

MythBuster: Suicidal Ideation

MYTH: “Asking young people about suicidal thoughts or behaviours will only put ideas in their heads”



Suicidal Ideation

What is suicidal ideation and how common is it among young people?

The term 'suicidal ideation' refers to thoughts that life isn't worth living, ranging in intensity from fleeting thoughts through to concrete, well thought-out plans for killing oneself, or a complete preoccupation with self-destruction. These thoughts are not uncommon among young people. **It is estimated that between 22% and 38% of adolescents have thought about suicide at some point in their lives, with between 12% and 26% reporting having had such thoughts in the previous year (1).**

Why is it important to assess suicidal ideation in young people?

The majority of young people who experience suicidal ideation will not go on to take their lives, however any report of suicidal ideation should be taken seriously. Even when it is mild, and is only reported on one occasion, suicidal ideation has been found to be associated with clinically significant symptoms of depression (2). Furthermore, **young people experiencing persistent, severe suicidal ideation are at increased risk of attempting suicide (3).** Evidence suggests that the relationship between suicidal ideation and suicide attempts is mediated by the burden of psychosocial **risk factors** (see box) that a young person is exposed to (4). Young people experiencing suicidal ideation in the absence of other risk factors are at a relatively low-risk, whereas those experiencing suicidal ideation in addition to exposure to multiple risk factors are at high-risk. A previous suicide attempt is one of the most salient risk factors for a young person later dying by suicide (5).

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Risk Factors Associated with Suicidal Behaviour in Young People (6)

- A previous suicide attempt
- Mental health and substance use disorders
- Physical illness: terminal, painful or debilitating illness
- Family history of suicide, alcoholism and/or other psychiatric disorders
- A history of abuse: sexual, physical or emotional
- Social isolation and/or living alone
- Bereavement in childhood
- Family disturbances
- Unemployment, change in occupational or financial status
- Rejection by a significant person e.g. relationship breakup
- Recent discharge from psychiatric hospital

Are there opportunities to intervene when a young person is experiencing suicidal ideation?

Young people are typically reluctant to seek professional help for mental health problems (7) and as suicidal ideation increases, their intention to seek help decreases further (8-9). However many young people do seek general medical care in the month preceding suicidal behaviour (3, 10). **Health and other professionals who have ongoing contact with young people (e.g. GPs, teachers, school counsellors, sports coaches, youth workers) are well-placed to detect risk.** While young people are unlikely to disclose suicidal thoughts unprompted (10), they may do so if asked specifically about it (11). Therefore professionals must be alert to possible **warning signs** (see below) and should ask about suicidal ideation and behaviour rather than relying on the young person to spontaneously report it. If the subject is approached sensitively, only a minority of people will deny suicidal intent when they are in fact planning suicide (12).

Although in the majority of cases a suicide attempt will be preceded by one or more warning signs this is not always the case. Not every suicide is preventable.

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Signs a young person may be suicidal (see 13)

- Threatening to hurt him/herself or suicide
- Looking for ways to suicide e.g. seeking access to pills, weapons, or other means
- Deliberately hurting him/herself i.e. by scratching, cutting, or burning
- Talking or writing about death, dying or suicide
- Hopelessness
- Rage, anger, seeking revenge
- Acting recklessly or engaging in risky activities, seemingly without thinking
- Feeling trapped, like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family or society
- Anxiety, agitation, changes in sleep or appetite
- Dramatic changes in mood
- No reason for living, no sense of purpose in life

Won't asking a young person about suicidal ideation put “ideas in their head?”

The only way to assess suicide risk is to ask a young person directly whether they are experiencing suicidal thoughts or engaging in suicidal behaviours (12). However, professionals working with young people in a variety of settings (e.g. schools, youth or health centres) are often reluctant to do so. The fear for many is that they will ‘put ideas in their head’, making a subsequent suicide attempt more likely (14).

Despite the fact that this belief is a myth (15), unfortunately it is still quite common (e.g. 16). **Discomfort on the part of practitioners in addressing suicidal ideation with young people is likely to contribute to low detection rates of suicidal young people in a variety of settings.**

Schools are often hesitant to implement suicide prevention programs due to discomfort about raising the issue of suicidal ideation with students (17). Similarly, GPs are often reluctant to ask about suicide for fear of triggering suicidal behavior (18). Mental health professionals (19) and university counsellors (20) also do not routinely ask about suicidal risk factors or behaviour among high-risk clients.

There is no evidence that talking to a young person about suicidal thoughts or behaviour is harmful

Is there evidence that talking about suicidal behaviour is harmful?

There is no evidence that talking to a young person about suicidal thoughts or behaviour is harmful (21-22). Over 30 years of crisis hotline experience and 20 years of school-based prevention programs have failed to document any cases of stimulating suicidal behaviour through the discussion of the topic (21).

Evidence of a ‘suicide contagion’ effect relating to inappropriate media coverage of suicide (23) may have contributed to a fear of talking about suicidal ideation with young people. However, it is exposure to certain styles of media reporting (e.g. sensationalist, glamourising stories) that is associated with an increased risk of suicidal behaviour, rather than exposure to discussion of suicide more generally. Through media coverage and the high prevalence of suicidal behaviour in their age-group, young people will already be familiar with the topic of suicide. Talking about it will not “plant the idea in their head” (21).

What does all this mean for those working with young people?

Professionals working with young people can be assured that they **should not avoid talking to young people at-risk of developing, or currently experiencing a mental health disorder, or engaging in self-harm about suicidal thoughts or behaviours** (24-25). The best way to assess for suicidal ideation is by directly asking the young person (25). Adolescents are often relieved and grateful for the opportunity to discuss their plans openly (3).

