Suicide Warning Signs in Clinical Practice

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This review discusses suicide warning signs in clinical practice and has three simple goals: 1) to help practitioners differentiate in a clinically meaningful fashion between warning signs and risk factors for suicide; 2) to articulate the link among warning signs for suicide, hopelessness, and intent to die; and 3) to assist practitioners in applying warning signs in day-to-day clinical practice, doing so in a concrete and effective manner.

Introduction
The concept of warning signs in health care is certainly not new. They have been used in the general public health community for many years, effectively targeting high-profile problems such as heart attack, stroke, and diabetes [1,2]. Most, if not all, of us can recite warning signs for heart attack, stroke, or diabetes with some ease and accuracy. Interestingly, the approach only recently has been applied to suicide [3••], despite the fact that it has been an international public health problem for decades. The general goal of warning signs is to improve public recognition and response to targeted problems, thus improving long-term health outcomes. In the case of suicide, the goal is simple and straightforward: increase the overall number of suicidal individuals accessing care and, accordingly, save lives.

Rudd et al. [3••] discussed the outcome of an American Association of Suicidology-sponsored consensus panel on warning signs for suicide, which represented a first effort to clarify the considerable confusion in the public health and clinical practice community about the topic. Although warning signs for suicide are routinely made available to the general public through suicide awareness curricula, materials published by state and federal agencies, and on the Internet, there has been no scientific or clinical scrutiny, oversight, or coordination [4•]. The net result has been a confusing mix of messages, risk factors, related recommendations, and educational campaigns. A study conducted by Mandrusiak et al. [4•] found more than 3000 identifiable suicide warning signs on the Internet, clearly in sharp contrast to the goal of establishing a succinct and effective public health message about suicide risk. Many of the warning signs listed were irrelevant, inaccurate, or woefully wrong. The impact of such public confusion about suicide risk is poorly understood at this point, but at a minimum, it doesn’t help with the provision of appropriate and effective care, much less adequate federal funding to support treatment development and application. The public confusion about warning signs tends to result in funding agencies questioning the utility of funding and scientific study, with the net outcome being benign neglect. A quick review of US federal funding for suicide research reveals the problem. Public confusion raises concerns among those on scientific review and legislative panels as to whether a targeted public health campaign has clear scientific support and credibility.

Differentiating Warning Signs and Risk Factors for Suicide
To provide an adequate foundation, several theoretical issues need to be addressed when exploring the construct of warning signs for suicide. First, we need to differentiate between a sign (something observed by another) and symptom (something reported to another). In contrast to warning signs for heart attack, stroke, and diabetes, warning signs for suicide include signs and symptoms. Symptoms have been the overwhelming focus of clinicians for decades. Second, it is important to recognize that warning signs and risk factors are very different constructs. As a result, they are applied differently in the clinical environment. Given their clear relationship to mental status, warning signs carry disproportionate weight in clinical decision making.

As Rudd [5••] first pointed out, the time frame over which most suicide risk factors are studied has very little clinical relevance, ranging from 1 year to more than 20 years. When managing a patient at risk for suicide, clinicians are worried about decisions over the course of the next few minutes, hours, or days, not years. Accordingly, the hope in identifying suicide warning signs is to nudge investigators to explore variables over clinically relevant and practically meaningful time frames—that is, time periods relevant to the day-to-day clinical context in which high-risk patients are actually evaluated and in which related decisions are made.
An overlap may exist between many identified risk factors and warning signs for suicide. All warning signs for suicide identified to date have been identified previously as risk factors. The literature on suicide risk factors is enormous, targeting a broad range of variables, including historic (or static) variables such as a previous suicide attempt, along with markers of current emotional or psychological functioning [6]. Perhaps the most distinguishing feature of a warning sign for suicide is that it relates to current functioning, with a proximal rather than a distal relationship to suicidal behavior. Warning signs are associated with near-term (minutes to hours to days) risk rather than acute (days to weeks) or longer-term (years) risk. Warning signs help to answer the critical question: what is my patient doing (observable signs) or saying (expressed symptoms) that elevates his or her risk to die by suicide in the next few minutes, hours, or days? This may well be the most important question answered by practicing mental health clinicians. Tragically, alarmingly little is known in the empirical literature about near-term risk. Despite the empirical limitations, the consensus panel identified those variables with the most promise and immediate impact on clinical practice.

