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Suicidal ideation and attempts in adults seeking outpatient psychodynamic psychotherapy

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Abstract

Suicide is an important cause of death in patients with mental health disorders, but little is known about the occurrence of suicidal ideation and attempts in outpatient psychotherapy patients. The aim of this study was to identify the proportion of patients with and correlates of suicidal ideation and attempts in community-based psychotherapy practices. Using 983 applications for reimbursement of psychotherapy from individual patients, reports about suicidal thoughts and suicide attempts were extracted along with demographic, biographic and clinical data. Multivariate logistic regression analysis was used to identify correlates of suicidal ideation and attempts by calculating odds ratios (ORs). Among the patients, 19% presented with suicidal thoughts (11% currently and 8% in the past) and 6% with suicide attempts. Important correlates of suicidal thoughts were male gender (OR 1.7), lower education (OR 1.8), early retirement (OR 2.9), death of a parent when younger than 5 years old (OR 3.3), violence experienced from various people (OR 2.1), self-harm behaviour (OR 7.9) and alcohol misuse (OR 1.7). Suicide attempts were associated with male gender (OR 5.6), lower education (OR 4.2), violence experienced from partner (OR 2.5) or from various people (OR 9.5) and self-harm behaviour (OR 15.0). These results show that the proportion of suicidal patients seeking outpatient psychotherapy is high. It should therefore be a central topic in clinical training. Biographic data such as the loss of a parent at an early age or experiencing violence are associated with who is at increased risk and should be explored in detail.

KEYWORDS

health services research, intentional injury, psychotherapy, risk, self-harm, suicide

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1 | INTRODUCTION

1.1 | Burden of suicidality

Suicides cause substantial loss of life years, emotional suffering among the bereaved friends and relatives, and various economic consequences for societies worldwide (Vasiliadis et al., 2015; Vigo et al., 2016; Walker et al., 2015; Yang & Lester, 2007). The global crude suicide rate was 9.2 per 100,000 individuals in 2019, with 12.6 in men and 5.7 in women (www.who.int), meaning that deaths by suicide are even more relevant, on a population level, than deaths by road accidents in many countries (Lopez et al., 2006; Yun & Son, 2016). In the United States, the rate is even higher, with 13.5 per 100,000 in 2020, making suicide the 12th leading cause of death for all ages in 2020 (Garnett et al., 2022).

Most suicides are preceded by thinking it over and making plans to carry it out. It is therefore important to identify suicidal thoughts in order to prevent suicide deaths (Schechter et al., 2022b). In fact, there is evidence that such thoughts are not uncommon: Lifetime suicide ideation was 14% in a national general population survey from the United States, with a median age of onset during the mid-20s (Kessler et al., 1999). Lifetime suicide attempts were 5%, of which 39% were serious, that is, with a clear intent to kill oneself. A representative survey conducted in England revealed similar numbers, with 12% having suicidal thoughts (without attempts) and 6% attempts (Richardson et al., 2022). In the World Mental Health Survey, across several countries, 9% reported suicidal ideation and 3% suicide attempts (Nock et al., 2008).

1.2 | Suicides and mental health

Poor mental health is one of the main drivers of death by suicide (Cavanagh et al., 2003; Glaesmer et al., 2020; Moller et al., 2022; Roy et al., 2021). A systematic review and meta-analysis of 203 studies showed that mortality due to unnatural causes (suicides and injuries) is seven times higher in patients with mental disorders compared to the general population (Walker et al., 2015). Similarly, people with increased distress have higher suicide-associated mortality rates (Hockey et al., 2022). The standardized mortality ratio for suicides in the first year after discharge from a psychiatric hospital was 134 among males and 208 in females in Norway (Hansen et al., 2001). When three or more disorders are present, the odds of death by suicide are nearly 20 times as high as without any psychiatric condition (Kessler et al., 1999). Suicide is an important cause of death for persons with various mental health conditions such as depression (G. K. Brown et al., 2000), borderline personality disorder (Black et al., 2004), obsessive-compulsive disorder (Torres et al., 2011), post-traumatic stress disorder (Schafer et al., 2022) or schizophrenia (Caldwell & Gottesman, 1990). Among a large group of patients with schizophrenia spectrum disorders, 13% died of suicide (Moreno-Kustner et al., 2021). Another group at risk are patients with substance abuse; a recent study from Hong Kong with 8270 participants

Key Practitioner Message

- The paper addresses the questions of how many patients seeking help in psychotherapy practices are suicidal and in which groups of patients a clinician should look especially closely for suicidal thoughts and attempts.
- We found that 19% of the patients presented with suicidal thoughts and 6% with suicide attempts. Suicide prevention should therefore be a central topic in clinical training.
- Patients who lost a parent early in life, who experienced violence, those with lower education, male gender and early retirement are at higher risk of suicidal ideation.

found that 3% of patients with polydrug use disorder take their own life (Chai et al., 2022). The standardized suicide-associated mortality ratio for cocaine users is 6.3 according to a recent meta-analysis (Peacock et al., 2021).

