emerges (Allsopp et al., 2019). Consequently, these factors have only limited clinical predictive value (Franklin et al., 2017; Voros et al., 2021).

In this context, researchers have advocated for incorporating suicide-specific diagnostic categories into mental disorder classification systems to address cur-

rent challenges in suicide assessment and intervention (Fehling & Selby, 2021; Obegi, 2021). In 2013, the American Psychiatric Association (APA) introduced suicidal behavior disorder as the first standalone suicide diagnosis in the DSM-5 section "Conditions for Further Study." This proposal aimed to encourage dedicated suicide research rather than treating suicide merely as a symptom of other mental disorders, thereby promoting clinical assessment and documentation of suicide risk (American Psychiatric Association, 2013). Subsequently, researchers have proposed additional diagnostic frameworks, including suicide crisis syndrome and acute suicidal affective disturbance, which focus on acute psychopathological features preceding suicide attempts to enhance risk assessment and prediction capabilities (Schuck et al., 2019; Tucker et al., 2016).

These efforts to establish standalone suicide diagnoses represent an innovative reconceptualization of suicide within existing diagnostic frameworks and may facilitate a paradigm shift in suicide risk assessment. This development has attracted considerable attention and discussion among researchers. This article systematically reviews the background, existing proposals, current controversies, and limitations of suicide-specific diagnoses, and proposes strategies for improvement to support suicide research and prevention efforts.

Although the etiology of suicide remains unclear, extensive research demonstrates that mental disorders constitute one of the strongest risk factors for suicidal behavior (Moitra et al., 2021; Turecki et al., 2019). Psychiatric inpatients and outpatients exhibit significantly higher suicide risk than patients with other medical conditions and the general population (Ajdacic-Gross et al., 2009; Mortensen et al., 2000).

Within current diagnostic frameworks, suicide is conceptualized as either a symptom of mental disorders or a potential negative outcome. As shown in Table 1 , DSM and ICD diagnostic criteria explicitly incorporate suicide-related thoughts and behaviors for depressive disorders, bipolar and related disorders, and borderline personality disorder. Numerous other mental disorders have also demonstrated strong associations with suicide (Xu et al., 2023), yet their diagnostic criteria do not include suicide-related items. This discrepancy may lead clinicians to attend differentially to suicide risk across disorders (Fehling & Selby, 2021). Specifically, Oquendo et al. (2008) noted that in many semi-structured clinical assessments, clinicians emphasize suicide risk evaluation for patients with potential mood disorders and personality disorders. In non-mandated settings, when patients deny symptoms of major depressive disorder or borderline personality disorder, clinicians may not continue to inquire about suicide. Conversely, Maung et al. (2022) argued that this discrepancy may exaggerate the relationship between certain mental disorders and suicide. Epidemiological surveys indicate that suicidal behavior occurs most frequently in mood disorders (including bipolar disorder and major depressive disorder) (Bertolote et al., 2004). This strong association may result partly from the nature of mood disorders themselves and partly from the inclusion of suicide in their diagnostic criteria. When individuals report suicidal ideation, they automatically meet one

symptom requirement for bipolar or major depressive disorder, increasing their probability of receiving these diagnoses over others. In summary, establishing a standalone suicide diagnosis in classification systems could enhance clinicians' attention to suicide risk across all mental disorders, promote comprehensive standardized assessment, and facilitate documentation as part of multi-axial diagnosis.

Table 1 Suicide-related descriptions and corresponding diagnoses in DSM and ICD

ICD-11	DSM-5
Bipolar and related disorders	Bipolar and related disorders
Bipolar I disorder	Single episode depressive disorder
Bipolar II disorder	Recurrent depressive disorder
Major depressive disorder	Borderline personality disorder
Recurrent thoughts of death or suicide	Recurrent thoughts of death (not just fear of death), recurrent suicidal ideation without a specific plan, a suicide attempt, or a specific plan for completing suicide; Recurrent suicidal behavior, gestures, threats, or self-mutilation

Note: Latest versions shown

Research advances in suicidology have provided empirical foundations for suicide-specific diagnoses. First, regarding prevalence, suicide frequently co-occurs with mental disorders but not exclusively. Early Western psychological autopsy studies found that over 90% of individuals who died by suicide had mental disorders (Cavanagh et al., 2003; Isometsä, 2001). In China, this proportion is significantly lower, with only 63% of suicide decedents having had mental disorders (Phillips et al., 2002). CDC survey data from the United States indicate that 54% of suicide decedents had no mental health problems (Stone et al., 2018). Although epidemiological findings may be influenced by insufficient healthcare utilization, inconsistent assessment tools, and cultural differences (Phillips, 2010), these data suggest that a substantial number of individuals die by suicide without pre-existing mental disorders, indicating that suicide may have unique risk factors and developmental mechanisms distinct from mental disorders.

Second, regarding biological mechanisms, serotonergic system dysregulation is common in major depressive disorder, alcohol use disorder, and individuals with suicidal tendencies. Comparative studies reveal distinct pathophysiological characteristics among these conditions (Underwood et al., 2018). Suicide decedents show higher 5-HT1A receptor binding rates independent of depressive disorders.

Additionally, inflammation, hypothalamic-pituitary-adrenal axis dysfunction, lipids, and endocannabinoids show promise as potential biomarkers to differentiate individuals with suicidal tendencies from those with other mental disorders (Johnston et al., 2022).

Finally, contemporary suicide theoretical models have shifted focus from genetic, clinical, and demographic factors to dynamic suicide processes and assessment of acute pre-suicidal states (Bagge et al., 2017, 2023; Bryan et al., 2020; Glenn & Nock, 2014). Phenomenological studies of suicide risk indicate a typical "pre-suicidal state" preceding the transition from suicidal ideation to action, often involving anxiety, panic, agitation, or psychological pain (Osváth, 2023). Similarly, Conner et al. (2022) interviewed patients with substance use disorders within 24 hours of a suicide attempt and found that individuals experience a range of cognitive (e.g., hopelessness), behavioral (e.g., alcohol use), emotional (e.g., dramatic emotional changes), and social (e.g., social withdrawal) symptoms in the 24 hours preceding an attempt. Additionally, ecological momentary assessment applications in suicidology provide more refined, symptom-based methods for studying dynamic features of suicide (朱佳鑫等, 2024). This approach uses smartphone apps, phone calls, electronic diaries, and physiological sensors for random sampling, capturing patterns of suicidal thoughts and behaviors in real-world contexts and facilitating investigation of pre-suicidal state characteristics and acute risk predictors. Findings indicate that negative affect and sleep disturbances are important predictors of suicidal ideation and behavior (Sedano-Capdevila et al., 2021).

In summary, the proposal of suicide-specific diagnoses aligns with current clinical needs for suicide risk assessment and prediction, and corresponds with research advances on proximal risk factors and acute risk characteristics, holding significant theoretical and applied value.