Several additional distinctions exist between warning signs and risk factors that warrant mention. As Rudd et al. [3••] previously noted, warning signs can be differentiated from risk factors in accordance with the following features: definitional specificity, empirical foundation, time frame, nature of occurrence (static vs episodic), application context, implications for clinical practice, experiential character, and intended target group. In relation to risk factors, warning signs for suicide have tended to be less well-defined, have less clear or converging empirical support, are associated with near-term risk, and are episodic and variable in nature (ie, they come and go, sometimes rapidly). Similarly, risk factors can be applied individually, but warning signs are only meaningful as a constellation (ie, a collection of signs and symptoms). Risk factors possess an objective quality (eg, a history of previous suicide attempts), whereas warnings signs are observable and subjective (eg, talking or writing about dying by suicide, experience of hopelessness, feeling trapped). Finally, risk factors are geared toward experts—that is, researchers, scientists, and clinicians. Warning signs generally are intended for public consumption and use, with the primary goal of saving lives by improving recognition of those at risk and facilitating referral for professional care.

Rudd et al. [3••] offered the following definition of a suicide warning sign:

“A suicide warning sign is the earliest detectable sign that indicates heightened risk for suicide in the near term (ie, within minutes, hours, or days). A warning sign refers to some feature of the developing outcome of interest (suicide) rather than to a distinct construct (risk factor) that predicts or may be related to suicide."

What is clear from this definition is that warning signs should be associated with adverse events (suicide attempts and death) within very short time periods—time periods with great clinical relevance and impact. Accordingly, all clinicians should be aware of, assess, manage, and respond to suicide warning signs, applying them in rigorous fashion in their daily clinical work. This can be accomplished across a number of fronts, including some modifications to how we think about suicide intent, mental status, and the general construct of risk. Specific recommendations are provided subsequently.

**Warning Signs for Suicide: Expert Consensus**

The expert consensus panel organized by the American Association of Suicidology agreed on two critical points. First, warning signs for suicide need to be understood, presented, and applied in hierarchical fashion, with suicide threats or related behaviors differentiated from other warning signs. More specifically, the consensus panel identified the following observable signs and symptoms as indicating the need for immediate help or attention: someone threatening to hurt or kill himself or herself; someone looking for ways to kill himself or herself; someone seeking access to pills, weapons, or other means; and someone talking or writing about death, dying, or suicide [3••]. Second, clear instructions need to be provided as to what members of the general public need to do when they recognize an individual at risk for suicide. All publicly available materials include directions to call 911; instructions to seek help from a mental health provider; and the national (for the United States) crisis line number, 1-800-273-TALK. Suicide warning signs wallet cards are available at no cost from the Substance Abuse Mental Health Services Administration (http://mentalhealth.samhsa.gov/disasterrelief/publications/allpubs/walletcard/engwalletcard.asp). Also, the consensus panel included the following as warning signs for suicide: hopelessness, rage/anger/seeking revenge, acting reckless or engaging in risky activities seemingly without thinking, feeling trapped (like there’s no way out), increasing alcohol or drug use, withdrawing from family friends/family/society, anxiety/agitation/inability to sleep/sleeping all the time, dramatic mood changes, and no reasons for living/no sense of purpose in life. All of these can be translated seamlessly into existing models for risk assessment in clinical practice.

**Applying Suicide Warning Signs in Clinical Practice: General Guidelines**

Although they are intended for public consumption and use, it is important to recognize the role of suicide warning