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COPING WITH SUICIDAL THOUGHTS: A SURVEY OF PERSONAL EXPERIENCE

Gregory E. Simon,
Group Health Cooperative - Group Health Research Institute, 1730 Minor Avenue, #1600, Seattle, Washington 98101-1448

Cynthia Specht, and
DBSA, Chicago, Illinois

Allen Doederlein
DBSA, Chicago, Illinois

Gregory E. Simon: simon.g@ghc.org

Abstract

Objective—Describe use of services and self-care strategies by people experiencing suicidal thoughts.

Methods—Constituents of the Depression and Bipolar Support Alliance (n=611) completed an anonymous online survey regarding experience of suicidal ideation and use of a range of clinical services, community supports, and self-care strategies.

Results—Mental health providers were the most frequently used and the most favorably rated sources of support. Peer supports were less frequently used, bu also favorably rated. Emergency rooms and crisis lines were used less frequently and were rated less favorably. The most frequently-used self-care strategies included distracting activities, social activities, positive affirmations, exercise, and personal spiritual practices.

Conclusions—Peer support may be an under-utilized resource for coping with suicidal thoughts. Unfavorable ratings for emergency rooms and crisis clinics may indicate a need to develop more collaborative models of emergency care. Frequent use of spiritual practices suggests greater attention to spirituality in suicide prevention.

Suicide is the tenth-ranked cause of death in the US, accounting for nearly 40,000 deaths per year[1]. Non-fatal suicide attempts result in approximately 700,000 emergency department visits in the US annually[2]. Approximately 4% of US adults (and 7% of those under age 25) report experiencing thoughts of suicide or self-harm in a 12-month period[3].

Of US residents who report experiencing suicidal thoughts, only half report receiving care from specialty mental health providers [4, 5]. One third report receiving care from general medical providers, and one quarter report help from human service providers or other non-

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medical sources [5, 6]. For many people who experience thoughts of suicide, community resources, non-professional helpers, and self-care are the primary or sole sources of support [7].

The Depression and Bipolar Support Alliance (DBSA) conducted an informal online survey to describe use of various health and human services as well as use of specific self-care strategies by people who have experienced suicidal thoughts. The survey aimed to examine prevalence of use and users' perceptions of helpfulness for these various sources of support.

METHODS

DBSA is an education, advocacy, and support organization for people living with mood disorders; governed, staffed, and run primarily by people with lived experience of depression and bipolar disorder. DBSA's outreach activities include periodic constituent surveys regarding affected individuals' and family members' views regarding clinical, research, and policy issues. These surveys are available on the DBSA website, DBSAlliance.org, advertised via DBSA's electronic newsletters for constituents and chapter leaders, and highlighted via DBSA's social media channels. All surveys are anonymous; respondents are not asked to provide any identifying information.

A survey regarding individuals' personal experience of coping with suicidal thoughts was posted from February 28—May 28, 2013. Topics within the survey included personal experience with suicidal ideation and behavior, experiences with sources of care or support regarding suicidal ideation, experience with personal self-care or wellness strategies, and attitudes regarding suicide prevention. Survey items were developed collaboratively by DBSA staff, individuals with lived experience of suicidal ideation, and mental health researchers. Questions regarding specific sources of support and self-care strategies included both Likert-type ratings of helpfulness and space for free-text comments. The complete survey text is provided in the online appendix.

All respondents were advised regarding the goals and content of the survey, including intent to publish survey results. Because all responses were anonymous and no protected health information was collected, written informed consent was not required.

RESULTS

Of 611 survey respondents, 588 (96%) reported ever having "thoughts about harming yourself or killing yourself," 460 (75%) reported ever having "made a plan to harm yourself or try to kill yourself," 293 (48%) reported ever having "done something to try to kill yourself," 315 (52%) reported ever having been "admitted to a hospital because of suicidal thoughts or a suicide attempt," and 203 (33%) reported ever having been "treated or held against your will because of suicidal thoughts or a suicide attempt." Subsequent results are limited the 588 respondents reporting a history of suicidal thoughts.

Questions and responses regarding use of various sources of help or support are shown in the upper portion of Table 1. The most commonly reported sources of help for suicidal thoughts were mental health professionals (therapists and psychiatrists) and family members. Use of

peer support was also frequent, with three out of four receiving individual support from speaking with peers, over half attending an in-person peer support group, and one third receiving online peer support. One half reported ever seeking help from an emergency room because of suicidal thoughts, and only one third reported ever calling a crisis line.

