NIH Public Access
Author Manuscript
Am J Psychiatry. Author manuscript; available in PMC 2013 September 18.

Published in final edited form as:
Am J Psychiatry. 2008 November ; 165(11): 1383–1384. doi:10.1176/appi.ajp.2008.08020281.

Issues for DSM-V: Suicidal Behavior as a Separate Diagnosis on a Separate Axis

MARÍA A. OQUENDO, M.D., **ENRIQUE BACA-GARCÍA, M.D., Ph.D.**, **J. JOHN MANN, M.D.**, and **JOSÉ GINER, M.D., Ph.D.**

Suicidal behavior (death and attempts) is usually a complication of psychiatric conditions, most commonly mood disorders (1). However, it also occurs in schizophrenia, substance use disorders (particularly with alcohol), and personality and anxiety disorders, among others (1). About 10% of those who commit or attempt suicide have no identifiable psychiatric illness. However, our current nomenclature considers suicidal behavior a symptom of major depressive episode or borderline personality disorder.

During assessment, clinicians evaluate the principal diagnosis responsible for the chief complaint and use overview questions to identify comorbid conditions. If no evidence is found for major depressive episode or borderline personality disorder, questions about past suicidal behavior may not be pursued. Since the mental status examination targets the present condition, patients who deny suicidality may not be asked about past suicidal acts, potentially leading to an underestimate of suicide risk. Yet a history of suicidal behavior is the most reliably replicated risk factor for future suicide attempt or completion, whereas expressions of suicidality wax and wane and may be absent during an interview (2). Thus, current diagnostic algorithms may lead clinicians to overlook suicidal ideation or behavior in patients with posttraumatic stress disorder, where patients may contemplate suicide as an escape from their flashbacks, or in those with alcoholism, where disinhibition during intoxication may render patients less able to resist suicidal thoughts. Suicidality in these high-risk groups can easily go unidentified. Even when a clinician identifies suicidal ideation or behavior, the patient receives a diagnosis that does not highlight suicide risk as a focus of concern.

We recommend that suicidal behavior be considered a separate diagnostic category documented on a sixth axis. Suicidal behavior meets the criteria for diagnostic validity set forth by Robins and Guze (3), and it does so as well as most conditions we treat. It is clinically well described (4), research has identified postmortem and in vivo laboratory markers (1), it can be subjected to a strict differential diagnosis (4), follow-up studies confirm its presence at higher rates in those with a past diagnosis (2), and it is familial (5). With suicidal behavior in a sixth axis, it would be identified through review-of-systems questions, in addition to inquiry during the mental status examination.

This proposed solution would address both conceptual and practical issues. Suicidal behavior might be conceptualized as an impulse-control disorder not elsewhere classified, but it is not always impulsive. Classification among "other conditions that may be a focus of clinical attention" diminishes its hierarchical position among diagnoses. Practically, an axis for suicidal acts would compel clinical and administrative structures to determine the suicide risk status of individuals assessed in psychiatric settings. In this manner, suicide risk can be

Address correspondence and reprint requests to Dr. Oquendo, New York State Psychiatric Institute, 1051 Riverside Drive, Box 42, New York, NY 10032; mao4@columbia.edu).

The authors report no competing interests.

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

documented as part of a multiaxial diagnosis, giving it the prominence that it deserves in written reports and treatment planning for vulnerable patients.

Acknowledgments

Supported by NIMH grants MH-59710 and MH-62185; National Institute on Alcohol Abuse and Alcoholism grant AA-15630; Centro de Investigación Biomédica en Red de Salud Mental; and Fondo de Investigacion Sanitaria grants PI050500, PI06/0497, and FIS 01/0077-01.

References

1. Mann JJ. Neurobiology of suicidal behaviour. Nat Rev Neurosci. 2003; 4:819–828. [PubMed: 14523381]
2. Oquendo MA, Currier D, Mann JJ. Prospective studies of suicidal behavior in major depressive and bipolar disorders: what is the evidence for predictive risk factors? Acta Psychiatr Scand. 2006; 114:151–158. [PubMed: 16889585]
3. Robins E, Guze SB. Establishment of diagnostic validity in psychiatric illness: its application to schizophrenia. Am J Psychiatry. 1970; 126:983–987. [PubMed: 5409569]
4. Posner K, Oquendo MA, Gould M, Stanley B, Davies M. Columbia Classification Algorithm of Suicide Assessment (C-CASA): classification of suicidal events in the FDA's pediatric suicidal risk analysis of antidepressants. Am J Psychiatry. 2007; 164:1035–1043. [PubMed: 17606655]
5. Brent DA, Oquendo M, Birmaher B, Greenhill L, Kolko D, Stanley B, Zelazny J, Brodsky B, Bridge J, Ellis S, Salazar JO, Mann JJ. Familial pathways to early-onset suicide attempt: risk for suicidal behavior in offspring of mood-disordered suicide attempters. Arch Gen Psychiatry. 2002; 59:801–807. [PubMed: 12215079]