Three existing suicide diagnostic proposals have emerged: suicidal behavior disorder, suicide crisis syndrome, and acute suicidal affective disturbance. This section introduces these diagnostic frameworks and reviews their research progress using the Feighner criteria for diagnostic development (Feighner et al., 1972). The Feighner criteria comprise five components: (1) description of typical symptoms or symptom clusters, including prevalence, age of onset, precipitating factors, and other characteristics; (2) differentiation from other mental disorders to exclude borderline and suspected cases; (3) laboratory studies identifying biological markers; (4) follow-up studies establishing similar clinical course or prognosis; and (5) family studies identifying similar familial characteristics.

3.1 Suicidal Behavior Disorder

Previous research demonstrates that prior suicide attempts increase risk for suicide death, with approximately 7-13% of attempters eventually dying by suicide, particularly within 1-2 years of the attempt (Bostwick et al., 2016; Prabhakar et al., 2021). However, in clinical assessment, suicide attempts are

often conflated with other self-harm behaviors, compromising accuracy. Given the importance of suicide attempts, DSM-5 proposed suicidal behavior disorder (SBD) (American Psychiatric Association, 2013).

In SBD, a suicide attempt is defined as a self-initiated sequence of behaviors with the expectation that they will result in one's own death. This definition clarifies suicidal intent—the behavior must aim to cause death, distinguishing it from emotion-regulation self-injury. Exclusion criteria specify consciousness states during the attempt and motivational considerations. Additional specifiers address method lethality (violent vs. nonviolent), degree of medical lethality (high vs. low), and attempt dynamics (planned vs. impulsive), with the past year designated as the current episode period and 12-24 months as early remission. To meet SBD criteria, an individual must have made at least one suicide attempt within the past 24 months, not merely experienced suicidal ideation or preparatory behaviors (see Table 2).

SBD prevalence varies substantially across samples. A retrospective chart review of Korean adolescent psychiatric inpatients (n=215) found a prevalence of 33.5% (Song et al., 2022), while another study of incarcerated non-clinical adolescents (n=262) reported 7.6% prevalence (Lasisi et al., 2022). Regarding differential diagnosis, SBD shows high comorbidity with non-suicidal self-injury disorder. In adolescent samples, non-suicidal self-injury disorder predicts SBD, with parent-child relationship problems potentially facilitating this progression (Song et al., 2022). Additionally, SBD is closely associated with borderline personality disorder. Nearly half of patients meeting SBD criteria (n=92) also had borderline personality disorder, and these individuals were nine times more likely to repeat suicide attempts than SBD patients without borderline personality disorder, exhibiting higher levels of emotional dysregulation, shame, impulsivity, anxious attachment, and childhood trauma (Ducasse et al., 2020). Biological marker research on SBD has focused on endocrine indicators, with studies showing impaired hypothalamic-prolactin axis regulation in depressed patients with SBD, particularly those with medically serious attempts (Duval et al., 2023).

SBD holds pioneering significance for suicide diagnosis development by establishing clear criteria for suicide attempts and increasing the likelihood that individuals with attempt histories will be identified and treated (Groschwitz et al., 2015; Oquendo & Baca-Garcia, 2014). However, as a distal risk factor, suicide attempt history cannot provide early warning for imminent suicidal behavior (Glenn & Nock, 2014; Rudd, 2006). Therefore, researchers have proposed two additional diagnostic frameworks incorporating acute symptoms preceding suicide attempts to enable assessment and prediction of proximal suicide risk.

Table 2 Diagnostic Criteria for Suicidal Behavior Disorder

A. The individual has made a suicide attempt within the past 24 months
B. Does not meet criteria for non-suicidal self-injury (i.e., self-injury to the surface of the body not intended to result in death, performed to relieve negative

emotional/cognitive states or achieve positive emotional states)
C. This diagnosis does not apply to suicidal ideation or preparatory behaviors
D. The behavior was not performed during delirium or psychosis
E. Not performed purely for political or religious purposes

Note: Less than 12 months since last attempt = current episode; 12-24 months = early remission

3.2 Suicide Crisis Syndrome

Suicide crisis syndrome (SCS) originated from research on suicide trigger states, initially comprising three dimensions: overwhelming hopelessness, rumination flooding, and near-psychotic somatization (Yaseen et al., 2010; Yaseen et al., 2012). Building on this work and incorporating advances in proximal risk factor research, Galynker et al. (2017) proposed SCS as an acute pre-suicidal mental state characterized by affective and cognitive dysregulation and behavioral responses to real or perceived threats, typically emerging hours or days before suicide. The DSM-style criteria for SCS consist of five components organized into Criteria A and B. Entrapment (Criterion A) represents the core symptom—affective rather than cognitive state (see Table 3) (O'Connor & Kirtley, 2018; Williams, 2001). Criterion B includes four domains: affective disturbance, cognitive decontrol, hyperarousal, and social withdrawal. Affective disturbance comprises rapid emotional oscillation, severe anxiety, acute anhedonia, and psychological pain. Cognitive decontrol includes rumination, cognitive rigidity, thought suppression failure, and rumination flooding. Hyperarousal includes agitation, hypervigilance, irritability, and insomnia. Social withdrawal includes social isolation and communication avoidance. Symptoms in both Criteria A and B have demonstrated associations with imminent suicide risk (Yaseen et al., 2019). SCS diagnosis requires meeting both Criterion A and all four categories of Criterion B, without requiring explicit suicidal intent.

Clinical feature research has led to development of the self-report Suicide Crisis Inventory and its revised version (SCI-2) (Bloch-Elkouby et al., 2021; Galynker et al., 2017). Both one-factor and five-factor models of SCI-2 show good fit across multiple countries, supporting SCS structural validity (Menon et al., 2022; Park et al., 2023; Wu et al., 2022). An epidemiological survey (n=5,528) during the COVID-19 pandemic revealed varying SCS prevalence rates across countries, ranging from 3.6% (Israel) to 16.2% (Poland), with lower rates among older, male, and married participants and minimal racial/ethnic differences (Rogers, McMullen, et al., 2023). Multiple follow-up studies demonstrate SCS predicts suicide attempts even after controlling for depression, anxiety, and suicidal ideation (Bafna et al., 2022; Bloch-Elkouby et al., 2021; Yaseen et al., 2019). For example, psychiatric inpatients meeting SCS criteria showed seven times higher risk of suicide attempts within 4-8 weeks post-discharge and more frequent suicidal ideation than non-SCS patients (Yaseen et al., 2019). Another follow-up study found that patients reporting both SCS and suicidal ideation had significantly higher one-month incidence of suicidal behavior than those

reporting only ideation or neither (Rogers et al., 2022). Entrapment and cognitive decontrol emerged as the strongest predictors, while social withdrawal showed weaker predictive power (Bloch-Elkouby et al., 2021). Laboratory research by Calati et al. (2020) proposed hypotheses for SCS biomarkers based on existing suicide-related markers: entrapment may relate to hypothalamic-pituitary-adrenal axis dysfunction and corticotropin-releasing hormone/cortisol dysregulation; affective disturbance may involve altered dopaminergic circuits in reward/anti-reward systems and endogenous opioid function; cognitive decontrol may reflect altered cognitive-neural functions in executive function, attention, and decision-making; social withdrawal may relate to available oxytocin levels.

