Addressing Acute Suicidality: A Paradigm Shift in Suicide Prevention and Public Health Practices

Christina Walker & Alexis Alltop
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Please feel free to email us with any questions, suggestions, or reflections from this presentation:

Christina Walker: cwalker@healthiercolorado.org

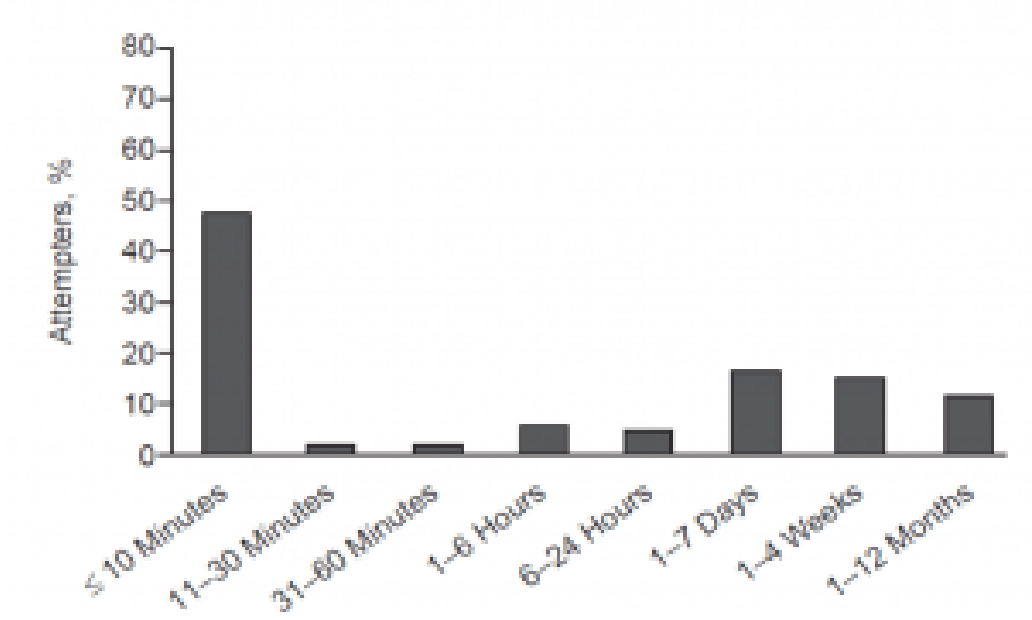
Alexis Alltop: aalltop@healthiercolorado.org

Suicide: "A death caused by self-injury, where the intention is to die" (CDC, 2022a)	**Suicidal Ideation:** "Thoughts, ideas, or ruminations about the possibility of ending one's life" (ICD-11) "Thinking about, considering or planning suicide." (U.S. CDC)	**Suicide Attempt/ Suicidal Bevahiors:** "when people harm themselves with the intent of ending their life" (NIMH-Suicide Prevention)
Suicide decedent: a person who dies by suicide.	**Suicidality:** "the risk of suicide, usually indicated by suicidal ideation or intent to commit suicide, especially as evident in the presence of a well-elaborated plan (APA).	**Suicidal Intent:** "A clear desire and plan to commit suicide" (DSM-5) Suicide intent can escalate and de-escalate rapidly

Exploring assumptions about suicide & suicidality:

1. Suicide is a result of one or more mental health conditions
2. If a mental health condition is adequately treated, an individual will not escalate to the point of suicidality.
3. The progression from suicidal ideation to suicidal behaviors occur in a linear fashion, and if a mental health condition has progressed to the point of suicidality, there are behavioral warning signs that provide time and opportunity for intervention
4. Death by suicide can be prevented as long as someone intervenes when an individual exhibits said behavioral warning signs

Duration of Suicidal Crises:



Graphic: In a 2001 study, 85.5% of people in the hospital following a suicide attempt reported their planning steps took place within 1 week of the attempt, and 66% reported it occurred within 12 hours. (Deisenhammer et al.)

Another study that included interviews with survivors of near-fatal suicide attempts found that **one in four study participants reported contemplating suicide for less than 5-minutes**, with only 13% reporting that they deliberated for 1 or more days (Simon et al, 2001).

A study from the Harvard T.H. Chan School of Public Health, interviewed 153 survivors ages 13-34 of near-lethal suicide attempts and respondents were asked **"How much time passed between the time you decided to complete suicide and when you actually attempted suicide?"** One in four deliberated for less than 5 minutes!"