Also shown in the upper portion of Table 1 are responses regarding perceived helpfulness of each source of support. Ratings of helpfulness were limited to those reporting some use of that service or resource. Respondents' experiences varied considerably, with every resource being described as very helpful by a significant proportion and every resource being described as harmful by at least a few. Interactions with therapists or psychiatrists were described most favorably, with over 80% of respondents describing those interactions as "somewhat" or "very" helpful. Various types of support from peers (individually, in support groups, or online) were described as very "somewhat" or "very" helpful by 65–80% of respondents. Respondents' experiences with emergency rooms and crisis clinics were more mixed, with approximately half reporting those encounters as "somewhat" or "very" helpful but 10–15% describing them as harmful. Experiences with support from family members or clergy were similarly mixed. Respondents' free-text comments (see online appendix) illustrate the diversity of experience with different sources of support.

Additional analyses examined perceived helpfulness according to personal history of suicide attempt (see online appendix for details). Talking with primary care physicians was rated as not helpful or harmful by 49% of those with a history of suicide attempt compared to 29% of those without a suicide attempt. Talking with family members regarding suicidal thoughts was rated as not helpful or harmful by 56% of those with a personal history of suicide attempt compared to 40% of those without such history. Helpfulness ratings for other services or resources did not differ between those with and without a history of suicide attempt.

Questions and responses regarding use of various self-care strategies are shown in the bottom portion of Table 1. Over 80% of respondents reported some experience with positive self-talk; prayer or meditation; social contact; physical activity; scheduling activities to stay busy; or distraction by movies, television, or other entertainment. Nearly two thirds reported ever having used alcohol or street drugs to attempt to manage suicidal thoughts.

Also shown in the bottom portion of Table 1 are responses regarding perceived helpfulness of various self-care strategies. Most self-care strategies were described as "somewhat" or "very" helpful by 70% or more of respondents. Prayer or meditation was most often rated as very helpful—by nearly one third of survey participants. In contrast, use of alcohol or street drugs was infrequently reported as helpful and was experienced as harmful by nearly 40%. Taking extra medication to cope with suicidal thoughts was reported as very helpful by about one in five respondents and as harmful by an approximately equal number. Free-text comments (see online appendix) illustrate the diversity of experience with various self-care strategies.

Additional analyses examined perceived helpfulness of self-care strategies according to personal history of suicide attempt (see online appendix). Respondents with a personal

history of suicide attempt were more likely than those without such a history to report that using extra medication to manage suicidal thoughts was not helpful or harmful (45% vs. 30%). Perceived helpfulness of other self-care strategies did not vary according to personal history of suicide attempt.

When asked about attitudes toward suicide prevention, 73% of respondents “somewhat” or “strongly” agreed with the statement that “suicide is often preventable”. While 72% “somewhat” or “strongly” agreed that involuntary treatment is sometimes necessary, 52% “somewhat” or “strongly” endorsed being reluctant to speak with health care providers about suicidal ideation. Opinions regarding preventability of suicide, willingness to speak with providers about suicidal thoughts, and appropriateness of involuntary treatment did not differ significantly between respondents with and without either a personal history of suicide attempt or a with and without personal history of involuntary treatment (details in online appendix)

DISCUSSION

The methods of this survey (anonymous responses to a broad public invitation) result in important limitations. We are not able to describe respondents’ demographic characteristics, diagnoses, or histories of treatment. We cannot determine the number of people reached by survey invitations or the proportion of those reached who responded. Consequently, we cannot assess representativeness of this sample compared to all people living with mood disorders or all people who experience suicidal thoughts. Compared to previous community surveys regarding suicidal thoughts [4, 5], our survey respondents were more likely to report use of specialty mental care. Likelihood of responding to the survey may have been related to past experiences; those who were especially satisfied or especially dissatisfied with specific services may have been more likely to respond.

Despite those limitations, these data provide a unique view of the experiences and views of people who have experienced suicidal thoughts or attempted suicide. We are not aware of other data regarding the use of and perceived helpfulness of the full range of professional services, community services, and self-care for people experiencing thoughts of suicide or self-harm.