SCS systematically incorporates short-term predictors of suicide, providing a reference framework for assessment and diagnosis that concisely describes the acute psychological process preceding suicidal behavior. Its key advantage lies in assessing suicide risk without relying on patients' self-reported suicidal intent, potentially improving accuracy when patients deny or conceal suicidal ideation during mental status examinations.

Table 3 Diagnostic Criteria for Suicide Crisis Syndrome

A. Entrapment (an urgent desire to escape from a situation perceived as intolerable and inescapable)

B. Associated Features (must include at least one item from each category)

a. Affective Disturbance (at least one of the following): - Rapid emotional oscillation (rapid escalation of negative emotions or intense emotional fluctuations within short timeframes) - Severe anxiety (extreme worry, agitation, and catastrophic expectations, possibly with dissociation or sensory disturbances) - Acute anhedonia (new or worsened inability to experience or anticipate interest or pleasure) - Psychological pain (intense unpleasant negative emotions characterized by anguish, fragmentation, and woundedness)

b. Cognitive Decontrol (at least one of the following): - Rumination (intense or persistent thinking about one's distress and its causes) - Cognitive rigidity (inability to deviate from repetitive negative thought patterns, dismissing any solutions other than suicide) - Thought suppression failure (repeated unsuccessful attempts to suppress negative or disturbing thoughts) - Rumination flooding (more intense form of rumination involving overwhelming flood of negative thoughts with head pressure or pain)

c. Hyperarousal (at least one of the following): - Agitation (feeling restless or tense) - Hypervigilance (increased perception of and sensitivity to potential danger) - Irritability (excessive emotional reactions to ordinary or minor stimuli such as annoyance, impatience, anger) - Insomnia (difficulty falling and/or staying asleep)

d. Social Withdrawal (at least one of the following): - Social isolation (withdrawing or narrowing social activities) - Communication avoidance (avoiding contact

with close others)

3.3 Acute Suicidal Affective Disturbance

Based on clinical experience, the ideation-to-action framework, and empirical risk factor research, Joiner et al. (2016) proposed acute suicidal affective disturbance (ASAD) to describe and evaluate acute suicide risk. ASAD is conceptualized as a time-limited acute suicidal state independent of major depressive disorder, bipolar disorder, or substance use (Tucker et al., 2016). ASAD diagnostic criteria comprise four components (see Table 4). Criterion A specifies the characteristic of rapidly intensifying suicidal intent within hours or days, operationalized as the strength of desire to cause death through self-injurious behavior. Criterion B involves negative cognitions or behaviors toward others and/or self. Criterion C reflects hopelessness about the possibility of improvement in Criteria A and B. Criterion D emphasizes multiple hyperarousal symptoms including agitation, irritability, insomnia, and nightmares. ASAD diagnosis requires meeting all Criteria A-D.

Clinical research has developed the unidimensional Acute Suicidal Affective Disturbance Inventory (ASADI) (Tucker et al., 2016). ASADI total scores predict suicide attempt history and effectively differentiate multiple attempters, single attempters, and non-attempters, as well as attempters, ideators, and non-ideators. Additionally, ASAD mediates relationships between distal risk factors and suicide. Depressive and social anxiety symptoms relate to suicide risk indirectly through ASAD (Buckner et al., 2020), and negative cognitive styles (including brooding, reflection, and anxiety sensitivity cognitive concerns) and suicide rumination relate to lifetime suicide attempts indirectly through ASAD (Rogers, Tucker, et al., 2019; Rogers & Joiner, 2018). These findings support ASAD's validity as a proximal risk factor structure. Studies examining relationships with other mental disorders support ASAD as a distinct suicide syndrome (Oh et al., 2022; Rogers, Chiurliza, et al., 2017). For example, network analysis revealed that ASAD symptom clusters differ from anxiety and depression clusters and show strong internal connectivity (Rogers, Hom, et al., 2019). ASAD and borderline personality disorder represent distinct yet highly correlated structures with overlapping symptoms (Jeon et al., 2022).

Table 4 Diagnostic Criteria for Acute Suicidal Affective Disturbance

A. Rapid increase in suicidal intent within hours or days (rather than weeks or months)
B. Marked social disconnection (e.g., social withdrawal, aversion to others, perceiving oneself as a burden) and/or self-disconnection (e.g., self-aversion, perceiving one's psychological pain as a burden)
C. Perception that the conditions in A and B are hopeless and unchangeable
D. Two or more hyperarousal symptoms (e.g., agitation, irritability, insomnia, nightmares)

Note: Symptoms occurring within the past week meet criteria for current episode

ASAD provides an alternative perspective for understanding acute suicidal states and offers a potential framework for suicide diagnosis. Through its four criteria, ASAD effectively captures rapid changes in suicidal intent, negative cognitive and emotional responses, and physical hyperarousal symptoms (Rogers & Joiner, 2018), helping clinicians identify and evaluate suicide risk levels and providing more targeted intervention guidance.

3.4 Summary

SBD, SCS, and ASAD all aim to facilitate suicide risk assessment and prediction, yet they differ in important ways. SBD represents a lifetime risk diagnosis designed to identify suicide attempts occurring within the past two years. SCS and ASAD represent near-term risk diagnoses intended to predict imminent suicidal behavior. The primary distinction between SCS and ASAD concerns the requirement for explicit suicidal intent. ASAD's core feature involves rapid intensification of suicidal intent, requiring explicit suicidal ideation, whereas SCS's core feature is entrapment and does not require explicit intent (Rogers, Galynker, et al., 2017). Network analysis has validated the relationship between ASAD and SCS, revealing a sparse network structure where each is largely independent of the other, with agitation, insomnia, and irritability potentially serving as bridging symptoms (Rogers, Jeon, et al., 2023).

