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Review Article

Suicidal Stabilization: Understanding and Defining Stabilization

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Abstract

Background: The term stabilization is widely used, yet its meaning varies significantly across settings, particularly regarding suicidal individuals. Lacking a standardized definition creates inconsistencies in care, leading to potential miscommunication among healthcare providers and gaps in treatment continuity. With confusion among the healthcare community, ambiguous language can amplify concerns with loved ones, employers, and the public.

Methods: This article describes a comprehensive systematic literature review using the PRISMA guidelines to explore the concept of suicidal stabilization, distinguishing it from broader terms and proposing a clear, research-based definition.

Results: Drawing from existing literature, assessment tools, and current evidence-based clinical frameworks, this study defines suicidal stabilization as a temporary state in which immediate risk has been mitigated, allowing for transition to appropriate levels of care. Key criteria include: absence of imminent suicidal intent, no recent suicidal behaviors, ability to engage in crisis management strategies, and a structured follow-up plan.

Conclusions: The findings emphasize the importance of precise terminology in suicide prevention efforts and highlight the need for consensus on criteria to enhance communication, treatment planning, and patient outcomes. Establishing a clear definition of suicidal stabilization is a crucial step in improving clinical interventions and ensuring a cohesive, effective response to suicidality.

Keywords: Stabilization; Suicide; Crisis; Emergency; Classification

Introduction

The term **"stabilization"** is frequently used in mental health care but lacks a **consistent definition**, leading to potential miscommunication and gaps in treatment. In some contexts, such as mood or psychotic disorders, stabilization may refer to the **end of an episode**. When applied to suicidality, however, the definition becomes even broader and more ambiguous.

In **acute settings** like hospitals or crisis centers, stabilization often means there is **no immediate risk**, with safety measured in minutes or hours. In **outpatient care**, stabilization may indicate that short-term risk has decreased, suggesting safety for days. In other cases, the term may imply **the full resolution** of a suicidal episode.

This variability creates **serious communication challenges** among professionals. For example, an **emergency department** may discharge a patient as "stabilized," meaning they are not in imminent danger, while an **outpatient clinician** may interpret this

as the individual being safe until their next session. Meanwhile, a **school counselor** could assume stabilization means the crisis has entirely passed. These **inconsistent interpretations** can result in misaligned care, inadequate follow-up, and increased risk for the individual.

To improve **continuity of care and patient safety**, the mental health field must establish **clear, standardized definitions** of stabilization across different settings. Without this, miscommunication will continue to hinder effective treatment and crisis intervention.

Methods

This systematic review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) and registered with PROSPERO, ID#1038409. Each search was conducted independently by two individuals, including a researcher with their PhD and a researcher with their M.S. The researchers systematically studied the EBSCO database for articles published between 06/2012 to 02/2025. The date these articles were last searched and accessed is 04/11/2025.

Search Strategy

Each author limited the search to peer reviewed articles in English, selected all publication types, and limited publication dates to 06/2012 to 02/2025. The following keyword search strategies were utilized: (Suicide OR suicidal) AND (stabilize); (Suicide OR suicidal) AND (stabilization); (Suicide OR suicidal) AND ("stabiliz"); (Suicide OR suicidal) AND (stabilized); (Suicide OR suicidal) AND (stabilizes); (Suicide OR suicidal) AND (stabilize) AND (definition); (Suicide OR suicidal) AND (stabilization) AND (definition); (Suicide OR suicidal) AND ("stabiliz") AND (definition); (Suicide OR suicidal) AND (stabilized) AND (definition); (Suicide OR suicidal) AND (stabilizes) AND (definition); (Suicide OR suicidal) AND (stabilize) AND (define); (Suicide OR suicidal) AND (stabilization) AND (define); (Suicide OR suicidal) AND ("stabiliz") AND (define); (Suicide OR suicidal) AND (stabilized) AND (define); (Suicide OR suicidal) AND (stabilizes) AND (define).

