HHS Public Access

Author manuscript

JAMA Pediatr. Author manuscript; available in PMC 2021 October 08.

Published in final edited form as:

JAMA Pediatr. 2013 July ; 167(7): 676. doi:10.1001/jamapediatrics.2013.149.

In Reply

Lisa M. Horowitz, PhD, MPH, **Jeffrey A. Bridge, PhD**, **Maryland Pao, MD**

Office of the Clinical Director, National Institute of Mental Health, National Institutes of Health, Bethesda, Maryland (Horowitz, Pao); Department of Pediatrics, The Ohio State University and the Research Institute at Nationwide Children's Hospital, Columbus, Ohio (Bridge).

Wintersteen et al suggest that the results of the Ask Suicide-Screening Questions (ASQ) study[1] should be interpreted with caution because the Suicidal Ideation Questionnaire (SIQ)[2] was used as the criterion standard. We respectfully disagree. The SIQ was designed to be administered, scored, and interpreted by mental health clinicians. Subjects are asked to give their best estimate of how often during the past month they had 30 different types of thoughts, ranging from "never" to "almost every day." If subjects score above a threshold, they are considered to have clinically significant suicidal ideation. By contrast, the ASQ was developed as a screening tool for non–mental health clinicians to help them detect suicidal ideation and past suicide attempts in young people. Use of the ASQ is not meant to replace a diagnostic assessment. From a statistical standpoint, the fact that 3 items selected for the ASQ were similar on the 2 instruments and were the ones most highly correlated with a positive SIQ score is to be expected and, moreover, reinforces that the candidate questions are measuring what we want them to—clinically significant suicidal ideation that may indicate suicidal risk and therefore warrants further evaluation from a trained mental health professional.

We agree that a prior suicide attempt is the most potent risk factor for future suicidal behavior and suicide yet is often omitted from screening instruments. Suicidal ideation has also been found to be a strong predictor of future suicidal behavior and death[3] and is one of the most frequently identified warning signs of suicide that warrants immediate attention.[4]

Since there is no instrument that accurately predicts completed suicide, we believe an instrument like the SIQ measuring clinically significant suicidal ideation is a worthy gold standard. While there are people who kill themselves without any known suicidal thoughts, this is relatively rare. The National Comorbidity Survey found that 90% of unplanned suicide attempts occurred within the first year of onset of suicidal ideation.[5] This appears to be an international phenomenon.[6]

A 16-year-old who presents to the emergency department with pelvic inflammatory disease and headaches, for example, and subsequently screens positive for suicide risk may have more of a chance of receiving a mental health referral/intervention because she was screened for suicide risk. Whether screening detects imminent risk or identifies a significant marker

Corresponding Author: Lisa M. Horowitz, PhD, MPH, Office of the Clinical Director, National Institute of Mental Health, National Institutes of Health, Clinical Research Center, Center Drive, Bldg 10, Room 6-5362, Bethesda, MD 20892 (horowitzl@mail.nih.gov).

Conflict of Interest Disclosures: None reported.

of emotional distress remains to be tested; either way, screening can capture youth whose suicidal ideation may have otherwise gone unrecognized.

Importantly, the ASQ is available in the public domain, at no additional cost. Suicidal ideation, behavior, and completed suicide are all public health threats; any future tools developed to aid clinicians with this challenging task should be made readily available for public health use.

In summary, the purpose of the ASQ is as Wintersteen et al stated: to “alert the clinician to the need for further evaluation of suicide risk.” We believe detection of suicidal ideation and past suicide attempts is a critical first step in preventing youth suicide and suicidal behavior.

References

1. Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med. 2012;166(12):1170–1176. [PubMed: 23027429]
2. Reynolds W Suicidal Ideation Questionnaire. Odessa, FL: Psychological Assessment Resources; 1987.
3. Bridge JA, Goldstein TR, Brent DA. Adolescent suicide and suicidal behavior. J Child Psychol Psychiatry. 2006;47(3–4):372–394. [PubMed: 16492264]
4. Rudd MD, Berman AL, Joiner TE Jr, et al. Warning signs for suicide: theory, research, and clinical applications. Suicide Life Threat Behav. 2006;36(3): 255–262. [PubMed: 16805653]
5. Kessler RC, Borges G, Walters EE. Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. Arch Gen Psychiatry. 1999;56(7):617–626. [PubMed: 10401507]
6. 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(2): 98–105. [PubMed: 18245022]