These three proposals provide reference templates for suicide diagnosis development, yet each has limitations. First, clinical feature descriptions lack clarity, and relationships among symptoms remain ambiguous. SBD essentially defines suicide attempts without describing phenomenological features, limiting clinical utility (Oliogu & Ruocco, 2024). SCS contains highly similar concepts lacking clear differentiation. For example, rumination and rumination flooding differ only in somatic symptoms, with flooding involving head discomfort, making it appear more like a severe rumination subtype rather than an independent component—a distinction lacking empirical support. Second, symptom combinations create heterogeneity. Both ASAD and SCS diagnostic criteria rely on multiple symptom combinations, resulting in substantial variation among patients meeting criteria. For instance, Patient A might present with entrapment, severe anxiety, rumination, and communication avoidance, while Patient B shows entrapment, psychological pain, cognitive rigidity, and communication avoidance. This heterogeneity increases clinical diagnostic and treatment complexity, yet current frameworks provide no guidance for managing patients with different symptom profiles. Finally, relationships between suicide symptoms and other mental disorder symptoms remain unclear. Although preliminary evidence suggests suicide diagnoses are distinct from other mental disorders, they share similar symptom presentations (e.g., hyperarousal in manic episodes, dissociation in panic attacks, social withdrawal in personality disorders) (Rogers & Joiner, 2018). Whether these similar symptoms differ in frequency, duration, or underlying mechanisms requires clarification to further delineate diagnostic boundaries.

4.1 Prediction False Negatives

Due to suicide's rarity in the general population and numerous impulsive attempts (Ryan & Oquendo, 2020; Simon et al., 2002), many suicide prediction indicators and models demonstrate suboptimal performance (Large et al., 2022). As a single-symptom model, suicide-specific diagnosis cannot comprehensively consider all individual suicide risk factors, potentially producing false negative results (Berman & Silverman, 2023). Unstable predictive validity may affect clinicians' risk decisions or documentation of lethal outcomes, increasing caution and uncertainty in assessment and intervention, and potentially creating legal liability (Wortzel et al., 2018).

Proponents argue that false negatives have always plagued suicide prediction, particularly when individuals actively conceal or deny suicidal intent, and that suicide diagnosis-based assessment may improve this situation (Obegi, 2021). For example, SCS diagnosis does not require explicit collection of suicide history, resulting in low face validity that patients may more readily accept. Furthermore, suicide diagnoses can enhance understanding of complex psychological dynamics related to suicide, providing more detailed information about associated psychological or behavioral symptoms—crucial for improving precise prediction and enabling timely prevention and intervention.

4.2 Stigma and Labeling

The primary controversy and potential risk of suicide diagnosis in practice concerns possible exacerbation of public stigma and labeling of suicidal individuals. Before dedicated suicide diagnoses existed, suicidal individuals might have been viewed as having other mental disorders. With a specific suicide diagnosis, those meeting criteria would be labeled as "suicide patients" (Wortzel et al., 2018). Research indicates that individuals labeled as suicidal face social rejection, discrimination, and negative bias, inducing loneliness, helplessness, and psychological distress, while also affecting treatment acceptance and effectiveness (Carpiniello & Pinna, 2017).

An alternative perspective suggests that mental disorder stigma primarily stems from misinformation, fear, and uncertainty (Klin & Lemish, 2008). Suicide diagnosis would not exacerbate but rather alleviate stigma (Cohen et al., 2023). By positioning suicide as a phenomenon with clear psychological and behavioral symptoms rather than an anomaly within mental disorders, suicide diagnosis could help suicidal individuals understand and accept their experiences while promoting public scientific understanding of suicide, reducing fear and misinformation. Clear, treatable suicide diagnoses may also increase patients' willingness to disclose suicidal thoughts to clinicians and enhance motivation to seek professional help (Cohen et al., 2023).

4.3 Oversimplification

Incorporating suicide as a separate diagnosis in mental disorder classification systems may imply a directional view that suicide is merely a disease. As noted, suicide results from multiple factors closely linked to political, social, cultural, and economic contexts (Stack, 2021), with varying understandings and attitudes across countries and regions. Viewing suicide as a mental disorder may cause neglect of its complexity within specific cultural and social contexts, oversimplifying understanding and leading to over-medicalization of suicidal individuals (Berman & Silverman, 2023).

Proponents argue that establishing a standalone diagnosis actually emphasizes suicide's complexity and uniqueness, directing researcher attention to suicide phenomena and promoting public understanding (American Psychiatric Association, 2013). Moreover, a suicide diagnosis does not preclude consideration of other contributing factors. Rather, it complements current diagnostic systems by systematically integrating multiple suicide-related factors and symptom presentations, helping clinicians implement more targeted interventions.

Future Directions

Suicide diagnoses help clinicians assess and intervene in suicide risk by identifying clinical features and precipitating factors of suicide crises, thereby preventing suicidal events. However, existing proposals remain immature, and future research must address four critical areas to establish validity, reliability, and clinical utility.

First, refine diagnostic criteria. Suicidal behavior exists along a continuous spectrum, with various behaviors and subtypes contributing differentially to risk (杨丽, 侯祥庆, 刘海玲, 2021). SBD should consider incorporating subtypes of suicide attempts and other categories of suicidal behavior, such as pre-suicide attempts and/or suicidal ideation, to better align with a syndrome model. ASAD and SCS were developed based on empirical research on proximal risk factors. As additional factors demonstrate associations with imminent risk—such as significant weight loss, clinicians' emotional reactions to patients, and recent psychiatric hospital discharge (Chu et al., 2015; Olfson et al., 2016; Yaseen et al., 2017)—ASAD and SCS must incorporate new evidence to develop maximally predictive diagnostic criteria for proximal suicide risk.

Second, clarify relationships with existing mental disorders. Future research must more deeply examine mechanisms underlying differences and similarities between suicide symptoms and other mental disorder symptoms to clarify their psychopathological relationships. Interdisciplinary research integrating neuroscience and physiology is particularly urgent. Neuroimaging and electrophysiological technologies can elucidate suicide's genetic and neural representations, identify unique genetic markers or neural mechanisms, provide clearer biological evidence, and establish more explicit differential diagnostic criteria.

Third, conduct longitudinal follow-up studies with diverse samples. Existing research relies on homogeneous samples and primarily cross-sectional designs. SBD, SCS, and ASAD studies have focused mainly on adult psychiatric inpatients and outpatients, making symptom presentation and stability inevitably influenced by comorbid disorders or pharmacological treatment. For example, one study found poor structural stability of ASAD in an eating disorder sample (Velkoff et al., 2023). Future research should expand samples and emphasize non-clinical populations (e.g., adolescents, older adults) to comprehensively understand applicability and effectiveness across age groups, cultural backgrounds, and social contexts. Additionally, cross-sectional designs cannot illuminate onset and developmental mechanisms, particularly for SCS and ASAD designed to predict acute risk. Although SCS has made progress in follow-up research, prediction variables have been limited to suicidal ideation and attempts (Berman & Silverman, 2023). Future studies should incorporate additional suicide types to strengthen evidence for predictive validity.

Fourth, develop comprehensive assessment tools. SBD lacks corresponding measures, preventing severity standardization. ASAD has only self-report instruments, with research focusing on lifetime version (ASADI-L) validation while current version (ASADI-C) psychometric properties require examination. SCS has both self-report and clinician-rated tools, but the self-report version does not cover all diagnostic criteria, lacking items for communication avoidance. Development of mature assessment tools and establishment of cutoff values will facilitate diagnostic validation and implementation.

