

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

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Separate research groups have independently argued the need for a suicide-specific diagnosis within the psychiatric diagnostic nomenclature. Although a suicide-specific diagnosis could possibly enhance clinical care and improve patient safety, some clinicians have expressed concerns regarding the legal risk of utilizing a suicide-specific diagnosis. In this column, the first of a 2-part series exploring the potential risks and benefits of a suicide-specific diagnosis, the authors draw from their decades of experience in clinical work, legal consulting, as well as the litigation of suicide and wrongful death lawsuits and contend that the bona fide use of a suicide-specific diagnosis would mitigate legal liability to clinicians.

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Increased efforts to address suicide have unfortunately yielded modest results, especially when it comes to decreasing the frequency of death by suicide. Clearly, continued efforts to identify new and improved methods for recognizing and mitigating suicide risk are needed. The clinical and scientific challenges inherent in treating and investigating suicide warrant novel approaches to a public health issue of paramount importance. The implementation of suicide-specific diagnoses has been proposed as one possible way to address this problem. In this special 2-part series, the proposed merits and potential unintended consequences of such diagnoses will be explored. Despite differing perspectives on these issues, the exchange which

follows represents a joint effort to advance the dialogue about suicide and to promote innovation.

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A patient is admitted to inpatient psychiatry, plainly psychotic, and receives a diagnosis of schizophrenia. A course of antipsychotic medications in combination with nonpharmacological treatments is administered with, over several days, good effect. Throughout hospitalization, suicide risk and symptoms of depression are regularly and competently assessed, and at no time were they deemed to be clinically significant. Nine days postadmission, the patient is discharged with a standard discharge plan, including some safety planning and a scheduled appointment with a social worker within 2 weeks of discharge. Approximately 12 hours post-discharge, suicidal ideation with lethal intent (as shown by the patient's communications to others) develops and escalates rapidly, culminating in the patient's death by suicide.

In pondering this case, several questions arise: was care adequate? What might have prevented this tragedy? What is the legal risk to the clinicians and/or hospital should they be sued? On the one hand, the care was, by definition, unsuccessful, considering the catastrophic outcome. Yet in another sense, care was as good as or better than usual, and it could be

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persuasively argued that the standard of care was met (eg, frequent and competent suicide risk assessment; aggressive and largely successful pharmacological and psychological treatments targeting the primary condition; a standard discharge plan with safety elements included). To the degree that the standard was met, legal risk is mitigated by a proportionate degree. But what, then, might have averted this disaster? In reply, what might have saved this patient is an anticipation of the possibility of a sudden surge of suicidal ideation with lethal suicide intent, and the implications thereof for postcare clinical activities, especially including a caring clinical contact within hours of discharge and detailed safety planning for the hours postdischarge.

To return to the case history, as noted above, the suicide risk assessment was handled reasonably well throughout hospitalization. The most thorough version of suicide risk assessment occurred at intake, and the notes from that intake assessment indicated that ~3 years before admission, the patient attempted suicide. Beyond noting its occurrence, the attempt is not further characterized, although the notes do state that this attempt was the patient's only reported lifetime attempt. In fact, records of the past attempt did exist; the patient visited the emergency room at another hospital after the suicide attempt. Those records revealed several characteristics of the attempt: that it occurred in the context of an abrupt change of residence, that its onset seemed very sudden, and that the intensity of the suicidal ideation and intent escalated rapidly, accompanied by marked agitation, irritability, a flood of ruminative thoughts of past failures and the absence of a future, feelings of being trapped in an unbearable life situation with no possibility of escape, and explicit statements of self-hatred.

Had the parameters of the past suicide attempt been foremost in the minds of discharge clinicians, discharge planning might have proceeded differently, in such a way that this patient's suicide might have been prevented. We have made the case elsewhere^{1,2} and will reiterate the point here that inclusion in the psychiatric nomenclature of a clinical syndrome associated with imminent risk of suicide would clarify discharge planning, improve safety planning, and thus mitigate legal liability for clinicians.³ Moreover, it would spur scientific research on the entity, improving our knowledge of its predictors, characteristics, and outcomes, thus further refining clinical care of at-risk

patients. The specific purpose of this column is to discuss how a suicide-specific diagnosis could enhance patient safety and to highlight how a bona fide use of the diagnosis could mitigate clinician legal liability.

