



# Suicide: A Transdiagnostic Phenomenon

Mark A. Schechter, MD; and Mark J. Goldblatt, MD

**S**uicide is a transdiagnostic phenomenon. All major disorders are associated with suicide risk,<sup>1</sup> and suicide is often thought about as a product of mental illness. However, evidence from psychological autopsy studies showing that approximately 90% of suicide decedents had a (retrospectively) diagnosable psychiatric illness may be overstated.<sup>2</sup> The most recent data from the Centers for Disease Control and Prevention revealed that 54% of suicide decedents were not known to have had a mental health condition of any kind.<sup>3</sup> Although some of these people might have undiagnosed mental illness at the time of death, suicide prevention strategies must include

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Mark A. Schechter, MD, is the Chair of Psychiatry, North Shore Medical Center; and an Instructor in Psychiatry, Harvard Medical School. Mark J. Goldblatt, MD, is an Associate Professor of Psychiatry, Harvard Medical School; and a Clinical Associate, McLean Hospital.

Address correspondence to Mark A. Schechter, MD, North Shore Medical Center, 81 Highland Avenue, Salem, MA 01970; email: mschechter@partners.org.

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attention to other possible reasons for vulnerability to suicidal states.

Most theories about suicide focus on the patient's subjective need to escape from an unbearable emotional experience of psychic pain that feels inescapable, and a perception of suicide as the only way out.<sup>4,5-7</sup> Various terms have been used to describe this experience, such as "anguish,"<sup>5</sup> "desperation,"<sup>8</sup> "mental pain,"<sup>9</sup> "psychache,"<sup>10</sup> and "entrapment,"<sup>4,6</sup> all of which speak to unbearable subjective distress that feels interminable and can lead to suicidal behavior. Mental illness is clearly an important risk factor for suicide, and specific characteristics of each illness contribute to this heightened risk (eg, depressive ruminations, severe anxiety, paranoid delusions). Understanding suicide risk by diagnosis can help to guide efforts at prevention and treatment. In this issue of *Psychiatric Annals*, we have four articles on major categories of psychiatric illnesses that are associated with suicide; each delineates risks associated with the disorder and offers important guidance on strategies for suicide prevention.

In the first article, "Management of Suicidality with Borderline and Narcissistic Features," Dr. Brandon T. Unruh uses the "lens of personality disorder" to demonstrate the value of understanding patterns of psychological vulnerabilities that can lead to states of unbearable emotional distress. He describes the

sensitivity of patients with borderline personality disorder to real or perceived disruptions in interpersonal relationships, and the vulnerability of patients with narcissistic personality disorder to threats to self-esteem. These dynamics are also often vulnerabilities in many who do meet criteria for these diagnostic categories. Dr. Unruh offers the model of Good Psychiatric Management to guide interventions that help to decrease risk of self-harm by helping patients to manage suicidal states and to feel more interpersonally connected.

In the second article, "Suicide in Schizophrenia Spectrum Disorders," Drs. Abigail L. Donovan, Julia Browne, Oliver Freudenreich, and Cori Cather emphasize that patients are at high risk for suicide at the onset of illness, prior to diagnosis and treatment. They also describe the increased risk with prolonged duration of psychosis. Psychotic disorders tend to have their onset in adolescence and emerging adulthood, with a potentially devastating impact on the young person's developmental trajectory. Early detection and therapeutic engagement, with specific attention to the psychological and developmental impact of the illness, are critical to suicide prevention.

In the next article, "Suicide Risk in Mixed States: Clinical and Preventive Perspectives," Drs. Alberto Forte, Benedetta Montalbani, Martina

Mastrangelo, Gaia Anibaldi, Gabriele Pasquale De Luca, Benedetta Imbastaro, and Maurizio Pompili discuss the heightened risk for suicide in mixed affective states. They emphasize the heightened risk in people who have mania with depressive symptoms, especially those with anxiety, irritability, and agitation, and make an important link between this experience and the unbearable, inescapable mental/emotional pain that has long been considered the core aspect of the suicidal state. Improving the recognition and treatment of these states is important in decreasing risk of suicide.