Conclusion

The proposal of suicide-specific diagnoses reflects developments in suicide research over the past decade and represents an important attempt to advance suicide assessment and prediction toward greater scientific precision. Suicide diagnoses can serve as reference frameworks for clinical suicide risk assessment and as foundations for transdiagnostic suicide algorithms, expanding suicide research beyond single diagnoses or populations and promoting interdisciplinary investigation. However, we must recognize that the challenges facing suicide risk assessment and prediction will not be fully resolved by adding a separate diagnosis, and existing proposals remain distant from clinical implementation. Sustained research and practice are needed to validate and refine suicide diagnoses, enhance predictive efficacy and applicability, and provide more reliable and effective support for clinical suicide prevention work.

References

朱佳鑫, 牛璐, 侯筱菲, 曾梦, 陈腾伟, 李同赫, … 周亮. (2024). 生态瞬时评估应用于自杀研究的可行性评价. 中国临床心理学杂志, 32(1), 46−50+31. https://doi.org/10.16128/j.cnki.1005-3611.2024.01.008.

杜睿, 江光荣. (2015). 自杀行为: 影响因素、理论模型及研究展望. 心理科学进展, 23(8),

1437−1452. https://doi.org/10.3724/SP.J.1042.2015.01437

杨丽, 侯祥庆, 刘海玲. (2021). 自杀行为筛查问卷的编制和信效度检验. 中国临床心理学杂志, 29(06), 1175−1181. https://doi.org/10.16128/j.cnki.1005-3611.2021.06.011.

肖水源. (2019). 自杀行为研究中的若干问题. 中华疾病控制杂志, 23(11), 1334−1337. https://doi.org/10.16462/j.cnki.zhjbkz.2019.11.007

肖水源. (2001). 自杀危险性的临床评估. 中国医师杂志, 2, 87−90.

Ajdacic-Gross, V., Lauber, C., Baumgartner, M., Malti, T., & Rössler, W. (2009). In-patient suicide—A 13-year assessment. *Psychiatrica Scandinavica, 120*(1), 71−75. https://doi.org/10.1111/j.1600-0447.2009.01380.x

Allsopp, K., Read, J., Corcoran, R., & Kinderman, P. (2019). Heterogeneity in psychiatric diagnostic classification. *Psychiatry Research, 279*, 15−22. https://doi.org/10.1016/j.psychres.2019.07.005

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Andreotti, E. T., Ipuchima, J. R., Cazella, S. C., Beria, P., Bortoncello, C. F., Silveira, R. C., & Ferrão, Y. A. (2020). Instruments to assess suicide risk: A systematic review. *Trends in Psychiatry and Psychotherapy, 42*, 276−281. https://doi.org/10.1590/2237-6089-2019-0092

Bafna, A., Rogers, M. L., & Galynker, I. (2022). Predictive validity and symptom configuration of proposed diagnostic criteria for the suicide crisis syndrome: A replication study. *Journal of Psychiatric Research, 156*, 228−235. https://doi.org/10.1016/j.jpsychires.2022.10.027

Bagge, C. L., Littlefield, A. K., & Glenn, C. R. (2017). Trajectories of affective response as warning signs for suicide attempts: An examination of the 48 hours prior to a recent suicide attempt. *Clinical Psychological Science, 5*(2), 259−271. https://doi.org/10.1177/2167702616681628

Bagge, C. L., Littlefield, A. K., Wiegand, T. J., Hawkins, E., Trim, R. S., Schumacher, J. A., Simons, K., & Conner, K. R. (2023). A controlled examination of acute warning signs for suicide attempts among hospitalized patients. *Psychological Medicine, 53*(7), 2768−2776. https://doi.org/10.1017/S0033291721004712

Berman, A. L., & Silverman, M. M. (2023). A suicide-specific diagnosis – The case against. *Crisis, 44*(3), 183−188. https://doi.org/2023060206554300358

Bertolote, J. M., Fleischmann, A., De Leo, D., & Wasserman, D. (2004). Psychiatric diagnoses and suicide: Revisiting the evidence. *Crisis, 25*(4), 147−155. https://doi.org/10.1027/0227-5910.25.4.147

Bloch-Elkouby, S., Barzilay, S., Gorman, B. S., Lawrence, O. C., Rogers, M. L., Richards, J., Cohen, L. J., Johnson, B. N., & Galynker, I. (2021). The revised suicide crisis inventory (SCI-2): Validation and assessment of prospective

suicidal outcomes at one month follow-up. *Journal of Affective Disorders, 295*, 1280−1291. https://doi.org/10.1016/j.jad.2021.08.048

Bolton, J. M., Gunnell, D., & Turecki, G. (2015). Suicide risk assessment and intervention in people with mental illness. *BMJ, 351*, h4978. https://doi.org/10.1136/bmj.h4978

Bostwick, J. M., Pabbati, C., Geske, J. R., & McKean, A. J. (2016). Suicide attempt as a risk factor for completed suicide: Even more lethal than we knew. *American Journal of Psychiatry, 173*(11), 1094−1100. https://doi.org/10.1176/appi.ajp.2016.15070854

Bryan, C. J., Butner, J. E., May, A. M., Rugo, K. F., Harris, J. A., Oakey, D. N., Rozek, D. C., & Bryan, A. O. (2020). Nonlinear change processes and the emergence of suicidal behavior: A conceptual model based on the fluid vulnerability theory of suicide. *New Ideas in Psychology, 57*, 100758. https://doi.org/10.1016/j.newideapsych.2019.100758

Buckner, J. D., Lewis, E. M., & Tucker, R. P. (2020). Mental health problems and suicide risk: The impact of acute suicidal affective disturbance. *Archives of Suicide Research, 24*(Suppl.1), 303−313. https://doi.org/10.1080/13811118.2019.1574688

Calati, R., Nemeroff, C. B., Lopez-Castroman, J., Cohen, L. J., & Galynker, I. (2020). Candidate biomarkers of suicide crisis syndrome: What to test next? A concept paper. *International Journal of Neuropsychopharmacology, 23*(3), 192−205. https://doi.org/10.1093/ijnp/pyz063

Campos, A. I., Van Velzen, L. S., Veltman, D. J., Pozzi, E., Ambrogi, S., Ballard, E. D., … Rentería, M. (2023). Concurrent validity and reliability of suicide risk assessment instruments: A meta-analysis of 20 instruments across 27 international cohorts. *Neuropsychology, 37*(3), 315−329. https://doi.org/10.1037/neu0000850

Carpiniello, B., & Pinna, F. (2017). The Reciprocal Relationship between Suicidality and Stigma. *Frontiers in Psychiatry, 8*, 35. https://doi.org/10.3389/fpsyt.2017.00035

Cavanagh, J. T. O., Carson, A. J., Sharpe, M., & Lawrie, S. M. (2003). Psychological autopsy studies of suicide: systematic review. *Psychological Medicine, 33*(3), 395−405. https://doi.org/10.1017/S0033291702006943

Chu, C., Klein, K. M., Buchman-Schmitt, J. M., Hom, M. A., Hagan, C. R., & Joiner, T. E. (2015). Routinized assessment of suicide risk in clinical practice: An empirically informed update. *Journal of Clinical Psychology, 71*(12), 1186−1200. https://doi.org/10.1002/jclp.22210

Cohen, L. J., Imbastaro, B., Peterkin, D., Bloch-Elkouby, S., Wolfe, A., & Galynker, I. (2023). A suicide-specific diagnosis. *Crisis, 44*(3), 175−182. https://doi.org/2023060206554300358

Conner, K. R., Kearns, J. C., & Denneson, L. M. (2022). Qualitative analysis of hospital patient narratives of warning signs on the day

of their suicide attempt. *General Hospital Psychiatry, 79*, 146−151. https://doi.org/10.1016/j.genhosppsych.2022.11.001

Ducasse, D., Lopez-Castroman, J., Dassa, D., Brand-Arpon, V., Dupuy-Maurin, K., Lacourt, L., Guillaume, S., Courtet, P., & Olié, E. (2020). Exploring the boundaries between borderline personality disorder and suicidal behavior disorder. *European Archives of Psychiatry and Clinical Neuroscience, 270*(8), 959−967. https://doi.org/10.1007/s00406-019-00980-8

Duval, F., Mokrani, M.-C., Danila, V., Lopera, F. G., Erb, A., & Tomsa, M. (2023). Hypothalamic-prolactin axis regulation in major depressed patients with suicidal behavior. *Psychoneuroendocrinology, 151*, 106050. https://doi.org/10.1016/j.psyneuen.2023.106050

Fehling, K. B., & Selby, E. A. (2021). Suicide in DSM-5: Current evidence for the proposed suicide behavior disorder and other possible improvements. *Frontiers in Psychiatry, 11*, 499980. https://doi.org/10.3389/fpsyt.2020.499980

Feighner, J. P., Robins, E., Guze, S. B., Woodruff, R. A., Jr., Winokur, G., & Munoz, R. (1972). Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry, 26*(1), 57−63. https://doi.org/10.1001/archpsyc.1972.01750190059011

Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., … Nock, M. K. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological Bulletin, 143*(2), 187−232. https://doi.org/10/f9vhxg

Galynker, I., Yaseen, Z. S., Cohen, A., Benhamou, O., Hawes, M., & Briggs, J. (2017). Prediction of suicidal behavior in high-risk psychiatric patients using an assessment of acute suicidal state: The suicide crisis inventory. *Depression and Anxiety, 34*(2), 147−158. https://doi.org/10.1002/da.22559

Glenn, C. R., & Nock, M. K. (2014). Improving the short-term prediction of suicidal behavior. *American Journal of Preventive Medicine, 47*(Suppl.2), S176−180. https://doi.org/10.1016/j.amepre.2014.06.004

Groschwitz, R. C., Kaess, M., Fischer, G., Ameis, N., Schulze, U. M. E., Brunner, R., … Plener, P. L. (2015). The association of non-suicidal self-injury and suicidal behavior according to DSM-5 in adolescent psychiatric inpatients. *Psychiatry Research, 228*(3), 454−461. https://doi.org/10.1016/j.psychres.2015.06.019

Isometsä, E. T. (2001). Psychological autopsy studies – A review. *European Psychiatry, 16*(7), 379−385. https://doi.org/10.1016/S0924-9338(01)00594-6

Jeon, M. E., Gomez, M. M., Stewart, R. A., & Joiner, T. (2022). Acute suicidal affective disturbance and borderline personality disorder symptoms: Distinct yet correlated constructs. *Journal of Affective Disorders, 325*, 62−72. https://doi.org/10.1016/j.jad.2022.12.131

Johnston, J. N., Campbell, D., Caruncho, H. J., Henter, I. D., Ballard, E.

D., & Zarate Jr, C. A. (2022). Suicide biomarkers to predict risk, classify diagnostic subtypes, and identify novel therapeutic targets: 5 years of promising research. *International Journal of Neuropsychopharmacology, 25*(3), 197−214. https://doi.org/10.1093/ijnp/pyab083

Joiner, T. E., Simpson, S., Rogers, M. L., Stanley, I. H., & Galynker, I. (2018). Whether called acute suicidal affective disturbance or suicide crisis syndrome, a suicide-specific diagnosis would enhance clinical care, increase patient safety, and mitigate clinician liability. *Journal of Psychiatric Practice, 24*(4), 274−278. https://doi.org/10.1097/pra.0000000000000315

Klin, A., & Lemish, D. (2008). Mental disorders stigma in the media: Review of studies on production, content, and influences. *Journal of Health Communication, 13*(5), 434−449. https://doi.org/10.1080/10810730802198813

Large, M., Soper, C. A., & Ryan, C. (2022). Suicide risk assessment. *The Lancet Psychiatry, 9*, 938−939. https://doi.org/10.1016/S2215-0366(22)00314-5

Lasisi, M. D., Nuhu, F. T., Adebayo, F., Eseigbe, E. E., & Sheikh, T. L. (2022). Spectrum and predictors of suicidal risk among incarcerated youth in a correctional facility in Kaduna, Northern Nigeria. *Vulnerable Children and Youth Studies, 17*(2), 147−158. https://doi.org/10.1080/17450128.2021.1990456

Maung, H. H. (2022). Mental disorder and suicide: What's the connection? *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine, 47*(3), 345−367. https://doi.org/10.1093/jmp/jhab015

Menon, V., Bafna, A. R., Rogers, M. L., Richards, J., & Galynker, I. (2022). Factor structure and validity of the revised suicide crisis inventory (SCI-2) among Indian adults. *Asian Journal of Psychiatry, 73*, 103119. https://doi.org/10.1016/j.ajp.2022.103119

Moitra, M., Santomauro, D., Degenhardt, L., Collins, P. Y., Whiteford, H., Vos, T., & Ferrari, A. (2021). Estimating the risk of suicide associated with mental disorders: A systematic review and meta-regression analysis. *Journal of Psychiatric Research, 137*, 242−249. https://doi.org/10.1016/j.jpsychires.2021.02.053

Mortensen, P. B., Agerbo, E., Erikson, T., Qin, P., & Westergaard-Nielsen, N. (2000). Psychiatric illness and risk factors for suicide in Denmark. *Lancet, 355*(9197), 9−12. https://doi.org/10.1016/s0140-6736(99)06376-x

Obegi, J. H. (2021). Is suicidality a mental disorder? Applying DSM-5 guidelines for new diagnoses. *Death Studies, 45*(8), 638−650. https://doi.org/10.1080/07481187.2019.1671546

O'Connor, R. C., & Kirtley, O. J. (2018). The integrated motivational–volitional model of suicidal behaviour. *Philosophical Transactions of the Royal Society B: Biological Sciences, 373*(1754), 20170268. https://doi.org/10/gdwppk

Oh, Y., Lee, S., Rogers, M. L., & You, S. (2022). Assessment of acute and non-acute suicide crisis symptoms: Validation of the Korean version of the acute

suicidal affective disturbance inventory. *Frontiers in Psychology, 13*, 1034130. https://doi.org/10.3389/fpsyg.2022.1034130

Olfson, M., Wall, M., Wang, S., Crystal, S., Liu, S.-M., Gerhard, T., & Blanco, C. (2016). Short-term suicide risk after psychiatric hospital discharge. *JAMA Psychiatry, 73*(11), 1119−1126. https://doi.org/10.1001/jamapsychiatry.2016.2035

Oliogu, E., & Ruocco, A. C. (2024). DSM-5 suicidal behavior disorder: A systematic review of research on clinical utility, diagnostic boundaries, measures, pathophysiology and interventions. *Frontiers in Psychiatry, 15*, e1278230. https://doi.org/10.3389/fpsyt.2024.1278230

Oquendo, M. A., & Baca-Garcia, E. (2014). Suicidal behavior disorder as a diagnostic entity in the DSM-5 classification system: Advantages outweigh limitations. *World Psychiatry, 13*(2), 128−130. https://doi.org/10.1002/wps.20116

Oquendo, M. A., Baca-García, E., Mann, J. J., & Giner, J. (2008). Issues for DSM-V: Suicidal behavior as a separate diagnosis on a separate axis. *The American Journal of Psychiatry, 165*(11), 1383−1384. https://doi.org/10.1176/appi.ajp.2008.08020281

Oquendo, M. A., & Bernanke, J. A. (2017). Suicide risk assessment: Tools and challenges. *World Psychiatry, 16*(1), 28−29. https://doi.org/10.1002/wps.20396

Osváth, P. (2023). Recent approaches in suicide research. The psychology and neurobiology of the pre-suicidal state. *Psychiatria Hungarica, 38*(1), 17−27.

Park, J. Y., Rogers, M. L., Bloch-Elkouby, S., Richards, J. A., Lee, S., Galynker, I., & You, S. (2023). Factor structure and validation of the revised suicide crisis inventory in a Korean population. *Psychiatry Investigation, 20*(2), 162−173. https://doi.org/10.30773/pi.2022.0208

Phillips, M. R. (2010). Rethinking the role of mental illness in suicide. *American Journal of Psychiatry, 167*(7), 731−733. https://doi.org/10.1176/appi.ajp.2010.10040589

Phillips, M. R., Yang, G., Zhang, Y., Wang, L., Ji, H., & Zhou, M. (2002). Risk factors for suicide in China: A national case-control psychological autopsy study. *Lancet, 360*(9347), 1728−1736. https://doi.org/10.1016/S0140-6736(02)11681-3

Prabhakar, D., Peterson, E. L., Hu, Y., Chawa, S., Rossom, R. C., Lynch, F. L., … Ahmedani, B. K. (2021). Serious suicide attempts and risk of suicide death. *Crisis, 42*(5), 343−350. https://doi.org/2021091603424600735

Regehr, C., Paterson, J., Sewell, K., Birze, A., Bogo, M., Fallon, B., & Regehr, G. (2022). Tolerating risk: Professional judgment in suicide risk assessment. *Social Service Review, 96*(1), 4−33. https://doi.org/10.1086/718580

Rogers, M. L., Bafna, A., & Galynker, I. (2022). Comparative clinical utility of screening for suicide crisis syndrome versus suicidal ideation in relation to suicidal ideation and attempts at one-month follow-up. *Suicide and Life-Threatening Behavior, 52*(5), 866−875. https://doi.org/10.1111/sltb.12870

Rogers, M. L., Chiurliza, B., Hagan, C. R., Tzoneva, M., Hames, J. L., Michaels, M. S., … Joiner, T. E. (2017). Acute suicidal affective disturbance: Factorial structure and initial validation across psychiatric outpatient and inpatient samples. *Journal of Affective Disorders, 211*, 1−11. https://doi.org/10.1016/j.jad.2016.12.057

Rogers, M. L., Galynker, I., Yaseen, Z., DeFazio, K., & Joiner, T. E. (2017). An overview and comparison of two proposed suicide-specific diagnoses: Acute suicidal affective disturbance and suicide crisis syndrome. *Psychiatric Annals, 47*(8), 416−420. https://doi.org/10.3928/00485713-20170630-01

Rogers, M. L., Hom, M. A., & Joiner, T. E. (2019). Differentiating acute suicidal affective disturbance (ASAD) from anxiety and depression symptoms: A network analysis. *Journal of Affective Disorders, 250*, 333−340. https://doi.org/10.1016/j.jad.2019.03.005

Rogers, M. L., Jeon, M. E., Zheng, S., Richards, J. A., Joiner, T., & Galynker, I. (2023). Two sides of the same coin? Empirical examination of two proposed characterizations of acute suicidal crises: Suicide crisis syndrome and acute suicidal affective disturbance. *Journal of Psychiatric Research, 162*, 123−131. https://doi.org/10.1016/j.jpsychires.2023.05.001

Rogers, M. L., & Joiner, T. E. (2018). Lifetime acute suicidal affective disturbance symptoms account for the link between suicide-specific rumination and lifetime past suicide attempts. *Journal of Affective Disorders, 235*, 428−433. https://doi.org/10.1016/j.jad.2018.04.023

Rogers, M. L., McMullen, L., Liang, Y., Perez, N., Richards, J. A., Akülker, G., & Galynker, I. (2023). Cross-national presence and sociodemographic correlates of the suicide crisis syndrome. *Journal of Affective Disorders, 329*, 1−8. https://doi.org/10.1016/j.jad.2023.02.076

Rogers, M. L., Tucker, R. P., Law, K. C., Bauer, B. W., Smith, C. E., Capron, D. W., … Joiner, T. E. (2019). The relationship between negative cognitive styles and lifetime suicide attempts is indirect through lifetime acute suicidal affective disturbance symptoms. *Cognitive Therapy and Research, 43*(2), 354−364. https://doi.org/10.1007/s10608-018-9968-8

Rudd, M. D. (2006). Fluid vulnerability theory: A cognitive approach to understanding the process of acute and chronic suicide risk. In T. E. Ellis (Ed.), *Cognition and suicide: Theory, research, and therapy* (pp. 355−368). American Psychological Association.