It is particularly important to assess for the presence of suicidal ideation if a young person is self-harming as the combination of self-harm and intention to die is the single greatest risk factor for completed youth suicide (17). There is considerable evidence to suggest that deliberate, non-suicidal self-injury can be distinguished from self-harm that is intended to result in death (26). While it is important to distinguish between these two behaviours in clinical practice, it is not always easy to do so. The best approach is to ask the young person directly if they are suicidal. The presence of other risk factors should also be assessed.

Any reports of suicidal ideation need to be thoroughly investigated using direct questioning to determine the extent of the thoughts, the presence or absence of suicidal behaviour, the presence or absence of a suicide plan, and to evaluate other psychosocial risk factors.

Other Resources

Mental Health First Aid Guidelines for Suicidal Thoughts and Behaviours: practical advice for non-professionals on what kind of questions to ask, how to keep someone safe and how to link them in with professional help. www.mhfa.com.au/Guidelines.shtml

Training on suicide intervention is available across Australia through the ASIST program. www.lifeline.org.au/learn_more/livingworks

References

1. Nock, M., Borges, G., Bromet, E. et al. (2008). *Suicide and suicidal behavior*. *Epidemiological Reviews*, 30(1). 133-154.
2. Evans, E., Hawton K., Rodham, K. & Deeks J. (2005) *The prevalence of suicidal phenomena in adolescents: a systematic review of population-based studies*. *Suicide and Life-Threatening Behavior* 35(3), 239-250
3. Hider P. (1998). *Youth suicide prevention by primary healthcare professionals: A critical appraisal of the literature*. NZHTA Report 4.
4. Fergusson, D. and Lynskey, M. (1995b) *Suicide attempts and suicidal ideation in a birth cohort of 16 year old New Zealanders*. *J Am Acad Child Adolescent Psychiat*, 34, 1308-1317.
5. Jacobs D. (Ed.) (1999). *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco: Jossey-Bass
6. Adapted from WHO (2000) *Preventing suicide a resource for general practitioners*.
7. Rickwood D. J., Deane F.P & Wilson C. (2007). *When and how do young people seek professional help for mental health problems?* *Med J Australia* 187(7)
8. Deane F.P., Wilson C.J., Ciarrochi J. (2001) *Suicidal ideation and help-negation: not just hopelessness or prior help*. *Clin Psychol* 57: 901-914
9. Wilson C.J., Deane F.P., Ciarrochi, J. (2005). *Can hopelessness and adolescents' beliefs and attitudes about seeking help account for help negation?* *J Clin Psychol* 61: 1525-1539.
10. Pfaff J.J., Acres, J. & Wilson, M. (1999). *The role of general practitioners in parasuicide: A Western Australia perspective*. *Arch Suicide Res* 5: 20-214
11. McKelvey R.S, Davies L.C., Pfaff J.J, et al. (1998) *Psychological distress and suicidal ideation among 15-24-year-olds presenting to general practice: a pilot study*. *Aust NZ J Psychiat* 32:344-348
12. Morris R. & Gask L. (2006) *Assessment and immediate management of people at risk of harming themselves*. *Psychiatry* 5(8)
13. Adapted from *Mental Health First Aid (2008) Suicidal Thoughts and Behaviours: First Aid Guidelines*
14. Guo B. & Harstall C. (2002) *Efficacy of suicide prevention programs for children and youth*. *Health Technology Assessment* 26: series A
15. Hall, K. (2002) *Suicide prevention topic 7: Does asking about suicidal ideation increase the likelihood of suicide attempts? A critical appraisal of the literature*. NZHTA Report
16. Monk L. & Samra J. (2007) *Working With the Client Who is Suicidal: A Tool for Adult Mental Health and Addiction Services*. Centre for Applied Research in Mental Health and Addiction
17. Bridge J. Al., Goldstein, T. R. , Brent, D. A. (2006) *Adolescent suicide and suicidal behaviour*. *J. Child Psychol Psychiatry* 47: 372-394
18. Michel K. (2000). *Suicide prevention and primary care*. In K. Hawton & K. van Heeringen (Eds.), *International handbook of suicide and attempted suicide* (pp. 661-674). Chichester, England: Wiley.
19. Coombs D.W., Miller H.L., Alarcon R., et al. (1992). *Presuicide attempt communications between parasuicides and consulted caregivers*. *Suicide and Life-threatening Behavior*. 22: 289-302
20. Hahn W.K. & Marks L.I. (1996) *Client Receptiveness to the Routine Assessment of Past Suicide Attempts*. *Prof Psychology: Res Pract* 27(6): 592-594
21. Kalafat, J. (2003). *School approaches to youth suicide*. *Am Behav Scientist*, 46 (9), 1211-1223.
22. Mann J.J, Apter A., Bertolote J. et al. (2005). *Suicide Prevention Strategies: A Systematic Review*. *JAMA*; 294(16): 2064.
23. Pikris J. Blood R.W. *Suicide and the media, I: reportage in nonfictional media*. *Crisis*. 2001; 22:146-154
24. Thobaben, B (1997) *Suicide Myths and Health Care Provider*. *Home Care Provider* 2(3)
25. Shain B.N. & The Committee on Adolescence (2007) *Suicide and Suicide Attempts in Adolescents*. *Pediatric* 120:669-676
26. Kelly M., Jorm, F. J., Kitchener, B. A. & Langlands, R. L. (2008) *Development of mental health first aid guidelines for deliberate non-suicidal self-injury: A Delphi study*. *BMC Psychiatry*, 8: (62)

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