- 24% said less than 5 minutes
- 24% said 5-19 minutes
- 23% said 20 minutes to 1 hour
- 16% said 2-8 hours
- 13% said 1 or more days

Sources:

- Deisenhammer EA, Ing CM, Strauss R, et al. The duration of the suicidal process: how much time is left for intervention between consideration and accomplishment of a suicide attempt? J Clin Psychiatry. 2009;70(1):19-24.
- Simon, T.R., Swann, A.C., Powell, K.E., Potter, L.B., Kresnow, M., and O'Carroll, P.W. Characteristics of Impulsive Suicide Attempts and Attempters. SLTB. 2001; 32(supp):49-59.
- Harvard T.H. Chan School of Public Health "Means Matter: Duration of Suicidal Crises"

Two Proposed Suicide-specific diagnoses:

Suicidality Affective Disturbances (ASAD)
ASAD describes a "time-limited arousal state" that is "characterized by drastic spikes in suicidality."
The four key features of this proposed diagnosis are:

- (1) "A drastic increase in suicidal intent over the course of hours or days (not weeks or months);
- (2) Marked social alienation (e.g., social withdrawal, perceived liability on others) and/or self-alienation (e.g., self-hatred, perceptions that one's self is an onerous burden);
- (3) Perceptions that the above criteria are hopelessly intractable;
- (4) Two or more manifestations of overarousal (agitation, irritability, insomnia, nightmares)."

These symptoms must be experienced within **hours to days, as opposed to weeks to months**, and cannot be accounted for by other conditions like mood disorders or substance use

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Suicide Crises Syndrome:

- **Proposed criteria for Suicide Crisis Syndrome (SCS) for adults ages 18-80.**
    - **A. Frantic Hopelessness/Entrapment:** The feeling there is an intolerable and unsolvable problem, and there is no solution, leading to a feeling of being trapped with no exit.
    - **B1. Affective disturbance**: experiencing emotional pain, depressive turmoil, panic-dissociation, extreme anxiety and strange sensations; anhedonia/ emotional numbness.
    - **B2: Loss of Cognitive Control**: Overwhelming negative thoughts with head pain or pressure. This can include ruminations, cognitive rigidity, thought suppression, and ruminative flooding.
    - **B3: Disturbances in Arousal:** Irritability and Agitation increase, especially at night.
    - **B4: Social withdrawal.**

Modifiers that increase risk:

- Suicidal ideation (SI): moderator that makes SCS worse, but **SI is not required to be present** for suicide attempts or for a person to meet the criteria for SCS. This is already in the DSM as a modifier
- Suicidal behavior disorder (SBD), which is already included in the DSM as a modifier.
- Acute Suicidal Affective Disturbance (ASAD): Exponential increase in suicidal ideation. This could represent a late stage of SCS and is not yet in DSM as a modifier.

Key Themes:

Theme #1: Sense of Urgency and Opportunity:

- No need to wait until there is a suicide-specific diagnoses in the DSM.
- Participants wanted to find ways to spread the information they learned in the short and long term.
- Ripple effects were sparked by the convening.

Theme #2: Education and Ending the Stigma around Suicidality:

- Existing stigma around mental health conditions and suicide is a major barrier to mainstream acceptance of acute suicidality as a diagnosis.
- Need a comprehensive public awareness and education campaign emphasizing that suicidality can manifest in various forms / degrees of urgency.
- Public awareness around these phenomena could be increased through media, or other public health campaign approaches.
- Awareness building is key, because the acute onset of suicidality is not just impacting people with existing mental illness, and even with protective factors, people can still be at risk for suicidality.

Theme #3: Multifaceted Simultaneous Approach:

- From public health/prevention, early intervention, treatment, medical crisis support, and ongoing recovery, there is a continuum of services and supports that all need to understand suicidality as a mental health condition.
- Attendees also raised the idea that all parts of the continuum could be educated and make changes at the same time.

Seizing the Moment: Recommendations for Research, Practice, and Policy:

Research:

- Utilize the data and research to advocate for a suicide-specific diagnosis, like Suicide Crisis Syndrome and Acute Suicidal Affective Disturbance, to be included in the DSM, International Classification of Diseases (ICD), or other diagnostic tools
- Prioritize additional research around the proposed diagnoses, suicidal crises, and the onset of acute suicidality.
- Partner with clinicians to create new or improve existing screenings, assessments, and interventions

Practice:

- Utilize the proposed diagnostic criteria to train existing clinicians and educate new clinicians through higher education institutions and peer support models
- Create cross-disciplinary educational opportunities
- Health system need to modify current screenings and assessments

Policy:

- Build a public awareness and education campaign.
- Allocate suicide prevention resources at night.
- Host a follow-up convening focused on understanding strengths, gaps, and opportunities to improve policies and systems across the state of Colorado.

Notes: