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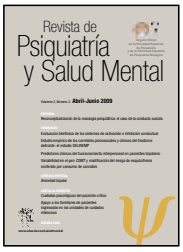

EDITORIAL

Reconceptualizing psychiatric nosology: the case of suicidal behavior

Reconceptualización de la nosología psiquiátrica: el caso de la conducta suicida

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Suicide claims approximately one million lives annually worldwide,[1] resulting in an estimated 20 million years of healthy life lost through premature death or disability (DALYs).[2] For each suicide death, there are an estimated 8-25 non-fatal suicide attempts,[3] with considerable variation by age group, for example in the US,[4,5] reported ratios of non-fatal attempt to suicide in adolescents are up to 87:1 and in adults over 65 years of age only 4:1. Based on national epidemiological data, it was estimated that in the US in 2003 there were approximately 500/100 000 suicide attempts per year, a ratio of approximately 50:1 attempts to suicides.[6]

Suicidal behavior (death and attempts) is most often a complication of psychiatric conditions with over 90% of those who die by suicide having a psychiatric illness,[7] with mood disorders representing 60%of all cases.[8] Suicide attempt rates are also elevated among individuals with psychiatric disorders, with rates of 29%in bipolar disorder, 16% in major depressive disorder,[9] 16-29% in alcohol use disorders,[10-13] and 23-30% in psychotic disorders,[14,15] compared to 2.7%reported in general population surveys.[7] Anxiety disorders[16] and personality disorders[17] are also associated with increased risk for suicidal behavior. Comorbidity of psychiatric conditions also increases risk for suicidal behavior. A recent analysis of NCS data found that while depression was most strongly associated with the onset of suicidal ideation, it was the presence of other disorders related to impulse control (substance disorder, conduct disorder) and anxiety/agitation (e.g. PTSD) that were most strongly associated with progression from ideation to attempt.[18] Approximately 10%of individuals who die by or attempt suicide have no identifiable psychiatric illness.[8]

Given the close association of psychiatric disorders and suicidal behavior and the seriousness of the outcomes, identification and assessment of suicide-related thoughts or behaviors should be an integral element of clinical practice. However, in the current DSM IV diagnostic nosology suicidal behavior is considered only in the context of a symptom of major depressive episode (MDE) or of borderline personality disorder (BPD). As a consequence, evaluation and assessment instruments used in clinical settings that are derived from this nosology such as the mental status examination are far from optimally designed to detect suicidal risk. During assessment, clinicians evaluate the principal diagnosis responsible for the chief complaint and use overview questions to identify comorbid conditions. Finding no evidence for MDE or BPD, questions about past suicidal behavior may not be pursued. Thus, current diagnostic algorithms may lead clinicians to overlook suicidal ideation or behavior for example, in post-traumatic stress disorder where patients may contemplate suicide as an escape from their flashbacks, or in alcoholism, where disinhibition during intoxication may render patients less able to resist suicidal thoughts. Such high-risk individuals are prone to non-identification. Moreover, even if MDE of BPD are present, the mental status examination targets the current condition and so patients denying current suicide-related thoughts or behaviors may not be asked about past suicidal

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acts. This also potentially leads to an underestimate of suicide risk as a history of suicidal behavior is the most reliably replicated risk factor for future suicide attempt or completion, whereas expressions of suicide-related thoughts and behaviors wax and wane and may be absent during an interview.[19] Even in situations where suicidal ideation or behavior is identified, clinicians have a situation in which the diagnosis does not highlight suicide risk sufficiently as a focus of clinical concern.

We have recommended that suicidal behavior be considered a separate DSM diagnostic category and documented on a sixth axis. Suicidal behavior meets criteria for diagnostic validity as set forth by Robins et al[20] as well as most of the conditions we treat.[21] This type of approach would permit both categorization and documentation of suicide related behaviors as we have described in Columbia Classification Algorithm of Suicide Assessment C-CASA.[22] That is, non-suicidal self-injury or patients with a history or a suicide attempt, aborted attempt or interrupted attempt would be flagged on this axis facilitating their identification for clinical attention and care.

This proposed solution would address both conceptual and practical issues that attend to the question of the assessment and evaluation of suicide risk in clinical settings. Some might argue that an additional diagnosis or a separate axis is not necessary. For example, suicidal behavior might be conceptualized as an "impulse-control disorder not elsewhere classified". However, we know that it is not always impulsive. In a different vein, were one to situate suicidal behavior in the category of "other conditions that may be a focus of clinical attention", it would be relegated to a minor position within the diagnostic hierarchy, out of step with the severity of potential consequences of suicidal behavior. Another proposed approach has been to add an extra modifying digit to primary DSM IV diagnosis in the manner that severity and recurrence are indicated. While this has some nosological merit, it is impractical in a clinical context, as the numbering system of DSM diagnoses is arcane and little used. Moreover, such an approach once again buries very important clinical information as an adjunct to diagnosis and fails to give it appropriate emphasis.

Establishing suicidal behavior as a separate category on a sixth axis, would mean that in addition to inquiry during the MDE and BPD sections of the mental status examination, suicidal behavior would be systematically assessed and identified through a review of systems questions. Practically, establishing an axis, rather than a diagnostic category, for suicidal acts will compel the development of clinical and administrative structures for the determination of suicide risk status for individuals assessed in psychiatric settings. In this manner, its presence can be documented a part of a multi-axial diagnosis, giving it the prominence that it deserves in written reports and treatment planning for vulnerable patients.

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