Identification, Screening, Eligibility, and Inclusion

A total of 161 search results were generated, with 16 duplicates identified. After removing all duplicates, the 145 articles generated by the systematic search were screened through the titles and/or abstracts. The two independent screeners were searching each title and abstract for any mention of all "stabiliz" related terms. 113 of these articles were removed and deemed ineligible for the present study, as all "stabiliz" related terms identified were either used passively or not applicable to the scope of concern and were found lacking a clearly identifiable definition. The 32 remaining articles that were deemed eligible beyond title and abstract were assessed and examined for relevance and inclusion. In moving through the remaining 32 articles, 0 articles demonstrated use of any "stabiliz" related terms in concert with a definition that would be applicable and generalizable to the broader field. Therefore, the systematic review of all 145 articles in EBSCO's Academic Search Complete database that were published between 06/2012 to 02/2025 demonstrates a lack of an agreed upon, operationalizable definition of stabilization in the literature.

Bias and Certainty Assessment

This article has little risk of bias, as it is a systematic investigation to identify any current definitions of suicide stabilization instead of an outcome study to synthesize. Relatedly, as a systematic, comprehensive investigation was undertaken, there is a high level of certainty regarding lack of a generalizable, agreed upon definition.

Literature Review

The clarification of "stabilization" is essential in suicide prevention work, as this concept directly impacts client safety and determines the level of care required. A thorough literature review reveals that while the term "stabilization" is frequently used, it is rarely, if ever, precisely defined in a general sense. In mental health literature, the concept of stabilization is used in various ways, depending on the setting and purpose. For instance, in acute care settings such as emergency departments or crisis intervention units, stabilization frequently refers to ensuring the immediate physical and emotional safety of an individual at risk of suicide [1]. This may involve de-escalation techniques, safety planning, or short-term hospitalization [2].

Conversely, in outpatient and therapeutic contexts, stabilization may signify a longer-term reduction in suicidal ideation and behaviors, often measured by specific clinical criteria [3]. In these settings, stabilization is not merely the absence of acute risk but also involves the development of coping mechanisms, adherence to treatment, and engagement in protective factors [4]. A review of over 140 related articles found no instances where stabilization was clearly defined beyond context-specific usage. The search involved scanning the text of each article for variations of "stabiliz-" (e.g., stabilize, stabilization, stabilized). In the few cases where a definition was provided, it was constrained to the parameters of a specific study. For example, [5] defined stabilization as "completion of 4 weeks during which the patient had a mean score of ≤7 on the 17-item Hamilton Depression Rating Scale and ≤7 on the Bech-Rafaelsen Mania Scale." While this definition establishes measurable criteria, it is based on depression and mania scales rather than suicidality itself, offering no clarification on what constitutes suicidal stabilization. Further complicating the issue, [6] noted that suicide rates can vary based on differing definitions, building on research by [7], which explored the distinction between suicide attempts and deliberate self-injury. While these findings do not directly define stabilization, they underscore how critical terms in suicidology are often used without a universally accepted definition. Even widely recognized resources, such as the Columbia Classification Algorithm of Suicide Assessment (C-CASA) [8], which provides standardized definitions for suicidality-related terms, do not define stabilization. Some studies attempt to infer stabilization through the absence of symptoms, typically using suicide-specific assessment tools like the CAMS Suicide Status Form – 4 (SSF-4), the Co-

lumbia-Suicide Severity Rating Scale (C-SSRS), and the Beck Scale for Suicide Ideation [3,9,10]. However, these studies fail to quantify stabilization beyond a numerical threshold, leaving its meaning ambiguous in clinical practice. Given the life-or-death implications of stabilization in suicidality, the lack of a clear, standardized definition poses a significant risk to individuals in crisis. Without a universally accepted framework, stabilization continues to be interpreted inconsistently across settings, leading to potential gaps in care and misaligned treatment approaches. Addressing this issue is critical to ensuring effective communication, continuity of care, and patient safety in suicide intervention.

An Aligned Definition

If the field of suicidology aims to stabilize individuals struggling with suicidal thoughts or plans, it is crucial to first define what stabilization means. The current system directs individuals toward crisis services yet offers few structured pathways toward treatment and long-term recovery [3]. introduces the concept of suicidal resolution, which moves beyond temporary stabilization to indicate that an individual is no longer experiencing ongoing suicidal ideation to a clinically significant degree. Suicidal resolution does not necessitate the complete eradication of suicidal thoughts but instead requires sustained improvement over time. Specifically, it is achieved when suicidal feelings, thoughts, or behaviors are reduced to a modest level for three consecutive sessions, and the individual demonstrates the ability to reliably manage these thoughts and emotions [3].

To create a working definition for suicidal resolution, we first examine criteria. The criteria, per the Collaborative Assessment and Management of Suicidality's Suicide Status Form includes:

- Self-reported low risk of suicide
- No suicidal behavior
- Ability to effectively manage suicidal thoughts/feelings for an indefinite period of time moving forward/the foreseeable future
- Completed stabilization plan
- Ability to verbalize changes and skills being utilized
- Positive outcome of a mental status evaluation
- Plan to manage effectively moving forward
- The first three criteria have been maintained for 3 sessions, or a minimum of 2 weeks

These criteria include skill use, a completed stabilization plan, measures over time, clinical judgement, and a relapse/prevention plan for future use. Additional components that provide support, but are not measures of resolution, include possible referrals, support groups, and ongoing therapy. This information provides the ability to define suicidal resolution as a clinically measurable state in which an individual who has previously experienced suicidal thoughts, feelings, or behaviors has demonstrated sustained improvement, effective coping, and the ability to manage suicidal ideation over time. It is not defined by the total eradication of suicidal thoughts but rather by a consistent reduction in risk and an individual's capacity to maintain safety independently. The definition can be taken a step further, in a format congruent with the DSM, in stating that suicidal resolution has been achieved when an individual meets the following criteria:

- Self-reported low risk of suicide
- No suicidal behaviors
- Demonstrated ability to effectively manage suicidal thoughts and feelings for an indefinite period moving forward
- Completion of a stabilization plan that outlines coping strategies and crisis management steps
- Ability to verbalize changes in thinking and skills being utilized for managing distress
- Positive outcome on a mental status evaluation indicating emotional and cognitive stability
- Development of a long-term plan for maintaining safety and preventing relapse
- Sustained stability over a minimum of three consecutive sessions or 2 weeks

This definition ensures that suicidal resolution is not solely based on symptom reduction but also includes skill acquisition, clinical assessment, and long-term planning. It provides a structured framework for treatment providers to assess progress, improve communication across care settings, and offer individuals a clear path from crisis toward lasting recovery. By adopting suicidal resolution as a standardized outcome measure, the field begins to shift away from vague, inconsistent definitions of stabilization and toward a clear, evidence-based framework that ensures continuity of care, promotes lasting recovery, and ultimately saves lives.

Creating Stratification and Definitions

With the term resolution defined, a foundation is created for three additional terms being proposed, suicidal stabilization, suicidal reprieve and suicidal crisis. Although the terms still allow for some variance in regard to the length of time an individual is able to manage their suicidal ideation, it also provides structure and expectations as to what the time frames will be.

Suicidal Stabilization

Stabilization is similar to resolution, although time limited and with more supports in place. Stabilization is the "working phase" of the process in which there should be some feeling of confidence in the individuals ability, and *willingness*, to work the therapeutic process. The criteria, following the model created for suicidal resolution, includes:

- Self-reported low to moderate risk of suicide since the last session, ranging from 3 days to approximately 1 week
- Effective management of suicidal behavior since the last session

- Ability to effectively manage suicidal thoughts/feelings until the next session and slightly beyond (next session plus 24 – 48 hours)
- Actively working toward goals in a stabilization plan
- Ability to verbalize changes in suicidality and skills being utilized
- Positive outcome of a mental status evaluation

This creates a definition for suicidal stabilization as: a clinically recognized state in which an individual experiencing suicidal thoughts, urges, or behaviors has reached a level of safety where immediate risk has been mitigated. The individual is able to effectively manage suicidal thoughts and feelings between clinical sessions and can resume most daily functioning. This stage allows the individual to engage in further treatment and recovery planning, including planning for ongoing care, if needed. This state is time-limited and intended to ensure that the individual is no longer at acute risk, while continuing to work toward resolution.

This is a time period that has not traditionally received much discussion in the field of mental health. Traditional views tended to be black and white. You were either in a crisis and at the hospital or released home and back to normal. This is not how suicidality works and the language and systems in place need to adapt to how clients and patients experience suicidality. This adaptation will allow patients and clients to trust the system and believe that the system is working for them.

Suicidal Reprieve

Suicidal reprieve is the first step towards resolution and the step prior to stabilization, in that the individual and their supports can effectively, although not reliably, manage suicidal thoughts for time periods ranging from several hours to 3 days (72 hours), providing time for stabilization services to be initiated. The criteria, following this model, includes:

- Active ability to implement a safety plan, crisis response plan, or other brief method to increase safety until additional services are available, approximately 72 hours or less
- No intention of suicide attempt or suicide behavior prior to engaging with additional services
- Ability to manage suicidal thoughts/feelings, potentially with help from natural supports, until the next session
- Ability to verbalize skills taught in safety plan/crisis response plan/brief method
- Ability to act upon safety plan if needed

Reprieve is then:

a clinical state, ranging from two to seventy-two hours, in which an individual is not stable and continues to experience suicidal thoughts and urges, although is able to reliably implement a safety plan independently or with the help of others, to mitigate safety risk as they work toward stabilization.

This stage will likely require a higher level of professional contact, including multiple sessions per week or possibly daily, and allows the individual to engage in becoming more skillful with a higher level of support.

Suicidal Crisis

A suicidal crisis is the period during which an individual experiences intense suicidal thoughts, urges, or behaviors that create an immediate risk of self-harm or suicide. It is characterized by a rapid escalation in suicidal ideation, intent, or behavior, necessitating immediate intervention to ensure safety [11]. It is a state of emotional and psychological distress in which the person may feel overwhelmed, hopeless, and unable to cope with their current situation, often resulting in escapism, or the need to escape the emotional pain due to an inability to manage the pain effectively [13] (Lee, In review). The Substance Abuse and Mental Health Services Administration [12] describes a suicidal crisis as an urgent situation requiring immediate clinical assessment and intervention to prevent self-harm or death. This is the "help seeking" stage, when individuals, loved ones, or supports seek emergency services upon recognizing the condition. A suicidal crisis can include a variety of criteria, as follows, with the hallmark being the first:

- Acknowledgement of suicidal thoughts and ideation, potentially including a plan and/or intent
- **Rapid onset and fluctuation, where, u**nlike chronic suicidal ideation, which may persist for extended periods, the suicidal crisis often emerges quickly and can fluctuate in intensity [14].
- Emotional distress, which is often reported severe psychological pain, feelings of worthlessness, and an overwhelming desire to escape their suffering [15].
- Cognitive constriction, where suicidal individuals experience cognitive narrowing, limiting their ability to generate alternative solutions to their problems [16].
- Impaired problem solving, including Feelings of despair and an inability to envision a future without pain are core features of a suicidal crisis [17].
- Increased risk factors, such as substance abuse, traumatic event, or loss

The suicidal crisis is considered a medical emergency and often requires immediate intervention, although SAMSHA estimates that only 10% are considered emergent and require hospitalization. The remaining 90% are classified as urgent and routine and can typically be managed through outpatient services in the days to come [12].

Differentiating Suicidal Crisis and Suicidal Ideation and Behavior

Although the two often overlap, they are not the same and can exist independently of each other. A suicidal crisis represents a critical period where an individual is at heightened risk of attempting suicide [18]. Unlike passive ideation, which may involve fleeting thoughts of death, a suicidal crisis often includes a sense of urgen-

cy, impaired judgment, and an increased likelihood of attempting suicide within hours or days if intervention is not provided [19]. Suicidal ideation refers to thoughts of death or self-harm. There are individuals that experience chronic suicidal ideation and are also extremely skilled at maintaining safety and functioning in their lives. Others may have a suicidal crisis, rooted in escapism and focused on specific drivers (Lee, in review). Suicidal behavior includes acts of self-injury with varying intent, ranging from an actual attempt to rehearsal and experimentation. This is also different from non-suicidal self-injury (NSSI), as NSSI is conducted without any intention of suicide or as a directed activity or step in that direction.

Conclusion

The topic of suicide is important, not only in behavioral health, but in general medicine and our society. Clear definitions and understanding of terminology are critical in the ongoing endeavors to treat, research, and prevent suicide, and stabilization is a key component in clarifying the concepts. Although the literature highlights the importance of recognizing key characteristics of suicide and implementing evidence-based interventions to reduce risk, a universally accepted language to discuss the topic is vital in making progress. Continued research is necessary to define, refine, and standardize definitions to improve care for individuals experiencing suicidal episodes.

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