Individuals with one or more mental health conditions are also about seven times more likely to attempt suicide (Kessler et al., 1999), with the highest odds among patients with mania (odds ratio [OR] 29.7) and major depression (OR 11.0). Another group at risk for suicidal ideation and attempts are patients with borderline personality disorder (Black et al., 2004; M. Z. Brown et al., 2002; Doering et al., 2010).

A meta-analysis combining 365 studies found that patients with depression have 2.5 times the odds of suicide ideation, and history of abuse was associated with 1.9 times increased odds (Franklin et al., 2017). A combination of internalizing mental health disorders and experience of weapon violence or sexual abuse can increase the probability of suicide attempts considerably (Bery & Tanner-Smith, 2022).

1.3 | Transition from ideation to action

Not all people who think about taking their lives eventually follow through with these thoughts and take action. In order to help prevent suicides, it is important to know what factors increase the risk of action and what factors could potentially be protective.

In a meta-analysis including 27 individual studies, only four variables explained some of the likelihood of moving from ideation to action; these were anxiety disorders, post-traumatic stress disorder, drug use disorder and a sexual abuse history (May & Klonsky, 2016). A prospective study published 3 years later identified additional predictors of transition from ideation to attempt: non-suicidal self-harm, exposure to self-harm among friends and family, and openness as a personality factor (Mars et al., 2019). It is therefore especially important to look at these variables when investigating suicide attempts. While doing so, it is essential to keep in mind that suicidal ideation does not develop because of one single risk factor being present but

rather follows a complex interplay of life experiences. Trans-individual empirical studies have only a limited capacity to investigate these complex relationships. However, such empirical data can be used to check whether they support conceptual considerations such as the Hope Theory (Snyder, 2002), the Escape from Self Theory (Baumeister, 1990), the Interpersonal Psychological Theory of Suicide (Van Orden et al., 2010), the Integrated Motivational-Volitional Model (O'Connor & Pirkis, 2016) or the Three-Step Theory (Klonsky & May, 2015). The latter one assumes that pain (emotional and/or physical) without hope that the pain will ever end increases the likelihood of suicidal ideation, whereas the experience of being connected with life (with other people, a project or any other any sense of perceived purpose) is a strong protective factor. The transition from ideation to action then depends on the actual 'capability' to attempt suicide, in terms of dispositional, acquired and practical conditions. 'Acquired capability' refers to a person's continued or repeated experience of pain, fear and death, for example, physical or sexual abuse, non-suicidal self-injury or combat training. Practical conditions such as access to means (e.g., weapons) and knowledge of how to use them increase the likelihood of attempted suicide.

1.4 | Treatment in outpatient psychotherapy

It is clear that acute and chronic suicidal thoughts as well as attempts are common issues in daily mental health care (Leaune et al., 2021) and are important topics for clinical training (Kleespies et al., 1993). Surprisingly though, little is known about the treatment of patients with suicidal ideation or after suicide attempts in outpatient psychotherapy. Most literature focuses on suicide risk factors and prevention strategies on the population level (Opitz-Welke & Konrad, 2022; Vasiliadis et al., 2015; Zalsman et al., 2016) or in hospitals (Powell et al., 2000), but rarely in community-based practices or outpatient clinics (Asnis et al., 1993; Naidoo & Collings, 2017).

People seeking outpatient therapy present with a variety of problems, most often unexplained somatic complaints, followed by anxiety, depression and hopelessness, guilt, shame, self-doubt, experienced deficits in social relations and reduced regulation of emotions (Singer et al., 2021). Adults often have affective disorders, personality disorders, anxiety disorders, somatoform disorders, eating disorders or substance abuse, and often a combination of these (Gaebel et al., 2013; Henkel et al., 2018, 2019).

