EClinicalMedicine 23 (2020) 100399

Contents lists available at ScienceDirect

EClinicalMedicine

journal homepage: https://www.journals.elsevier.com/eclinicalmedicine

Commentary

Suicidal thinking as a valuable clinical endpoint

Evan M. Kleiman

Rutgers, The State University of New Jersey

ARTICLE INFO

Article History:
Received 7 May 2020
Revised 14 May 2020
Accepted 15 May 2020
Available online xxx

In this issue, Griffin and colleagues [1] present data on repeat hospital presentations among those who visit the hospital due to suicidal thinking (also called suicidal ideation). They found that about 4 in 10 people who visited the hospital once for suicidal thinking did so again within five years. Just under 2 in 10 people visited the hospital again for a more severe reason (e.g., self-harming behaviors). This paper had many strengths including the large, high-risk, longitudinal sample that provided insight into the long-term outcomes among those who visit the hospital due to suicidal thinking. Although there are many strengths to this paper, for the remainder of this commentary, I will focus on one particular strength: the use of suicidal thinking as a valuable clinical endpoint. Large longitudinal studies typically focus on suicidal behavior rather than suicidal thoughts, making this strength particularly unique. Although work on suicidal behaviors is incredibly valuable, as others (e.g., Jobes and Joiner [2]) have noted, there is also great value in studying suicidal thinking. In the sections below, I will: (1) discuss reasons why suicidal thinking is a valuable clinical endpoint and (2) propose several (of many) areas where research on suicidal thinking is most needed.

Why should we study suicidal thinking? We have a better chance to help more people in need. Cross-national prevalence studies [3] find that just under 3% of people will attempt suicide in their lifetime but more than three times that number (9.2%) will have suicidal thoughts. Focusing on suicidal thinking allows researchers to study a far larger group of individuals. Moreover, individuals who have suicidal thoughts are one of the highest risk groups for eventual suicidal behaviors and death [4]. Researchers interested in studying suicidal behaviors and death would find few groups at greater risk for suicide than those who have had suicidal thoughts. Indeed, one of the only groups at greater risk for (subsequent) suicidal behaviors and suicide death are people who have already attempted suicide [4]. Although suicide attempters are an obviously high-need group, by definition people cannot be in this group until they have already engaged in a behavior researchers and clinicians hope to prevent.

Preventing suicidal thinking means preventing suicidal behaviors and reducing distress. "Ideation-to-action" frameworks of suicide [5] propose that suicidal thinking is one of the first steps on the pathway to suicidal behaviors. According to these theories, preventing suicidal thinking should also mean preventing suicidal behaviors. Of course, not all people who have suicidal thoughts will eventually act on them. Even in the absence of suicidal behaviors, however, suicidal thoughts are still distressing [6] and impairing [7]. Moreover, several interventions successfully reduce risk for suicide attempts, but do so in a way that does not also target the underlying suicidal thinking. This means that we have a large number of people who are certainly better off than they were before the treatment (because they are less likely to act on their suicidal thoughts) but are still impaired (because they are still having suicidal thoughts). Taken together, reducing suicidal thinking would mean preventing suicide attempts but also improving functioning among a substantial number of people who may be otherwise missed by treatments that solely target suicidal behaviors.

What should we study? Considerably more research on suicide is needed in many areas so it would be impossible to identify all of the places where we should focus our attention. Given this, I conclude this commentary by highlighting two (of potentially many) themes for future research that build off of work done by Griffin et al. [1] and others who have studied suicide thinking. First, it is important to explore suicidal thinking in settings beyond the hospital. Only about one third of people who die by suicide have contact with a mental healthcare provider in the year before they die [8]. It is important to explore what suicidal thinking looks like among those who do not see a mental healthcare provider. One particularly valuable location to explore suicidal thinking is primary care, where approximately 75% of people who die by suicide visit in the year before their death. Finally, as Jobes and Joiner [2] note, several treatments designed for suicidal behaviors do not have an appreciable effect on suicidal thinking. This may possibly be because of a focus on preventing one from acting on suicidal thoughts, not preventing the suicidal thoughts in the first place. Thus, it is crucial that we modify existing treatments (or potentially create new ones) to address suicidal thinking, which should have downstream effects on suicidal behavior in addition to improvements in functioning.

Declaration of Competing Interest

The author declares no conflict of interest.

DOI of original article: http://dx.doi.org/10.1016/j.eclinm.2020.100378.
E-mail address: evan.kleiman@rutgers.edu

https://doi.org/10.1016/j.eclinm.2020.100399

References

[1] Griffin E, Kavalidou K, Bonner B, O'Hagan D, Corcoran P. Risk of repetition and subsequent self-harm following presentation to hospital with suicidal ideation: a longitudinal registry study. EClinicalMedicine 2020 Published online. doi: 10.1016/j.eclinm.2020.100378.

[2] Jobes DA, Joiner TE. Reflections on suicidal ideation. Crisis 2019;40(4):227–30. doi: 10.1027/0227-5910/a000615.

[3] Nock MK, Borges G, Bromet EJ, et al. Cross-national prevalence and risk factors for suicidal ideation, plans, and attempts. Br J Psychiatry 2008;192:98–105. doi: 10.1192/bjp.bp.107.040113.

[4] Franklin JC, Ribeiro JD, Fox KR, et al. Risk factors for suicidal thoughts and behaviors: a meta-analysis of 50 years of research. Psychol Bull 2017;143:187–232. doi: 10.1037/bul0000084.

[5] Klonsky ED, Saffer BY, Bryan CJ. Ideation-to-action theories of suicide: a conceptual and empirical update. Curr Opin Psychol 2018;22:38–43. doi: 10.1016/j.copsyc.2017.07.020.

[6] Kleiman EM, Turner BJ, Fedor S, Beale EE, Huffman JC, Nock MK. Examination of real-time fluctuations in suicidal ideation and its risk factors: results from two ecological momentary assessment studies. J Abnorm Psychol 2017;126(6):726–38. doi: 10.1037/abn0000273.

[7] McCarty CA, Russo J, Grossman DC, et al. Adolescents with suicidal ideation: health care use and functioning. Acad Pediatr 2011;11(5):422–6. doi: 10.1016/j.acap.2011.01.004.

[8] Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry 2002;159(6):909–16. doi: 10.1176/appi.ajp.159.6.909.