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Integrating models of suicidality in Canadian suicidology: A narrative synthesis

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Abstract

Background: Suicide remains a critical public health issue requiring approaches that move beyond static models. Traditional frameworks often operate in isolation, limiting their relevance in high-intensity settings, such as emergency departments (EDs). There is a growing need for integrative models that reflect the fluid and complex nature of suicidality in acute care.

Objective: This narrative synthesis explores how diverse theoretical models can inform emergency nursing practice by framing suicidality as a dynamic and evolving process. The aim is to improve suicide risk assessment through an integrated, clinically relevant approach.

Methods: A narrative synthesis was conducted to examine empirical and conceptual models with demonstrated relevance to emergency mental health. Frameworks included the Suicidal Careers Model, Narrative-Crisis Model, attachment theory, developmental perspectives, gender-based frameworks, and Suicide Crisis Syndrome (SCS). These models were selected for their predictive value, clinical utility, and explanatory power.

Results: Suicidality emerges through the interaction of long-term vulnerabilities and acute crisis states. The integrated framework highlights the roles of insecure attachment, identity disruption, gender-based risk factors, and developmental stage. Special focus is placed on the experiences of gender-diverse individuals, who often fall outside traditional risk models.

Conclusion: A multidimensional, developmentally attuned framework enhances suicide risk detection and intervention in emergency settings. By accounting for identity, relational context, and crisis dynamics, this approach supports more inclusive and effective prevention strategies in frontline care.

Keywords: suicide, emergency nursing, suicidal careers, narrative-crisis model, attachment styles, developmental stages, Canadian suicidology

Introduction

Suicide remains a complex and urgent public health issue in Canada. Although national rates have remained relatively stable over the past two decades, certain populations—particularly youth and Indigenous communities—continue to experience disproportionately high rates (Government of Canada, 2023; World Health Organization, 2023; Zulyniak et al., 2022). Suicide is the second leading cause of death among Canadian youth aged 15–24, emphasizing the need for early, evidence-informed prevention strategies (Bennet et al., 2015; Orri et al., 2020; Skinner et al., 2012).

Emergency departments (EDs) serve as critical access points for individuals in suicidal crisis, especially in rural areas lacking other mental health resources (Cunningham, 2009; Hatcher et al., 2018; Hickman et al., 2018; Kyanko et al., 2022; McCabe et al., 2001). Despite this central role, EDs are often poorly equipped to assess suicidality effectively. Clinicians rely heavily on static tools with limited predictive validity, contributing to inconsistent outcomes and increased strain on healthcare systems (Awan et al., 2022; Carter et al., 2024; Large et al., 2018).

Further complicating care, suicidality is not a formal psychiatric diagnosis. Patients are typically treated for related conditions

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like depression or schizophrenia, which may overlook the core mechanisms of suicidal ideation (D'Arrigo, 2024; McHugh et al., 2019; O'Connor & Nock, 2014; Sanati, 2009; Sher, 2024; Wasserman et al., 2021).

Clinical suicidology remains fragmented, with multiple models used in isolation. This narrative synthesis addresses that gap by framing suicidality as a dynamic process requiring integrated, multidimensional assessment. By combining empirical and theoretical insights, this paper advocates for a more unified, evidence-based approach to risk formulation and intervention (Galynker, 2017; Jobes, 2016; Klonsky et al., 2018).

Background

Traditional approaches to suicide risk assessment have been highly variable, inconsistent, and often ineffective (Belsher et al., 2019; Carter et al., 2017; Large et al., 2018). The widespread reliance on static, actuarial tools—such as the SAD PERSONS Scale, Columbia Suicide Severity Rating Scale (C-SSRS), and other predictive checklists—has proven insufficient for accurately identifying individuals at imminent risk of suicide (Bolton et al., 2015; Mulder et al., 2016; Quinlivan et al., 2017). While these tools offer structured screening measures, their predictive validity remains weak, with many studies demonstrating high false-positive and false-negative rates, leading to unnecessary hospitalizations for some while overlooking those at highest risk (Franklin et al., 2017; McCabe et al., 2018; Ribeiro et al., 2016). Additionally, these one-time assessments fail to account for the fluctuating nature of suicidality, treating risk as a fixed category rather than a dynamic process (Bryan et al., 2020; Galynker, 2017; Jobes & Joiner, 2019).

These models are understood best, not in isolation but, as interdependent frameworks that together provide a more complete picture of suicidality. For instance, while the Suicidal Careers Model (Maris, 2000) explains how suicidality unfolds across time, the Narrative-Crisis Model (Galynker, 2017) explains why a crisis state may suddenly emerge, despite long-term risk factors. This highlights the importance of assessing both chronic and acute risk factors within the same patient encounter. Similarly, attachment theory (Mikulincer & Shaver, 2018) provides insight into long-term relational vulnerabilities that shape help-seeking patterns, while the suicide crisis syndrome (SCS; Galynker, 2023) identifies acute pre-suicidal states that necessitate immediate intervention. By synthesizing these perspectives, emergency nurses can adopt a more flexible and clinically sensitive approach to suicide risk assessment.

Understanding Suicidality as a Dynamic, Evolving Process

The concept of suicidal careers (Maris, 2000) emphasizes that suicidality develops over time, shaped by a combination of acute stressors, trait vulnerabilities, and interpersonal dynamics (Joiner, 2005; Klonsky et al., 2018; Rudd, 2006). Despite this, EDs frequently treat suicidality as an isolated crisis, rather than a process requiring long-term assessment and intervention (Bryan et al., 2020; Carter et al., 2017; McCabe et al., 2018).