Runeson, B., Odeberg, J., Pettersson, A., Edbom, T., Adamsson, I. J., & Waern, M. (2017). Instruments for the assessment of suicide risk: A systematic review evaluating the certainty of the evidence. *PLOS ONE, 12*(7), e0180292. https://doi.org/10.1371/journal.pone.0180292

Ryan, E. P., & Oquendo, M. A. (2020). Suicide risk assessment and prevention: Challenges and opportunities. *Focus: The Journal of Lifelong Learning in*

Psychiatry, 18(2), 88—99. https://doi.org/10.1176/appi.focus.20200011

Schuck, A., Calati, R., Barzilay, S., Bloch-Elkouby, S., & Galynker, I. (2019). Suicide crisis syndrome: A review of supporting evidence for a new suicide-specific diagnosis. *Behavioral Sciences & the Law, 37*(3), 223—239. https://doi.org/10.1002/bsl.2397

Sedano-Capdevila, A., Porras-Segovia, A., Bello, H. J., Baca-García, E., & Barrigon, M. L. (2021). Use of ecological momentary assessment to study suicidal thoughts and behavior: A systematic review. *Current Psychiatry Reports, 23*(7), 41. https://doi.org/10.1007/s11920-021-01255-7

Simon, T. R., Swann, A. C., Powell, K. E., Potter, L. B., Kresnow, M., & O'Carroll, P. W. (2002). Characteristics of impulsive suicide attempts and attempters. *Suicide and Life-Threatening Behavior, 32*(Suppl.1), 49—59. https://doi.org/10.1521/suli.32.1.5.49.24212

Song, I. M., Joung, Y.-S., Kim, B.-U., Lee, H., Cha, J. Y., Jang, C. W., & Ahn, B. M. (2022). Clinical and psychosocial characteristics related to self-harm in adolescent admitted to psychiatric wards in Korea: A retrospective chart review. *Journal of the Korean Medical Association, 65*(11), 758—770. https://doi.org/10.5124/jkma.2022.65.11.758

Stack, S. (2021). Contributing factors to suicide: Political, social, cultural and economic. *Preventive Medicine, 152*, 106498. https://doi.org/10.1016/j.ypmed.2021.106498

Stone, D. M., Simon, T. R., Fowler, K. A., Kegler, S. R., Yuan, K., Holland, K. M., … Crosby, A. E. (2018). Vital Signs: Trends in State Suicide Rates - United States, 1999-2016 and Circumstances Contributing to Suicide - 27 States, 2015. *MMWR. Morbidity and Mortality Weekly Report, 67*(22), 617–624. https://doi.org/10.15585/mmwr.mm6722a1

Tucker, R. P., Michaels, M. S., Rogers, M. L., Wingate, L. R., & Joiner, T. E. (2016). Construct validity of a proposed new diagnostic entity: Acute suicidal affective disturbance (ASAD). *Journal of Affective Disorders, 189*, 365—378. https://doi.org/10.1016/j.jad.2015.07.049

Turecki, G., Brent, D. A., Gunnell, D., O'Connor, R. C., Oquendo, M. A., Pirkis, J., & Stanley, B. H. (2019). Suicide and suicide risk. *Nature Reviews Disease Primers, 5*(1). https://doi.org/10.1038/s41572-019-0121-0

Underwood, M., Kassir, S., Bakalian, M., Galfalvy, H., Dwork, A., Mann, J., & Arango, V. (2018). Serotonin receptors and suicide, major depression, alcohol use disorder and reported early life adversity. *Translational Psychiatry, 8*, 279. https://doi.org/10.1038/s41398-018-0309-1

Velkoff, E. A., Brown, T. A., Kaye, W. H., & Wierenga, C. E. (2023). Confirmatory factor analysis of acute suicidal affective disturbance in a sample of treatment-seeking eating disorder patients. *Journal of Affective Disorders, 326*, 155—162. https://doi.org/10.1016/j.jad.2023.01.089

Voros, V., Tenyi, T., Nagy, A., Fekete, S., & Osvath, P. (2021). Crisis concept re-loaded? The recently described suicide-specific syndromes may help to better understand suicidal behavior and assess imminent suicide risk more effectively. *Frontiers in Psychiatry*. https://doi.org/10.3389/fpsyt.2021.598923

Williams, J. H. (2001). *Suicide and attempted suicide: Understanding the cry of pain*. Penguin.

World Health Organization. (2014). *Preventing suicide: A global imperative*. Retrieved April 17, 2024, from https://www.who.int/publications/i/item/9789241564779

World Health Organization. (2021). *Suicide worldwide in 2019: Global health estimates*. Retrieved April 17, 2024, from https://www.who.int/publications/i/item/9789240026643

Wortzel, H. S., Nazem, S., Bahraini, N. H., Matarazzo, B. B., & Silverman, M. M. (2018). The potential perils of a suicide-specific diagnosis. *Journal of Psychiatric Practice, 24*(5), 354–358. https://doi.org/10.1097/PRA.0000000000000333

Wu, C. Y., Lee, M. B., Rogers, M. L., Chan, C. T., Chen, C. Y., Richards, J., & Galynker, I. (2022). A validation study of the Taiwanese suicide crisis inventory version 2 to detect suicidality in an online population survey. *Journal of Suicidology, 17*(2), 124–133. https://doi.org/10.30126/JoS.202206_{17}(2).0004

Xu, Y. E., Barron, D. A., Sudol, K., Zisook, S., & Oquendo, M. A. (2023). Suicidal behavior across a broad range of psychiatric disorders. *Molecular Psychiatry, 28*(7), 2764–2810. https://doi.org/10.1038/s41380-022-01935-7

Yaseen, Z., Katz, C., Johnson, M., Eisenberg, D., Cohen, L., & Galynker, I. (2010). Construct development: The suicide trigger scale (STS-2), a measure of a hypothesized suicide trigger state. *BMC Psychiatry, 10*, 110. https://doi.org/10.1186/1471-244X-10-110

Yaseen, Z. S., Galynker, I., Cohen, L. J., & Briggs, J. (2017). Clinicians' conflicting emotional responses to high suicide-risk patients-association with short-term suicide behaviors: A prospective pilot study. *Comprehensive Psychiatry*. https://doi.org/10.1016/j.comppsych.2017.03.013

Yaseen, Z. S., Gilmer, E., Modi, J., Cohen, L. J., & Galynker, I. (2012). Emergency room validation of the revised suicide trigger scale (STS-3): A measure of a hypothesized suicide trigger state. *PLOS ONE, 7*(9), e45157. https://doi.org/10.1371/journal.pone.0045157

Yaseen, Z. S., Hawes, M., Barzilay, S., & Galynker, I. (2019). Predictive validity of proposed diagnostic criteria for the suicide crisis syndrome: An acute presuicidal state. *Suicide and Life-Threatening Behavior, 49*(4), 1124–1135. https://doi.org/10.1111/sltb.12495

Note: Figure translations are in progress. See original paper for figures.