Specific treatments for people with suicidal experiences have been developed, and their effectiveness has been proven in various patient groups, for example, Dialectical Behavior Therapy (Linehan et al., 2015), Mentalization-based Therapy (Bateman & Fonagy, 2008), Cognitive Behavioral Suicide Prevention Therapy (Haddock et al., 2016) or the Integrative Psychodynamic Approach of the Boston Suicide Study Group (Schechter et al., 2019), in addition to more general approaches of psychotherapy. Therefore, effective treatments are available; however, it is unclear as to how often these topics are relevant for the outpatient setting.

1.5 | Study aim

The aim of this study was therefore to identify the proportion of patients with suicidal ideation and attempts in community-based psychotherapy practices. We also wanted to find out which groups of patients are at particular risk of presenting with suicidal thoughts and attempts because they might not reveal this during the first visits out of fear of being referred to a psychiatric hospital or because of shame (Farber, 2020). It is therefore important for clinicians to know the correlates of suicidal experiences not only on the general population level but more specifically in the group of patients seeking outpatient psychotherapy.

2 | METHOD

2.1 | Study material

In Germany, the costs for psychotherapy are covered by the statutory health insurances based on a carefully developed process: First, the patient discusses with the therapist whether and what type of outpatient psychotherapy is needed. After they agree on that, the patient completes a short application form for reimbursement of outpatient psychotherapy. This form is accompanied by another form completed by the therapist containing information about the International Classification of Diseases, 10th version (ICD-10) diagnoses, previous treatments in this practice, and the planned treatment as well as a consultative medical report if the therapist is a psychologist. These three forms are sent to the health insurance. In addition, the therapist prepares a report of about two to four pages explaining the need for psychotherapy. The health insurance is blinded to the content of this report for privacy reasons. Instead, the report is sent in a sealed envelope to another therapist with special expertise who reviews it and makes a recommendation to the health insurance for reimbursing therapy or not. These reviewers are appointed by the health authorities and serve several health insurance companies. Most private insurances follow a similar procedure. These reports must contain diagnostic findings about the current symptoms as well as the emotional and cognitive functioning of the patient, including suicidal thoughts and attempts.

Via one reviewer, we have access to a pool of about 40,000 pdf files of applications for psychodynamic psychotherapy for adults submitted to various health insurances between 2003 and 2017. As the psychotherapists do not know in advance to what reviewer their report is being sent, the preparation of the texts is independent of the individual reviewer. As such, the reports are unbiased in this regard.

2.2 | Study design and data extraction

From the pool of applications, we took a random sample of 1000 copies stratified by year. The applications (with forms and reports) were

first processed so that all person-identifying information about the therapist and the patient was blacked. We then extracted data about suicidal ideation and previous attempts together with other clinical, demographic and biographic details from the reports and the forms.

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. All procedures involving human subjects/patients were approved by the responsible ethics board of the state of Rhineland-Palatinate (# 2018-13321). As the reports were anonymized, no written consent was obtained. This was approved by the ethics board. A detailed description of the procedures and the sample has been published elsewhere (Singer et al., 2022).

2.3 | Definition of suicidal experiences

We differentiated between suicidal thoughts and suicide attempts. For each of them, it was noted whether it was 'currently and/or in the past', or 'in the past only', or 'never' or 'not mentioned'. We did not create a code for 'currently only' because whenever patients come to a therapist with current suicidal ideation, they most likely have had such thoughts already before that day.

As a suicide attempt cannot be 'current' when the patient visits the therapist, we named it 'recent'. To be coded as 'recent', the suicide attempt had to have happened shortly (days or few weeks) before the first consultation with the therapist or between the visits. Example: 'Mrs. X was in a psychiatric hospital for 6 weeks after a suicide attempt, because she did not know anymore what to do. She felt anxious and insecure, with ruminations. She had financial worries and constantly argued with her partner. [...] Between her 14th and 18th year of life, she attempted suicide 5 times, either with tablets or by slitting her wrists.' This was coded as 'suicidal thoughts: currently ± in the past' and 'suicide attempts: currently ± in the past'. As an umbrella term for both suicidal thoughts and suicide attempts, we use the word 'suicidal experiences'.

2.4 | Definition of potential correlates of suicidal experiences

We investigated a range of potential correlates of suicidal experiences, based on existing evidence (Franklin et al., 2017; Kessler et al., 2015; Knipe et al., 2022; Leckning et al., 2022; Nock et al., 2008; Pandeya et al., 2022; Roy et al., 2021; Schechter et al., 2022a; Simon et al., 2001), on theory (Gerisch, 2020; Glaesmer et al., 2020; Schechter et al., 2022a) and on our clinical experience. We also considered the nature of the data (i.e., no self-reports) and the number of reports available while selecting the variables for the analysis.