In combination with population-based data from other sources [4–6], these survey findings have implications for suicide prevention efforts across a range of healthcare and human service settings. While respondents to our surveys typically reported positive experiences with specialty mental health providers, only half of community residents experiencing suicidal ideation (and half of people dying by suicide) receive specialty mental health care[4, 8]. A larger proportion of people experiencing suicidal ideation see general medical providers[5, 6], but our survey respondents reported such contacts as only moderately helpful. Improving the quality or helpfulness of suicide prevention services in general medical settings appears to be a priority.

Our survey findings also suggest additional attention to experiences with emergency resources. Our respondents reported relatively low utilization of emergency rooms and crisis

clinics, the expected sources of round-the-clock emergency care for suicide risk. In addition, those emergency resources were among the services most often rated as unhelpful or harmful. This higher rate of negative experiences may reflect the circumstances in which individuals often encounter these services: an urgent or crisis situation in which people may fear coercive or involuntary treatment. A 2009 survey of users of a suicide prevention helpline found generally high rates of satisfaction [9]. Nevertheless, the more frequent negative ratings for emergency or crisis service settings suggests a reconsideration of how these services might collaborate more with people in crisis. A survey of emergency department providers [10] identified a need for additional training regarding assessment, counseling, and referral for people with suicidal thoughts. Addressing consumers' negative perceptions of existing emergency services may require additional training for emergency care providers or increased availability of alternative emergency care resources, including respite services and peer-provided services.

Services most frequently used were among those described as most helpful, and those least often used were rated less favorably. The exceptions to this pattern were support from family members and peer support services (both peer support group and online peer support). Support from family members was often used, but also had relatively high prevalence of unfavorable experiences. Conversely, peer support services were used by fewer than half of those responding, but were among the most favorably rated by our survey respondents. This combination of relatively infrequent use and high rates of perceived helpfulness suggests a missed opportunity: increasing awareness and availability of organized peer support resources could have significant benefit for people who experience suicidal thoughts.

Self-care activities appear to be the most common strategies for dealing with suicidal thoughts. This finding is consistent with Alexander and colleagues' [7] previous assessment of lived experience of suicidal ideation. High rates of utilization and high ratings for helpfulness of prayer or meditation were notable. Spirituality or religious practice are not emphasized by most structured psychotherapies for mood disorders or by therapies specifically developed to manage suicidal ideation. Our findings suggest that mental health and human service providers may want to ask people presenting with suicidal ideation about their use of a variety of spiritual practices. Our data suggest that meditation, prayer, and other personal spiritual practices can be helpful self-care tools for a significant proportion of people coping with suicidal thoughts. While personal spiritual practices were often rated as helpful, it is notable that talking with clergy or other spiritual advisors received relatively low ratings for helpfulness.

Also of note were high rates of use and high ratings for helpfulness of various activities to distract attention from suicidal thoughts (exercise, social contact, entertainment). Providers should consider these strategies as potentially useful parts of self-care or crisis-management plans.

Use of extra medication was often rated unfavorably (second only to use of alcohol and street drugs). We cannot determine, however, whether respondents were describing provider-supervised use of "rescue" medications, or self-directed over-use of anxiolytic or sedative-hypnotic drugs.

Attitudes regarding suicide prevention revealed an important paradox. Over 70% of respondents agreed that suicide is often preventable, and a similar proportion agreed that involuntary or forced treatment is sometimes necessary. Nevertheless, over half indicated reluctance to speak with doctors or therapists regarding suicidal thoughts. Our survey did not address reasons for that reluctance. Understanding and addressing barriers to open communication regarding suicidal thoughts should be a priority for future research.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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References