In the final article, “Suicide and Substance Use Disorder,” Dr. Hilary S. Connery, Francesca M. Korte, and Dr. R. Kathryn McHugh underscore the often underrecognized fact that having a substance use disorder (SUD) is an independent and modifiable risk factor for suicide. They emphasize that the risk may be higher than it first appears because overdose deaths by suicide are undercounted by standard medical examiner practices. Suicidal contemplation is not binary (“yes/no”) but occurs on a continuum, and the risk of opioid deaths influenced by suicidal thinking is probably higher than reported. In addition, alcohol and other substances can cause behavioral disinhibition and increase risk of impulsive self-destructiveness, and opioids are potentially lethal. The current approach to suicide risk assessment in emergency departments can carry an implicit bias that risk related to SUDs is a choice, whereas that related to a mental

health condition is more likely illness related. Patients with severe SUDs may be particularly vulnerable to psychological states of desperation and disconnection that increase suicide risk. Understanding the risk conferred by SUD even in the absence of apparent psychiatric illness will help inform suicide risk assessment. In addition, active treatment of SUDs (eg, motivational interviewing, medication assisted treatment, connection with recovery coaches and outpatient care) is an important suicide prevention strategy.

Suicide transcends diagnostic categorization. Consideration of suicide prevention within psychiatric diagnostic categories can help clinicians to identify and modify diagnosis-specific vulnerabilities and thereby decrease suicide risk. Attention to the psychological and developmental impact of psychiatric illness is essential to treatment. Active engagement in treatment, with efforts to alleviate subjectively experienced unbearable emotional states, can help to mitigate suicide risk across all categories of mental illness.

REFERENCES

1. Harris EC, Barraclough B. Suicide as an outcome for mental disorders. A meta-analysis. *Br J Psychiatry.* 1997;170(3):205-228. <https://doi.org/10.1192/bjp.170.3.205> PMID:9229027
2. Hjelmeland H, Dieserud G, Dyregrov K, Knizek BL, Leenaars AA. Psychological autopsy studies as diagnostic tools: are they methodologically flawed? *Death Stud.* 2012;36(7):605-626. <https://doi.org/10.1080/07481187.2011.584015> PMID:24563941

3. Stone DM, Simon TR, Fowler KA, et al. Vital signs: trends in state suicide rates - United States, 1999-2016 and circumstances contributing to suicide - 27 states, 2015. *MMWR Morb Mortal Wkly Rep.* 2018;67(22):617-624. <https://doi.org/10.15585/mmwr.mm6722a1> PMID:29879094
4. O'Connor RC. Suicidal behavior as a cry of pain: test of a psychological model. *Arch Suicide Res.* 2003;7(4):297-308. <https://doi.org/10.1080/713848941>
5. Maltzberger JT. The descent into suicide. *Int J Psychoanal.* 2004;85(Pt 3):653-667. <https://doi.org/10.1516/3C96-URET-TLWX-6LWU> PMID:15228702
6. Galynker I. *The Suicidal Crisis: Clinical Guide to the Assessment of Imminent Suicide Risk.* Oxford, United Kingdom: Oxford University Press; 2017. <https://doi.org/10.1093/med/9780190260859.001.0001>
7. Klonsky ED, May AM. The three-step theory (3ST): a new theory of suicide rooted in the “ideation-to-action” framework. *Int J Cogn Ther.* 2015;8(2):114-129. <https://doi.org/10.1521/ijct.2015.8.2.114>
8. Hendin H, Haas AP, Maltzberger JT, Koestner B, Szanto K. Problems in psychotherapy with suicidal patients. *Am J Psychiatry.* 2006;163(1):67-72. <https://doi.org/10.1176/appi.ajp.163.1.67> PMID:16390891
9. Orbach I, Mikulincer M, Gilboa-Schechtman E, Sirota P. Mental pain and its relationship to suicidality and life meaning. *Suicide Life Threat Behav.* 2003;33(3):231-241. <https://doi.org/10.1521/suli.33.3.231.23213> PMID:14582834
10. Shneidman ES. Suicide as psychache. *J Nerv Ment Dis.* 1993;181(3):145-147. <https://doi.org/10.1097/00005053-199303000-00001> PMID:8445372