The *demographic variables* investigated were gender, age, school education, vocational training and country of birth. School education

was grouped into college, post-compulsory, compulsory or below, and unknown/not reported. Vocational training was categorized into university, higher vocational training, advanced vocational training, apprenticeship, other vocational training and no vocational training (yet). The countries of birth were grouped into Global North and Global South.

We also coded a range of life experiences, named *biographic data*. This included experience of violence (from partner, within family, outside family or none), separation of the parents (and if yes, at what age of the patient), death of parents (and if yes, at what age of the patient), employment (full-time, half-time, less than half-time, homemaker, in training, early retirement or age pension), partner (no partner, long-term or stable partnership or changing partners), death of partner (yes or no), parenthood (has blood-related children or is pregnant or has pregnant partner, has social children, has both blood-related and social children or has no children), somatic comorbidity (ICD-10 code) and chronic pain (episodes of any type of pain with a duration of at least 6 months; currently, only in the past or no). If no information about a certain experience was provided in the report, it was coded as 'not mentioned/unknown'.

Self-destructive behaviour was coded when the report stated that the patients currently or in the past abused alcohol or drugs (illegal or legal) or when they harmed themselves in terms of self-inflicting wounds and/or pain (cutting, hitting, burning etc. oneself), called 'self-harm' in the following. This could be with or without intent to die.

We did not consider the F-diagnosis to be a predictor in the statistical model because the diagnosis given depends on the symptoms, which includes suicidal ideation. However, the percentage of F-diagnoses in those with and without suicidal experiences is presented for information.

The definition and categorization of the variables was based on (a) variables from the census to make our finding comparable with population data wherever possible, (b) interest of members of our group for specific topics and (c) the material of the reports via an iterative process of inductive and deductive content analysis with the first 250 reports. By doing so, the data extraction sheet for the reports was revised nine times before it was ready for use with the entire sample. From the application forms, all variables were extracted as printed on the forms.

2.5 | Data analysis

We defined two endpoints: **suicidal thoughts** (either currently and/or in the past vs. not evident, i.e., never or not mentioned) and **suicide attempts** (either recently and/or in the past vs. not evident, i.e., never or not mentioned). An attempt usually implies that there are also suicidal thoughts.

Prevalence estimates of evident suicidal thoughts and suicide attempts were generated using cross-tabulations. When the number of events per category was small, it was combined with another category as long as it made sense from a clinical perspective.

Multivariate binary logistic regression analysis was conducted to determine the odds of suicidal thoughts and attempts by comparing the different categories per group. We applied three models: The first model included demographic variables, the second one demographic and biographic variables and the third one all variables (including self-destructive behaviour). This last group of variables was considered to be on the causal pathway and therefore modelled separately.

The maximum number of variables (and categories) to be included in the regression models was based on the number of applications available, with the rule of 20 observations per category to ensure sufficient power (Bujang et al., 2018; Singer, 2010).

Before performing the modelling, we tested each variable for evidence of effect modification by age or gender, using likelihood ratio tests.

In a next step, the likelihood of acting on the suicidal ideation was estimated by conducting binary logistic regression analyses with lifetime attempts as the outcome measure and the previously tested variables as predictors only among those with suicidal ideation.

The diagnoses and treatment of patients with and without suicidal experiences were explored using cross-tabulations. All analyses were performed using the statistical software STATA version 15.1 (StataCorp, Texas).

3 | RESULTS

3.1 | Sample

The 1000 sampled applications came from 983 different patients. We used only the first application per patient, thereby excluding 17 applications. The age of the patients at the time of the application ranged from 17 to 76 years (mean: 41 years). The majority was female (see Table 1 for more details).

3.2 | Suicidal experiences

Suicidal thoughts were present in 108 (11%) patients; 75 (8%) had suffered from this in the past but not currently; 258 (26%) of the patients denied having suicidal thoughts, and in 542 (55%) reports, it was not mentioned.

Five patients (1%) had recently attempted suicide, while 50 (5%) had done so in the past but not recently, 287 (29%) denied it, and in 641 reports (65%), it was not mentioned.

Taking current and previous episodes together, 183 (19%) patients presented with suicidal thoughts and 55 (6%) with suicide attempts.