1. National Center for Health Statistics. National Vital Statistics Reports. Hyattsville, MD: 2015. Deaths: Final Data for 2013.
2. Centers for Disease Control and Prevention. National Hospital Ambulatory Medical Care Survey: 2008 Emergency Department Summary Tables. Atlanta: Centers for Disease Control and Prevention; 2012. updated 2012 January 6, 2012; cited 2012 February 22, 2012 ; Available fromhttp://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/nhamcsed2008.pdf
3. Crosby AE, Han B, Ortega LAG, Parks SE, Gfronerer J. Suicidal thoughts and behaviors among adults aged > 18 years - United States, 2008–2009. MMWR Morb Mortal Wkly Rep. 2011; 60(13): 1–31.
4. Ahmedani BK, Perron B, Ilgen M, Abdon A, Vaughn M, Epperson M. Suicide thoughts and attempts and psychiatric treatment utilization: informing prevention strategies. Psychiatr Serv. 2012; 63(2):186–9. [PubMed: 22302340]
5. Bruffaerts R, Demyttenaere K, Hwang I, Chiu WT, Sampson N, Kessler RC, Alonso J, Borges G, de Girolamo G, de Graaf R, Florescu S, Gureje O, Hu C, Karam EG, Kawakami N, Kostyuchenko S, Kovess-Masfety V, Lee S, Levinson D, Matschinger H, Posada-Villa J, Sagar R, Scott KM, Stein DJ, Tomov T, Viana MC, Nock MK. Treatment of suicidal people around the world. Br J Psychiatry. 2011; 199(1):64–70. [PubMed: 21263012]
6. Bruffaerts, R.; Demyttenaere, K.; Borges, G.; Chiu, WT.; Kovess-Masfety, V.; Gureje, O.; Hwang, I.; Lara, C.; Sampson, NA.; Viarra, MC.; Nock, MK. Treatment of suicidal persons around the world. In: Nock, MK.; Borges, G.; Ono, Y., editors. Suicide: Global Perspectives from the WHO World Mental Health Surveys. Cambridge: Cambridge University Press; 2012.
7. Alexander MJ, Haugland G, Ashenden P, Knight E, Brown I. Coping with thoughts of suicide: techniques used by consumers of mental health services. Psychiatr Serv. 2009; 60(9):1214–21. [PubMed: 19723736]
8. Ahmedani BK, Simon GE, Stewart C, Beck A, Waitzfelder BE, Rossom R, Lynch F, Owen-Smith A, Hunkeler EM, Whiteside U, Operskalski BH, Coffey MJ, Solberg LI. Health care contacts in the year before suicide death. J Gen Intern Med. 2014; 29(6):870–7. [PubMed: 24567199]
9. Coveney CM, Pollock K, Armstrong S, Moore J. Callers' experiences of contacting a national suicide prevention helpline: report of an online survey. Crisis. 2012; 33(6):313–24. [PubMed: 22759662]
10. Betz ME, Sullivan AF, Manton AP, Espinola JA, Miller I, Camargo CA Jr, Boudreaux ED. Investigators E-S. Knowledge, attitudes, and practices of emergency department providers in the care of suicidal patients. Depress Anxiety. 2013; 30(10):1005–12. [PubMed: 23426881]

Table 1

Use and perceived helpfulness of professional services, other supports, and self-care strategies when experiencing suicidal thoughts

	Ever Used N=588		Perceived helpfulness among those ever using*							
			Harmful		Not Helpful		Somewhat Helpful		Very Helpful	
SOURCES OF HELP OR SUPPORT										
Talking to a therapist or counselor	511	87%	8	2%	56	11%	234	46%	213	42%
Talking to a psychiatrist	476	81%	20	4%	71	15%	237	50%	148	31%
Talking to family members	448	76%	65	14%	155	35%	162	36%	66	15%
Talking to peers	430	73%	36	8%	104	24%	191	44%	199	23%
Talking to a family or primary care doctor	373	63%	16	4%	133	36%	166	45%	58	16%
Attending a support group	303	52%	10	3%	51	17%	143	47%	99	33%
Going to an emergency room	281	48%	37	13%	79	28%	103	37%	62	22%
Talking to clergy or a spiritual advisor	220	37%	39	18%	53	24%	87	40%	41	19%
Calling a crisis clinic	205	35%	25	12%	52	25%	87	42%	41	20%
Online peer support	176	30%	10	6%	40	23%	84	48%	42	24%
SELF-CARE STRATEGIES										
Doing things to say busy	567	96%	10	2%	107	19%	296	52%	154	27%
Movies, TV, or other entertainment	560	95%	19	3%	162	29%	296	53%	83	15%
Doing things with other people	554	94%	16	3%	116	21%	296	53%	126	22%
Positive self-talk or affirmations	532	90%	7	1%	174	33%	268	50%	83	16%
Physical exercise	506	86%	6	1%	96	19%	275	54%	129	26%
Prayer, meditation, or spiritual practice	493	84%	15	3%	127	26%	203	41%	148	30%
Taking extra medication	425	72%	71	17%	93	22%	182	43%	79	19%
Drinking alcohol or using street drugs	376	64%	159	42%	98	26%	90	24%	29	8%

*Limited to those ever using this service or strategy. Sample size for each row equals number in “Ever Used” column.