RESEARCH ON SUICIDE-SPECIFIC DIAGNOSES

Researchers and clinicians alike have advocated for the inclusion of a clinical entity that specifically captures suicidality.³ In the contemporary edition of the gold standard classification system for mental disorders, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), a suicide-specific diagnosis was included as a condition for further study: suicidal behavior disorder (SBD).⁴ Per the proposed diagnostic criteria, SBD would be assigned to individuals who have made a suicide attempt within the past 2 years. Although knowledge of past suicidal behavior is clinically informative, SBD is limited in that it neither provides information regarding when an individual will go on to make a suicide attempt, nor does it provide information on symptoms that co-occur with acute-onset suicidal crises. Namely, SBD ignores one's current suicide risk by neglecting to include short-term risk factors or warning signs that may signal imminent suicide risk. Furthermore, given the substantially elevated suicide risk often present in the hours, days, and weeks postdischarge from an inpatient setting,⁵ there is a need to better characterize acuity within a suicide-specific entity.

Two potential suicide-specific diagnostic entities that meet these criteria have been independently proposed (Table 1): acute suicidal affective disturbance (ASAD) and suicide crisis syndrome (SCS). Readers are referred to Rogers et al⁶ for an in-depth overview and comparison of the 2 proposed conditions. Briefly, both disturbances reflect acute, rapidly increasing symptoms that precede suicidal behavior; moreover, each syndrome contains similar symptom domains (eg, overarousal, hopelessness, social withdrawal), although with differing emphasis placed on each symptom domain. Research has supported the factor structure, validity, and reliability of both ASAD¹ and SCS²; importantly, both ASAD and SCS are distinct from already-defined mood pathology. Together, the evidence suggests that a suicide-specific diagnosis—whether it is called ASAD or SCS—improves the characterization of suicidal crises and further enhances patient safety in the ability to predict suicide risk above and beyond other risk factors for suicide.

TABLE 1. Proposed Diagnostic Criteria for Acute Suicidal Affective Disturbance (ASAD) and Suicide Crisis Syndrome (SCS)

ASAD*	SCS†
<p>A. A drastic increase in suicidal intent over the course of hours or days, as opposed to weeks or months</p> <p>B. One (or both) of the following: marked social alienation (eg, social withdrawal, disgust with others, perceptions that one is a liability on others) and/or self-alienation (eg, self-hatred, perceptions that one's psychological pain is a burden)</p> <p>C. Perceptions that one's suicidality, social alienation, and self-alienation are hopelessly unchangeable</p> <p>D. Two (or more) manifestations of overarousal (ie, agitation, irritability, insomnia, nightmares)</p>	<p>A. Persistent or recurring feeling of entrapment and urgency to escape or avoid a perceived inescapable and unavoidable life situation. Although death may appear as the only escape, explicit suicidal ideation need not be (though may be) present</p> <p>B. Affective, behavioral, and cognitive changes associated with the experience of entrapment, including at least 1 item from a to d:</p> <p>a. Affective disturbance, as manifested by (1) emotional pain; (2) rapid spikes of negative emotions or extreme mood swings; (3) extreme anxiety that may be accompanied by dissociation or sensory disturbances; and/or (4) acute anhedonia (ie, a new or increased inability to experience interest or pleasure or imagine future experience of interest or pleasure)</p> <p>b. Loss of cognitive control, as manifested by (1) intense or persistent rumination about one's own distress and the life events that brought on distress; (2) an inability to deviate from a repetitive negative pattern of thought (cognitive rigidity); (3) an experience of an overwhelming profusion of negative thoughts, impairing ability to process information or make a decision (ruminative flood/cognitive overload); and/or (4) repeated unsuccessful attempts to suppress negative or disturbing thoughts</p> <p>c. Disturbance in arousal, as manifested by agitation, hypervigilance, irritability, and/or global insomnia</p> <p>d. Social withdrawal, as manifested by (1) withdrawal from or reduction in scope of social activity; and/or (2) evasive communication with close others</p>

Readers are referred to Rogers et al⁶ for an in-depth discussion of both ASAD and SCS.

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LEGAL CONSIDERATIONS FOR SUICIDE MALPRACTICE

Anecdotally, there exists some concern among clinicians that, despite the scientific support for the need for a suicide-specific diagnosis within the diagnostic

nomenclature, whether ASAD, SCS, or another entity, its use in clinical practice will be hampered due to concerns about attendant legal liabilities. On the basis of combined decades of experience in clinical work, legal consulting, as well as the litigation of suicide and wrongful death lawsuits, we contend that

a suicide-specific diagnosis—when based on sound empirical evidence and utilized routinely bona fide—need not carry any concerns regarding legal culpability. On the contrary, the bona fide utilization of a suicide-specific diagnosis would clarify discharge planning and improve safety planning, thus mitigating legal liability for clinicians. Indeed, the rigorous, routine, and scientifically backed assessment and management of suicide risk is the clinician's most reliable protector of patient safety and mitigator of legal liability. An in-depth overview of the standard of care for the detection, assessment, and management of suicide risk is beyond the scope of the present effort; however, we offer the reader gold standard accounts of the standard of care regarding the assessment and management of suicide risk.^{7,8}