3.3 | Factors associated with suicidal thoughts

We found no evidence for any effect modification by gender. There was some evidence that age modified the effect of parenthood on

suicidal thoughts: In younger patients (<40 years), those without children were more likely to have suicidal thoughts, whereas in older patients (from age 50 onwards), it was the opposite—those with children more often presented with suicidal thoughts ($p = 0.06$ for the likelihood ratio test). However, as the differences were not large, we decided not to stratify the following regression models.

The first model with demographic data only, Model 1, revealed male sex and lower educational levels as associated with suicidal thoughts (see Table 2 for details). The pseudo R^2 was 0.04.

When adding biographic data to these variables in Model 2, the variance explained doubled to $R^2 = 0.08$. Men appeared to have 1.6 times the odds of presenting with suicidal thoughts. People with post-compulsory education (OR 1.9) and with compulsory education (OR 1.9) had also higher odds compared to patients with a college degree. Those who had experienced violence in more than one area, for example, within the family and outside, had 2.4 times the odds of suicidal thoughts. Patients who had lost a parent at an age younger than 5 years were also at increased risk (OR 3.4). There was no evidence that the experience of parents' separation or of losing a partner due to death is associated with the occurrence of suicidal thoughts. Patients who were early retired were 3.1 times more likely to present with suicidal thoughts compared to those with at least half-time employment.

The model including self-destructive behaviour (Model 3) did not have considerably different effect estimates except for lower education, the effect for which decreased a little (from 1.9 to 1.7). The pseudo R^2 increased to 0.13. Alcohol abuse (OR 1.7) and self-harm behaviour (OR 7.9) appeared to be correlates of suicidal thoughts in addition to the other variables.

3.4 | Factors associated with suicide attempts

There was no evidence for effect modification by age or gender, though we noted that none of the men had told the therapist that he had experienced violence from his partner.

When including only demographic variables in the regression analysis (Model 1), 8% of the variance of suicide attempt occurrence was explained. Male gender (OR 2.6) and lower education (OR 3.3 for post-compulsory and 5.0 for compulsory education; 2.5 for no vocational training) appeared to be correlates of suicide attempts in this model.

Adding biographic variables to this (Model 2) increased the R^2 to 0.20. The effect of male gender increased to OR 3.8, whereas the effect of education decreased (see Table 3 for details). Patients who had experienced violence from their partner (OR 4.1) or from various people (OR 9.2) more often had attempted to take their own life.

When adding self-destructive behaviour (Model 3), 28% of the variance of suicide attempts was explained. The effect estimates changed somewhat, with males now having 5.6 times the odds of attempting suicide and people with compulsory education having 4.2 times the odds. However, the general picture did not change markedly. Patients with self-harm behaviour were 15 times more likely to

TABLE 1 Share of patients with suicidal experiences overall and per patient group

		With suicidal thoughts		With suicide attempts		All	
		N	% ^a	N	% ^a	N	% ^b
All patients		183	19%	55	6%	983	
Gender	Female	134	18%	34	4%	759	77%
	Male	49	22%	21	10%	222	23%
	Unknown					2	0.2%
Age	<30 years	39	21%	10	5%	182	19%
	30–39 years	47	18%	15	6%	258	26%
	40–49 years	64	21%	21	7%	303	31%
	50–59 years	28	14%	7	4%	200	20%
	60–69 years	4	13%	2	6%	32	3%
	70+ years	1	13%	0	0%	8	1%
School education	College	56	15%	11	3%	386	39%
	Post-compulsory	50	24%	16	8%	211	21%
	Compulsory or below	27	26%	14	13%	104	11%
	Unknown/not mentioned	50	18%	14	5%	282	29%
Vocational training	University or higher/advanced vocational	46	16%	9	3%	296	30%
	Apprenticeship/other	94	20%	31	7%	469	48%
	None (yet)	24	30%	9	11%	80	8%
	Unknown/not mentioned	19	14%	6	4%	138	14%
Country of birth	Global North	101	20%	29	6%	506	51%
	Global South	6	32%	1	5%	19	2%
	Unknown/not mentioned	76	17%	25	5%	458	47%
Experienced violence	No or not reported	108	16%	26	4%	673	68%
	(Only) outside family	4	15%	0	0%	26	3%
	(Only) from partner	5	23%	3	14%	22	2%
	(Only) within family	46	23%	12	6%	204	21%
	In >1 area	20	34%	14	24%	58	6%
Parents' death	Both still alive	51	17%	18	6%	296	30%
	One alive and the other not mentioned	25	17%	4	3%	150	15%
	At least one parent died after age 18 years	36	18%	16	8%	204	21%
	At least one parent died at age 12–18 years	4	12%	0	0%	34	3%
	At least one parent died at age 5–11 years	6	22%	0	0%	27	3%
	One parent died at age < 5 years	6	40%	0	0%	15	2%
	Both parents died at age < 5 years	0		0		0	0%
	Unknown/not mentioned	55	21%	17	7%	257	26%
Parents' separation	Not separated	68	17%	20	5%	389	40%
	Separated after age 18 years	4	18%	2	9%	22	2%
	Separated at age 12–18 years	4	10%	0	0%	40	4%
	Separated at age 5–11 years	10	16%	7	11%	61	6%
	Separated at age < 5 years	22	27%	9	11%	82	8%
	Unknown/not mentioned	75	19%	17	4%	389	40%
Employment	At least half-time or in training	97	17%	30	5%	571	58%
	Age pension	2	13%	0	0%	15	2%
	Early retirement	18	35%	6	12%	51	5%
	Homemaker or less than half-time	14	18%	3	4%	77	8%
	Unemployed	24	21%	8	7%	114	12%
	Unknown	28	18%	8	5%	155	16%