The Narrative-Crisis Model (Galynker, 2017) further refines this perspective, suggesting that suicidal states emerge from a profound sense of entrapment, where individuals feel emotionally, psychologically, and socially trapped with no perceived means of escape (Cohen et al., 2024; Goschin et al., 2013; O'Connor & Nock, 2014). This model has strong empirical support, demonstrating predictive utility for acute suicide risk—yet remains largely absent from standard ED risk assessment protocols (Galynker, 2017; McHugh et al., 2019; Ribeiro et al., 2016).

Attachment theory also plays a critical role in understanding suicidality, as early relational experiences shape patterns of emotional regulation, distress tolerance, and help-seeking behaviour (Mikulincer & Shaver, 2018; Bartholomew & Horowitz, 1991). Individuals with insecure attachment styles are significantly more likely to experience chronic suicidality, interpersonal sensitivity, and heightened distress reactivity (Allen et al., 2018; Levi-Belz et al., 2020). However, these developmental risk factors are often overlooked in brief ED encounters, despite their relevance to suicide risk assessment (Bryan et al., 2020; Hames et al., 2018; Jobes, 2016).

Lastly, research highlights clear gender- and culture-based disparities in suicide risk factors, yet most ED assessments fail to incorporate these nuances (Canetto & Sakinofsky, 1998; Kirmayer et al., 2022; Pollock et al., 2018). For example, males are less likely to disclose suicidal thoughts and often experience suicidality through externalized behaviors (e.g., substance use, aggression), while females and gender-diverse individuals may display internalized distress and more frequent, less lethal attempts (Rhodes et al., 2018; Skinner et al., 2022).

Methods

This study employs a narrative synthesis approach to integrate diverse theoretical frameworks on suicidality, offering a cohesive, clinically relevant perspective for emergency nursing in Canada. Narrative synthesis is well-suited to examining complex phenomena like suicidality, where multiple conceptual models provide complementary insights rather than competing explanations.

Peer-reviewed literature published between 2000 and 2023 was reviewed, focusing on models with empirical support and clinical relevance to suicide risk assessment and intervention. Databases searched included PubMed, PsycINFO, CINAHL, and Google Scholar. Models were selected based on their theoretical relevance, empirical validation, and applicability to emergency settings. Frameworks prioritized included the Suicidal Careers Model, Narrative-Crisis Model, attachment theory, developmental perspectives, and SCS. Studies focusing solely on biomedical or pharmacological approaches were excluded.

The synthesis process followed established narrative review guidelines. It involved extracting core theoretical contributions, identifying relationships between frameworks, and contextualizing findings within the Canadian healthcare landscape. Key dimensions—such as identity disruption, relational vulnerability, crisis states, and longitudinal risk—were integrated into a multidimensional conceptual model.

Rather than ranking models, this synthesis emphasizes how each contributes to a broader understanding of suicidality as a dynamic process. The result is a practical framework that supports frontline emergency care by guiding assessment, risk formulation, and intervention planning.

Figure 1 illustrates the structured process of narrative synthesis, outlining key methodological steps—from data sourcing and selection criteria to theoretical integration and final model development—ensuring a cohesive and evidence-based approach to suicidality research.

Conceptualizing Suicidality: An Integrated Framework

Understanding suicidality requires a multidimensional approach that accounts for individual trajectories, crisis states, identity disruptions, relational vulnerabilities, and developmental influences. Traditional models often approach suicide risk in fragmented ways: focusing either on biomedical pathology, social risk factors, or acute symptomatology, while neglecting the interactions between these dimensions (Franklin et al., 2017; Jobes, 2016; O'Connor & Kirtley, 2018). This narrative synthesis integrates key theoretical models to construct a cohesive, clinically applicable framework for suicidality.

Suicidal Careers: Understanding the Evolution of Suicidality

The concept of suicidal careers, introduced by Maris (2000), reframes suicidality as a fluid and evolving process rather than a fixed state. This model challenges static risk categorizations, recognizing that suicidality develops across time through recurrent crises, personal vulnerabilities, and shifting social contexts (Klonsky et al., 2018; Maris, 2002; Rudd, 2006). Unlike traditional models that emphasize short-term suicide prediction, the suicidal careers framework underscores the importance of longitudinal assessment and intervention, acknowledging that individuals move between periods of heightened risk and remission based on stressors, coping resources, and relational factors (Bryan et al., 2020; Large et al., 2018; McHugh et al., 2019).

Figure 1

Narrative Synthesis Methodology Flowchart

Suicidal trajectories often involve cumulative exposure to risk factors, such as early-life adversity, social disconnection, identity threats, and major life transitions, all of which contribute to increased vulnerability over time (Bolton et al., 2015; Sheftall et al., 2016; Turecki et al., 2019). This trajectory-based approach supports the need for continuous, dynamic suicide risk assessments rather than one-time screenings, particularly in emergency settings where individuals may be in different stages of suicidal progression (Carter et al., 2017; Ribeiro et al., 2016).

The Narrative-Crisis Model: Identity Disruptions and Suicidal Entrapment

Building on the suicidal careers framework, the Narrative-Crisis Model (NCM) highlights the role of identity fragmentation, existential distress, and cognitive constriction in the development of suicidality (Bryan et al., 2020; Galynker, 2017; O'Connor & Nock, 2014). This model posits that individuals who experience a loss of coherence in their self-narrative—whether through relational loss, career failure, or perceived social rejection—may enter a state of suicidal entrapment, where death becomes the only perceived resolution (Bloch-Elkouby et al., 2020; Goschin et al., 2013; Millner et al., 2020).

The NCM explains why some individuals transition from chronic suicidal ideation to acute suicidal crises, emphasizing the role of cognitive and affective dysregulation (Joiner, 2005; Klonsky et al., 2018; Ribeiro et al., 2016). In particular, intense rumination, cognitive rigidity, and an inability to envision alternative solutions contribute to a psychological narrowing of perceived choices (Galynker, 2023; Jobes, 2016; O'Connor & Kirtley, 2018). These findings underscore the clinical need for interventions that focus on restoring cognitive flexibility and reworking the suicidal narrative, particularly in emergency mental health contexts where risk assessments must differentiate between chronic and imminent suicidality (Bolton et al., 2015; Bryan et al., 2020; Large et al., 2018).

Attachment and Gender Differences in Suicidality

Attachment theory further informs suicide risk by elucidating how early relational patterns shape vulnerability to distress, emotional regulation, and help-seeking behaviour (Allen et al., 2018; Bartholomew & Horowitz, 1991; Mikulincer & Shaver, 2018). Individuals with insecure attachment styles, particularly anxious-preoccupied and dismissive-avoidant attachment, demonstrate heightened susceptibility to suicidality, as they struggle with intense emotional dysregulation, feelings of abandonment, and difficulty establishing secure relational bonds (Fonagy et al., 2016; Levi-Belz et al., 2020; Sheftall et al., 2016).

Gender differences also influence suicidal behaviour, lethality, and disclosure patterns. Males are less likely to express distress and may externalize suicidality through substance use, aggression, or impulsive acts, while females and gender-diverse individuals are more likely to experience chronic, internalized distress with repetitive non-lethal attempts (Canetto & Sakinofsky, 1998; Rhodes et al., 2018; Skinner & Sogstad, 2022). These differences highlight the need for gender-responsive suicide risk assessments that

account for how distress is expressed across different populations (Carter et al., 2017; Hames et al., 2018; Jobes, 2016).

Developmental Perspectives on Suicidality

Suicide risk varies significantly across the lifespan, with distinct developmental vulnerabilities shaping suicidal behavior at different ages (Erikson, 1950; McHugh et al., 2019; Orri et al., 2020). Children and adolescents are particularly sensitive to identity disruptions, peer rejection, and family conflict, whereas middle-aged adults often struggle with existential concerns, economic instability, or relational breakdowns (Joiner, 2005; Klonsky et al., 2018; McCabe et al., 2018). For older adults, social isolation, chronic illness, and loss of independence become significant suicide risk factors (Bolton et al., 2015; Orri et al., 2020; Turecki et al., 2019). Recognizing these developmental risk patterns is essential for age-sensitive interventions, ensuring that suicide prevention strategies align with the distinct needs and challenges of each life stage (Franklin et al., 2017; Jobes, 2016).

The SCS: Identifying Acute Suicidal States

The SCS refines our understanding of imminent suicide risk, identifying distinctive pre-suicidal states characterized by overwhelming entrapment, loss of cognitive control, hyperarousal, and acute social withdrawal (Galynker, 2017; Galynker, 2023; Ribeiro et al., 2016). This model provides an evidence-based alternative to static risk factors, offering predictive indicators of imminent suicide attempts that can enhance emergency risk assessments (Bryan et al., 2020; Large et al., 2017; Melzer, 2024). Recognizing these acute pre-suicidal states is particularly valuable for emergency nurses, as it enables real-time clinical judgment beyond traditional risk prediction models, improving early intervention and crisis de-escalation (Galynker, 2023; Jobes, 2016; O'Connor & Nock, 2014).

Figure 2 conceptualizes suicidality as a dynamic and evolving process, integrating longitudinal trajectories, identity disruptions, relational influences, developmental vulnerabilities, and acute crisis states to inform a comprehensive, multidimensional approach to suicide risk assessment and intervention.

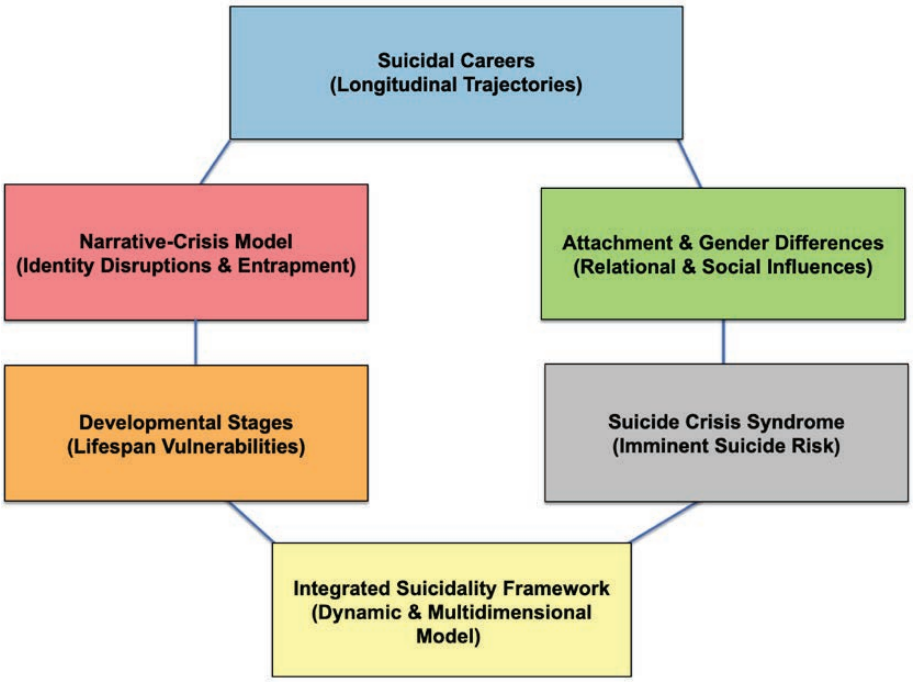
Implications for Emergency Nursing Practice: A Framework for Integrating Suicidality Models in Clinical Care

Emergency departments remain a primary point of contact for individuals experiencing acute suicidal crises, yet suicide risk assessment and management in emergency settings remain fragmented, inconsistent, and often inadequate (McCabe et al., 2018; Rhodes et al., 2018; Savioli et al., 2022). The prevailing reliance on static risk assessment tools—such as the Columbia Suicide Severity Rating Scale (C-SSRS) and the SAD PERSONS scale—fails to account for the fluctuating nature of suicidality, the influence of identity and relational disruptions, and the cognitive-affective markers of imminent suicide risk (Large et al., 2017; Quinlivan et al., 2017; Ribeiro et al., 2016). As a result, emergency nurses face significant challenges in differentiating transient distress from immediate suicide risk, often leading to misclassifications, unnecessary hospitalizations, or missed warning signs (Franklin et al., 2017; O'Connor & Nock, 2014).

This paper's findings suggest that a more comprehensive, integrative approach—one that synthesizes existing suicidology models within a clinically relevant framework—is necessary for improving suicide risk assessment and intervention in emergency nursing. By structuring suicidality assessment through the lenses of longitudinal risk trajectories, acute crisis markers, identity-based distress, relational vulnerabilities, and developmental considerations, this framework offers emergency nurses a

Figure 2

Integrated Suicidality Framework: A Multidimensional Conceptual Model



structured, yet flexible, approach to guide clinical decision-making in high-pressure environments.

Clinical Application Example

A 28-year-old male patient arrives at the ED following a suicide attempt by overdose. The nurse conducts a dynamic risk assessment using an integrated framework. His history of multiple past attempts and childhood trauma aligns with the Suicidal Careers Model (Maris, 2000), suggesting a chronic risk trajectory. However, he also displays intense cognitive rigidity, entrapment, and emotional dysregulation, which are indicators of SCS (Galynker, 2023), signaling an acute, imminent risk. Further exploration reveals a recent breakup and job loss, reflecting a narrative crisis (Galynker, 2017). Applying attachment theory (Mikulincer & Shaver, 2018), the nurse notes an avoidant attachment style, which may pose further risk for non-disclosure of lingering suicidality. This case illustrates how an integrative approach enhances risk detection and allows for more precise intervention.

A Framework for Emergency Suicide Care: Structuring Risk Assessment and Intervention

The application of suicidality models in emergency care requires an approach that is both theoretically grounded and pragmatically structured for use in clinical settings. Based on the key findings of this paper, the following framework provides an organizational structure for assessing and responding to suicidality in emergency nursing practice, integrating five essential dimensions of suicide risk formulation. As summarized in Table 1, an integrated suicide risk assessment framework in emergency nursing highlights longitudinal markers, acute crisis indicators, and individualized safety planning strategies.

1. Establishing a Longitudinal Risk Profile

A patient's suicidal history and trajectory over time offer essential insight into their current risk state and potential future risk. Traditional risk assessments often categorize individuals as low, moderate, or high risk, without considering how suicidality may evolve across different life events (Klonsky et al., 2018; Maris, 2000; Rudd, 2006). In contrast, assessing suicidal careers in emergency settings involves

- evaluating recurrent suicide attempts or chronic ideation to determine whether a patient exhibits persistent suicidality versus an acute, situational crisis (Franklin et al., 2017; McHugh et al., 2019; Ribeiro et al., 2016);
- identifying major life transitions and stressors—such as job loss, relational disruptions, financial instability, or early adulthood transitions—which often increase vulnerability to suicide (Bolton et al., 2015; Orri et al., 2020; Turecki et al., 2019);
- assessing cumulative vulnerabilities, including early trauma, social disconnection, and prior psychiatric hospitalizations, to determine whether an individual is following a trajectory of escalating risk (Jobes, 2016; McCabe et al., 2018; Sheftall et al., 2016).

2. Identifying Markers of Acute Crisis

Many patients in emergency settings experience a short-term suicidal crisis rather than chronic suicidality. The SCS framework provides a clinically validated method for identifying imminent suicide risk, differentiating it from long-term risk factors (Bryan et al., 2020; Galynker, 2017; O'Connor & Nock, 2014). Emergency nurses can improve risk detection by screening for

- cognitive rigidity and ruminative flooding, particularly in patients who report an inability to think about anything other than their current distress or suicide as their only perceived option (Goschin et al., 2013; Klonsky et al., 2018; Ribeiro et al., 2016);
- emotional dysregulation and distress intolerance, which manifests as panic, extreme agitation, or an inability to self-soothe (Franklin et al., 2017; Galynker, 2023; Millner et al., 2020);
- social withdrawal and disengagement, particularly among individuals who suddenly stop communicating with family or express a sense of "giving up" (Bolton et al., 2015; Bryan et al., 2020; McHugh et al., 2019).

3. Assessing Narrative and Identity Disruptions

Many individuals experiencing suicidality describe feeling trapped, hopeless, or like they have lost their sense of self or future. The Narrative-Crisis Model suggests that suicidality often stems from identity disintegration, wherein an individual can no longer see a meaningful path forward (Galynker et al., 2017; Jobes, 2016; O'Connor & Kirtley, 2018). Emergency nurses can apply narrative-based interviewing techniques to explore

- themes of perceived failure and loss, particularly in patients who report shattered life goals or humiliating setbacks (Franklin et al., 2017; Joiner, 2005; Klonsky et al., 2018);
- hopelessness and perceived entrapment, where individuals express a complete lack of alternatives or an overwhelming sense of despair (Bloch-Elkouby et al., 2020 ; Millner et al., 2020; O'Connor & Kirtley, 2018);
- cultural and generational influences, particularly among Indigenous and marginalized populations, where suicide risk is often shaped by historical trauma and social inequities (Kirmayer et al., 2022; Pollock et al., 2018; Skinner & Sogstad, 2022).

4. Incorporating Developmental and Relational Risk Factors

Suicide risk varies across different developmental stages, with distinct age-specific vulnerabilities and attachment-based influences (Erikson, 1950; Orri et al., 2020; Sheftall et al., 2016). Emergency nurses should

- assess attachment styles, as insecure attachment is associated with heightened distress, difficulty seeking support, and increased suicide risk (Bartholomew & Horowitz, 1991; Levi-Belz et al., 2020; Mikulincer & Shaver, 2018);
- tailor suicide interventions based on life stage, considering identity struggles in adolescence, career instability in young adulthood, and existential despair in older adulthood (Bolton et al., 2015; McCabe et al., 2018; Turecki et al., 2019).

5. Implementing Individualized Crisis Interventions and Safety Planning

Integrating these dimensions allows for a patient-centred, flexible approach to suicide intervention in emergency settings.

Emergency nurses can

- use a dynamic risk formulation model, recognizing that suicide risk is not static but fluctuates across life events and crises (Franklin et al., 2017; Jobes, 2016; O'Connor & Nock, 2014);
- develop individualized safety plans, incorporating short-term stabilization techniques alongside long-term coping strategies (Carter et al., 2017; McHugh et al., 2019);
- ensure collaborative discharge planning, preventing premature discharge of high-risk patients and ensuring continued mental health support (Bryan et al., 2020; Jobes, 2016; Quinlivan et al., 2017).

Conclusion

Suicide risk assessment and intervention in emergency nursing require a comprehensive, dynamic approach that moves beyond static risk stratification models. Current tools often fail to capture the fluid, identity-driven, and relational nature of suicidality (Franklin et al., 2017; Galynker, 2017; Jobes, 2016). This paper proposes an integrated clinical framework—drawing on suicidal careers, the Narrative-Crisis Model, developmental perspectives, and attachment theory—that enhances the ability of emergency nurses to identify and respond to suicidality in acute care settings.

The clinical application of suicidality models must reflect the challenges of emergency environments, where time constraints, patient variability, and high-stakes decision-making complicate suicide risk formulation (Bolton et al., 2015; McCabe et al., 2018). Traditional checklist-based tools lack predictive accuracy and often lead to unnecessary hospitalizations or failure to identify acute risk (Franklin et al., 2017; Large et al., 2017).

Table 1

Integrated Suicide Risk Assessment and Intervention Framework for Emergency Nursing

Assessment Dimension	Clinical Focus	Example Questions	Intervention Strategies
Longitudinal Risk Assessment *(Suicidal Careers)*	Identify chronic vs. acute suicidality by assessing past attempts, hospitalizations, and life transitions.	*"Have you experienced suicidal thoughts? How do your current feelings compare to past episodes?"*	Document past risk factors, identify destabilizing events, and assess escalating suicidality (Maris, 2000; Rudd, 2006; Klonsky et al., 2018; Franklin et al., 2017; Turecki et al., 2019).
Markers of Acute Crisis *(SCS)*	Screen for imminent risk, including cognitive rigidity, distress, and social withdrawal.	*"Do you feel trapped? Have you noticed changes in sleep, focus, or emotions?"*	Observe real-time affective dysregulation and use structured assessments (Galynker, 2017; Bryan et al., 2020; Ribeiro et al., 2016; Bolton et al., 2015; O'Connor & Nock, 2014).
Narrative and Identity Disruptions *(Narrative-Crisis Model)*	Explore themes of perceived failure, entrapment, and loss of identity.	*"What has led you to feel this way? What would need to change for things to feel different?"*	Use open-ended questions to reconstruct hope and meaning (Galynker, 2017; Jobes, 2016; O'Connor & Kirtley, 2018; Millner et al., 2020; Klonsky et al., 2018).
Relational and Developmental Risk Factors	Assess attachment styles, family relationships, and age-specific vulnerabilities.	*"How do you typically cope with distress? Who do you turn to for support?"*	Tailor interventions to life stage – specific risk factors (Mikulincer & Shaver, 2018; Sheftall et al., 2016; Erikson, 1950; Bartholomew & Horowitz, 1991; Levi-Belz et al., 2020).
Individualized Crisis Interventions and Safety Planning	Develop safety plans, dynamic risk formulations, and interdisciplinary care strategies.	*"What has helped you manage past crises? What steps can we take now to keep you safe?"*	Create personalized safety plans, ensuring follow-up and multi-disciplinary care (et al., 2017; Bryan et al., 2020; Quinlivan et al., 2017).

Note. SCS = Suicide Crisis Syndrome.

The proposed framework supports emergency nurses in

- differentiating between chronic suicidality and acute crisis to guide level-of-care decisions (Maris, 2000; Rudd, 2006; Klonsky et al., 2018);
- using narrative- and identity-based assessments to explore entrapment, loss of meaning, and disrupted self-concept (Galynker, 2017; O'Connor & Kirtley, 2018; Jobes, 2016);
- incorporating relational and developmental considerations, including attachment style and age-specific risk patterns (Erikson, 1950; Mikulincer & Shaver, 2018; Sheftall et al., 2016);
- personalizing safety planning and discharge strategies, moving beyond generic recommendations (Bryan et al., 2020; Carter et al., 2017).

Implications for Clinical Implementation and Future Research

This framework presents a practical, adaptable structure for improving risk detection, intervention, and patient outcomes. However, further empirical validation is needed. Future research should explore:

- the predictive accuracy of integrated models in emergency settings (Franklin et al., 2017);
- feasibility of implementing identity- and narrative-based assessments in clinical workflows (Galynker, 2017; O'Connor & Nock, 2014);
- the role of emergency nurses in post-discharge continuity of care (Bryan et al., 2020; Quinlivan et al., 2017).

Emergency nurses are often the first point of contact for individuals in suicidal crisis. By adopting a holistic, multidimensional approach—one that considers longitudinal, cognitive, relational, and developmental factors—emergency nursing can move toward a more precise, compassionate, and effective model of suicide prevention.

About the Author

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Conflicts of Interest

None reported.

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REFERENCES

Allen, J. G., Fonagy, P., & Bateman, A. W. (2018). *Mentalizing in clinical practice* (2nd ed.). American Psychiatric Publishing.

Awan, S., Diwan, M. N., Aamir, A., Allahuddin, Z., Irfan, M., Carano, A., Vellante, F., Ventriglio, A., Fornaro, M., Valchera, A., Pettorruso, M., Martinotti, G., Di Giannantonio, M., Ullah, I., & De Berardis, D. (2022). Suicide in healthcare workers: Determinants, challenges, and the impact of COVID-19. *Frontiers in Psychiatry, 12*, 792925. https://doi.org/10.3389/fpsyt.2021.792925

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*(2), 226–244. https://doi.org/10.1037/0022-3514.61.2.226

Belsher, B. E., Smolenski, D. J., Pruitt, L. D., Bush, N. E., Beech, E. H., Workman, D. E., Morgan, R. L., Evatt, D. P., Tucker, J., & Skopp, N. A. (2019). Prediction models for suicide attempts and deaths: A systematic review and simulation. *JAMA Psychiatry*, *76*(6), 642–651. https://doi.org/10.1001/jamapsychiatry.2019.0174

Bennett, K., Rhodes, A. E., Duda, S., Cheung, A. H., Manassis, K., Links, P., Mushquash, C., Braunberger, P., Newton, A. S., Kutcher, S., Bridge, J. A., Santos, R. G., Manion, I. G., McLennan, J. D., Bagnell, A., Lipman, E., Rice, M., & Szatmari, P. (2015). A youth suicide prevention plan for Canada: A systematic review of reviews. *Canadian Journal of Psychiatry, 60*(6), 245–257. https://doi.org/10.1177/070674371506000603

Bloch-Elkouby, S., Gorman, B., Schuck, A., Barzilay, S., Calati, R., Cohen, L. J., Begum, F., & Galynker, I. (2020). The suicide crisis syndrome: A network analysis. *Journal of Counseling Psychology, 67*(5), 595–607. https://doi.org/10.1037/cou0000423

Bolton, J. M., Gunnell, D., & Turecki, G. (2015). Suicide risk assessment and intervention in people with mental illness. *BMJ (Clinical research ed.)*, *351*, h4978. https://doi.org/10.1136/bmj.h4978

Bryan, C. J., Allen, M. H., Wastler, H. M., Bryan, A. O., Baker, J. C., May, A. M., & Thomsen, C. J. (2023). Rapid intensification of suicide risk preceding suicidal behavior among primary care patients. *Suicide and Life-Threatening Behavior, 53*(2), e12948. https://doi.org/10.1111/sltb.12948

Bryan, C. J., Butner, J. E., May, A. M., Rugo, K. F., Harris, J., Oakey, D. N., Rozek, D. C., & Bryan, A. O. (2020). Nonlinear change processes and the emergence of suicidal behavior: A conceptual model based on the fluid vulnerability theory of suicide. *New Ideas in Psychology*, *57*, 10.1016/j.newideapsych.2019.100758. https://doi.org/10.1016/j.newideapsych.2019.100758

Canetto, S. S., & Sakinofsky, I. (1998). The gender paradox in suicide. *Suicide & life-threatening behavior*, *28*(1), 1–23.

Carter, B., Young, S., Ford, K., & Campbell, S. (2024). The concept of child-centred care in healthcare: A scoping review. *Pediatric Reports*, *16*(1), 114–134. https://doi.org/10.3390/pediatric16010012

Carter, G., Milner, A., McGill, K., Pirkis, J., Kapur, N., & Spittal, M. J. (2017). Predicting suicidal behaviours using clinical instruments: Systematic review and meta-analysis of positive predictive values for risk scales. *The British Journal of Psychiatry: The Journal of Mental Science*, *210*(6), 387–395. https://doi.org/10.1192/bjp.bp.116.182717

Cohen, L. J., White, B. J., Miller, F. E., Karsen, E. F., & Galynker, I. I. (2024). Diagnosis of the SCS in the emergency department associated with significant reduction in 3-month readmission rates. *The Journal of Clinical Psychiatry*, *85*(4), 24m15320. https://doi.org/10.4088/JCP.24m15320

Cunningham, P. J. (2009). Beyond parity: Primary care physicians' perspectives on access to mental health care. *Health Affairs,*

28(Suppl 1), w490–w501. https://doi.org/10.1377/hlthaff.28.3.w490

D'Arrigo, T. (2024). One in five who attempt suicide have no prior mental illness. *Psychiatric News, 59*(5). https://doi.org/10.1176/appi.pn.2024.05.5.3

Erikson, E. H. (1950). *Childhood and society.* Norton.

Fonagy, P., Luyten, P., Moulton-Perkins, A., Lee, Y. W., Warren, F., Howard, S., Ghinai, R., Fearon, P., & Lowyck, B. (2016). Development and validation of a self-report measure of mentalizing: The reflective functioning questionnaire. *PloS one, 11(7),* e0158678. *https://doi.org/10.1371/journal.pone.0158678*

Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., Musacchio, K. M., Jaroszewski, A. C., Chang, B. P., & Nock, M. K. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological Bulletin*, *143*(2), 187–232. https://doi.org/10.1037/bul0000084

Galynker, I. (2017). *The suicidal crisis: Clinical guide to the assessment of imminent suicide risk.* Oxford University Press.

Galynker, I. (2023). *The suicidal crisis: Clinical guide to the assessment of imminent suicide risk* (2nd ed.). Oxford University Press. https://doi.org/10.1093/med-psych/9780197582718.001.0001

Goschin, S., Briggs, J., Blanco-Lutzen, S., Cohen, L. J., & Galynker, I. (2013). Parental suicide as a risk factor for suicidal behavior in offspring: A review of the literature. *Journal of Affective Disorders, 151(1),* 1-8.

Government of Canada. (2023). *Suicide mortality in Canada*. Public Health Infobase, Health Canada. https://health-infobase.canada.ca/mental-health/suicide-self-harm/suicide-mortality.html

Gunnell, D., Appleby, L., Arensman, E., Hawton, K., John, A., Kapur, N., Khan, M., O'Connor, R. C., & Pirkis, J. (2020). Suicide risk and prevention during the COVID-19 pandemic. *The Lancet Psychiatry, 7*(6), 468–471. https://doi.org/10.1016/S2215-0366(20)30171-1

Hames, J. L., Rogers, M. L., Silva, C., Ribeiro, J. D., Teale, N. E., & Joiner, T. E. (2018). A social exclusion manipulation interacts with acquired capability for suicide to predict self-aggressive behaviors. *Archives of Suicide Research: Official Journal of the International Academy for Suicide Research*, *22*(1), 32–45. https://doi.org/10.1080/13811118.2017.1304309

Hatcher, S., Whittaker, R., Patton, M., Miles, W. S., Ralph, N., Kercher, K., & Sharon, C. (2018). Web-based therapy plus support by a coach in depressed patients referred to secondary mental health care: Randomized controlled trial. *JMIR Mental Health, 5*(1), e5. https://doi.org/10.2196/mental.8510

Hickman, R., Fitzpatrick, J. J., & Alfes, C. M. (Eds.). (2018). *Handbook of clinical nursing: Critical and emergency care nursing*. Springer Publishing Company.

Jobes, D. A. *(2016). Managing suicidal risk: A collaborative approach (2nd ed.).* The Guilford Press.

Jobes, D. A., & Joiner, T. E. (2019*).* Reflections on suicidal ideation. *Crisis, 40(4),* 227–230. https://doi.org/10.1027/0227-5910/a000615

Joiner, T. E. (2005). *Why people die by suicide.* Harvard University Press.

Kirmayer L. J. (2022). Suicide in cultural context: An ecosocial approach. *Transcultural Psychiatry*, *59*(1), 3–12. https://doi.org/10.1177/13634615221076424.2017;62(4):296-297. doi:10.1177/0706743717695087

Klonsky, E. D., Qiu, T., & Saffer, B. Y. (2018). Recent advances in differentiating suicide attempters from suicide ideators. *Behavioral Sciences & the Law, 36*(2), 13–29. https://doi.org/10.1002/bsl.2338

Kyanko, K. A., Curry, L. A., Keene, D. E., Sutherland, R., Naik, K., & Busch, S. H. (2022). Does primary care fill the gap in access to specialty mental health care? A mixed methods study. *Journal of General Internal Medicine*, *37*(7), 1641–1647. https://doi.org/10.1007/s11606-021-07260-z

Large, M. M. (2018). The role of prediction in suicide prevention. *Dialogues in Clinical Neuroscience*, *20*(3), 197–205. https://doi.org/10.31887/DCNS.2018.20.3/mlarge

Levi-Belz, Y., Gvion, Y., & Apter, A. (2020). The serious suicide attempts approach for understanding suicide: Review of the psychological evidence. *OMEGA –Journal of Death and Dying*, *86*(2), 591–608. https://doi.org/10.1177/0030222820981235 (Original work published 2022)

Maris, R. W. (2000). *Comprehensive textbook of suicidology.* Guilford Press.

Maris R. W. (2002). Suicide. *Lancet (London, England)*, *360*(9329), 319–326. https://doi.org/10.1016/S0140-6736(02)09556-9

McCabe, J. B. (2001). Emergency department overcrowding: A national crisis. *Academic Medicine, 76*(7), 672–674.

McCabe, R., Garside, R., Backhouse, A., & Xanthopoulou, P. (2018). Effectiveness of brief psychological interventions for suicidal presentations: A systematic review. *BMC Psychiatry*, *18*(1), 120. https://doi.org/10.1186/s12888-018-1663-5

McHugh, C. M., Cordery, A., Ryan, C. J., Hickie, I. B., & Large, M. M. (2019). Association between suicidal ideation and suicide: Meta-analyses of odds ratios, sensitivity, specificity and positive predictive value. *BJPsych Open, 5*, e18, 1–12. https://doi.org/10.1192/bjo.2018.88

Melzer, L., Forkmann, T., & Teismann, T. (2024). Suicide crisis syndrome: A systematic review. *Suicide and Life-Threatening Behavior, 54*(3), 556–574. https://doi.org/10.1111/sltb.13065

Mikulincer, M., & Shaver, P. R. (2018). *Attachment in adulthood: Structure, dynamics, and change* (2nd ed.). The Guilford Press.

Millner, A. J., Robinaugh, D. J., & Nock, M. K. (2020). Advancing the understanding of suicide: The need for formal theory and rigorous descriptive research. *Trends in Cognitive Sciences, 24*(9), 704–716. https://doi.org/10.1016/j.tics.2020.06.007

Mulder, R., Newton-Howes, G., & Coid, J. W. (2016). The futility of risk prediction in psychiatry. *The British Journal of Psychiatry: The Journal of Mental Science*, *209*(4), 271–272. https://doi.org/10.1192/bjp.bp.116.184960

O'Connor, R. C., & Kirtley, O. J. (2018). The integrated motivational–volitional model of suicidal behaviour. *Philosophical Transactions of the Royal Society B: Biological Sciences, 373*(1754), Article 20170268. https://doi.org/10.1098/rstb.2017.0268

O'Connor, R. C., & Nock, M. K. (2014). The psychology of suicidal behaviour. *The Lancet. Psychiatry*, *1*(1), 73–85. https://doi.org/10.1016/S2215-0366(14)70222-6

Orri, M., Scardera, S., Perret, L. C., Bolanis, D., Temcheff, C., Séguin, J. R., Boivin, M., Turecki, G., Tremblay, R. E., Côté, S. M., & Geoffroy, M. C. (2020). Mental health problems and risk of suicidal ideation and attempts in adolescents. *Pediatrics*, *146*(1), e20193823. https://doi.org/10.1542/peds.2019-3823

Pollock, N. J., Naicker, K., Loro, A., Mulay, S., & Colman, I. (2018). Global incidence of suicide among Indigenous peoples: A systematic review. *BMC Medicine*, *16*(1), 145. https://doi.org/10.1186/s12916-018-1115-6

Quinlivan, L., Cooper, J., Meehan, D., Longson, D., Potokar, J., Hulme, T., Marsden, J., Brand, F., Lange, K., Riseborough, E., Page, L., Metcalfe, C., Davies, L., O'Connor, R., Hawton, K., Gunnell, D., & Kapur, N. (2017). Predictive accuracy of risk scales following self-harm: Multicentre, prospective cohort study. *The British Journal of Psychiatry:The Journal of Mental Science*, *210*(6), 429–436. https://doi.org/10.1192/bjp.bp.116.189993

Rhodes, A. E., Sinyor, M., Boyle, M. H., Bridge, J. A., Katz, L. Y., Bethell, J., Bennett, K., Szatmari, P., & Newton, A. S. (2018). Emergency department presentations and youth suicide: A case-control study. *The Canadian Journal of Psychiatry, 64*(2), 88–97. https://doi.org/10.1177/0706743718802799

Ribeiro, J. D., Franklin, J. C., Fox, K. R., Bentley, K. H., Kleiman, E. M., Chang, B. P., & Nock, M. K. (2016). Self-injurious thoughts and behaviors as risk factors for future suicide ideation, attempts,

and death: A meta-analysis of longitudinal studies. *Psychological Medicine, 46*(2), 225–236. https://doi.org/10.1017/S0033291715001804

Rudd, M. D., Berman, A. L., Joiner, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., Van Orden, K., & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior, 36*(3), 255–262. https://doi.org/10.1521/suli.2006.36.3.255

Sanati, A. (2009). Does suicide always indicate a mental illness? *London Journal of Primary Care, 2*(2), 93–94. https://doi.org/10.1080/17571472.2009.11493259

Savioli, G., Ceresa, I. F., Gri, N., Bavestrello Piccini, G., Longhitano, Y., Zanza, C., Piccioni, A., Esposito, C., Ricevuti, G., & Bressan, M. A. (2022). Emergency department overcrowding: Understanding the factors to find corresponding solutions. *Journal of Personalized Medicine, 12*(2), 279. https://doi.org/10.3390/jpm12020279

Sheftall, A. H., Asti, L., Horowitz, L. M., Felts, A., Fontanella, C. A., Campo, J. V., & Bridge, J. A. (2016). Suicide in elementary school-aged children and early adolescents. *Pediatrics, 138*(4), e20160436. https://doi.org/10.1542/peds.2016-0436

Sher, L. (2024). Suicide in individuals with no psychiatric disorders: What makes you vulnerable? *QJM: An International Journal of Medicine, 117*(5), 313–316. https://doi.org/10.1093/qjmed/hcad279

Skinner, M. S., & Sogstad, M**.** (2022). Social and gender differences in informal caregiving for sick, disabled, or elderly persons: A cross-sectional study. *SAGE Open Nursing, 8,* 1–10. https://doi.org/10.1177/23779608221130585

Skinner, R., & McFaull, S. (2012). Suicide among children and adolescents in Canada: Trends and sex differences, 1980–2008. *CMAJ: Canadian Medical Association Journal = journal de l'Association medicale canadienne, 184*(9), 1029–1034. https://doi.org/10.1503/cmaj.111867

Turecki, G., Brent, D. A., Gunnell, D., O'Connor, R. C., Nock, M. K., Pirkis, J., & Kirtley, O. J. (2019). Suicide and suicide risk. *Nature Reviews Disease Primers, 5*(1), 74. https://doi.org/10.1038/s41572-019-0121-0

Wasserman, D., Carli, V., Iosue, M., Javed, A., & Herrman, H. (2021). Suicide prevention in psychiatric patients. *Asia-Pacific Psychiatry, 13*(1), e12450. https://doi.org/10.1111/appy.12450

World Health Organization. (2023). *Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation* (2nd ed.). World Health Organization. https://www.who.int/publications/i/item/9789240081765

Zulyniak, S., Wiens, K., Bulloch, A. G. M., Williams, J. V. A., Lukmanji, A., Dores, A. K., Isherwood, L. J., & Patten, S. B. (2022). Increasing rates of youth and adolescent suicide in Canadian Women. *Canadian Journal of Psychiatry. Revue canadienne de psychiatrie, 67*(1), 67–69. https://doi.org/10.1177/07067437211017875