With regard to enhancing discharge planning, to take one example, suicide risk is potentiated in the immediate period following discharge from inpatient psychiatry.⁵ A suicide-specific diagnosis, such as ASAD or SCS, would signal to the treating clinician that extra supports, such as safety planning,⁹ would need to be provided—and perhaps at a greater frequency. The documentation of a diagnosis that reflects acute suicidality would also allow for a common language between the inpatient treatment team and outpatient treatment providers, signaling the need for increased vigilance regarding the assessment and monitoring of symptoms that comprise those diagnoses. If a clinician rigorously assesses for, monitors, administers proportionate treatment, and coordinates the provision of adequate follow-up services, the clinician is operating at the standard of care for the assessment and management of suicide risk. Good clinical care combined with good documentation is the surest way to avoid being a defendant in a malpractice action. When a lawyer initially reviews a potential case, all he or she typically has are the medical records. He or she is looking for a well-documented chart reflecting careful and thoughtful suicide assessments, a formulation of risk, and a plan to protect the patient from that risk. The inclusion of a suicide-specific diagnosis within the DSM would indicate to a lawyer that the clinician has actually considered suicide as a possible outcome and is appropriately addressing an intervention to prevent this outcome. Including a suicide-specific diagnosis can only help a clinician to avoid a malpractice suit by showing that at least the clinician considered the

issue. If the suicide-specific diagnosis is absent, that fact does not change the analysis of the potential case. We emphasize, however, that although documentation of actions taken is immensely important, additional considerations regarding patient safety are paramount.

Regarding further enhancing patient safety, it is interesting to ponder the intersection of regulatory bodies focused on patient safety and the need for a suicide-specific diagnosis. Patient safety is routinely monitored by The Joint Commission (JC), which is among the largest health care accreditation bodies in the United States. A sentinel event is defined by the JC as “a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following: Death; Permanent harm; Severe temporary harm”.¹⁰ One reviewable sentinel event is the “[s]uicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)”.¹⁰ Of the suicide-related sentinel events reported by hospitals to the JC, root cause analyses have revealed that ~80% are due to improper assessments.¹¹ The provision of a suicide-specific diagnosis, we argue, could aid in assessment efforts, and in turn, it could enhance patient safety.

We return to considerations regarding legal culpability. Importantly, we—one of us an attorney whose legal practice almost exclusively focuses on suicide and wrongful death due to medical malpractice, and 2 of us (a licensed clinical psychologist and board-certified psychiatrist) who regularly consult on legal matters regarding suicide—are unaware of any lawsuits related to the provisional DSM-5 diagnosis of SBD. This fact is potentially important as it highlights that the only existing suicide-specific diagnosis in the gold standard diagnostic nomenclature, however, fraught in its limited characterization of acute suicidal crises (cf., ASAD, SCS), has presumably not been used in suicide or wrongful death litigation when the diagnosis—or its constituents (ie, documentation of past suicide attempts)—are appropriately applied. (It is also possible that the proposed diagnosis is not used at all—indeed, DSM-5⁴ explicitly states that conditions for further study “are not intended for clinical use”^(p783)—which would also explain why we are aware of no lawsuits related to the use of the diagnosis).

Generally, to state a cause of action for medical malpractice, a plaintiff must allege facts that establish the breach of a legally recognized duty (standard of care) or obligation of the defendant health care provider that is causally connected to actual damages suffered by the plaintiff. For example, the duties of psychiatric inpatient staff include providing a safe environment of care, a competent systematic suicide risk assessment, proper staff training, proper communication, availability of information, continuity of care, effective leadership, correct observation levels, and procedural compliance—all patient safety rules. If those rules are broken causing patient harm, there is medical malpractice. The plaintiff proves the duty and breach elements by showing that the defendant's act or omission fell below the standard of care and, therefore, increased the risk of harm to the plaintiff. As Oquendo and Baca-Garcia³ state, "Instead of increasing liability, embracing suicidal behavior as a distinct disorder may enhance our ability to communicate during hand-offs and to maintain focus on it as a significant clinical concern". As we have outlined above, if clinicians fail to recognize risk factors and warning signs for suicide (cf., fail to adequately conduct a differential diagnosis in the case of bipolar disorder), they place themselves at increased risk of a medical malpractice lawsuit. By contrast, if a clinician detects suicide risk and rigorously assesses risk according to the standard of care, her or his risk of medical malpractice claims is proportionately mitigated. A suicide-specific diagnosis is a conduit to mitigating this liability.³

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