TABLE 1 (Continued)

		With suicidal thoughts		With suicide attempts		All	
		N	% ^a	N	% ^a	N	% ^b
Partner	Without partner	64	21%	21	7%	303	31%
	Stable partner	87	16%	27	5%	548	56%
	Changing partners	17	24%	3	4%	70	7%
	Unknown/not mentioned	15	24%	4	6%	62	6%
Partner's death	No or not mentioned	176	18%	54	6%	953	97%
	Yes	7	23%	1	3%	30	3%
Parenthood	No children or not mentioned	92	19%	29	6%	486	49%
	Has blood-related and/or social children or is pregnant/has pregnant partner	91	18%	26	5%	497	51%
Somatic comorbidity	No or not mentioned	117	18%	30	5%	666	68%
	Somatic comorbidity	66	21%	25	8%	317	32%
Chronic pain	No or not mentioned	145	18%	39	5%	812	83%
	Yes, at present or previously	38	22%	16	9%	171	17%
Self-harm behaviour	No or not mentioned	151	16%	39	4%	931	95%
	Yes, at present or previously	32	62%	16	31%	52	5%
Alcohol misuse	No or not mentioned	155	17%	47	5%	898	91%
	Yes, at present or previously	28	33%	8	9%	85	9%
Drug misuse	No or not mentioned	162	18%	49	5%	912	93%
	Yes, at present or previously	21	30%	6	8%	71	7%

^aPercentages describe the proportion of patients within this group who presented with suicidal thoughts/suicide attempts (row percentage).

^bPercentages describe the proportion of patients among all participants (column percentage).

have attempted to take their life. There was no evidence for an effect of age, country of birth, marital status, parenthood, parents' separation or parents' death on the occurrence of suicide attempts.

3.5 | Factors associated with suicide attempts among people with suicidal thoughts

Among patients where suicidal experiences were reported, the ones with lower education (OR 8.1), male gender (OR 3.3), history of violence (OR 8.1 for within couple violence and OR 5.2 for violence from different social groups), chronic pain (OR 3.7), self-harm behaviour (OR 8.4) and whose parents separated during childhood (OR 5.7) had a higher likelihood of acting on their thoughts and attempting to take their lives (Table 4).

3.6 | Diagnoses of patients with suicidal experiences

Compared to the entire group, diagnoses of mood and of personality disorders were more often present in patients with suicidal thoughts and suicide attempts (Table 5).

3.7 | Previous and current treatment

Previous or concurrent use of mental health care in terms of visits to psychiatrists, previous psychotherapy, admission to psychiatric or psychosomatic hospitals and intake of psychotropic medication was higher in patients with suicidal experiences (Figure 1).

Regarding the current psychotherapy, the mean number of sessions applied for was 85 in patients without evidence of suicidal experiences (range 20 to 440 sessions), 95 sessions in patients with suicidal thoughts (range 25 to 300) and 67 in patients with suicide attempts (range 10 to 223, $p = 0.006$), whereby gender modified this association ($p = 0.01$; Figure 2). Patients with suicide attempts more often applied for short-term psychotherapy (13%) than those with suicidal thoughts only (4%) or those without evidence for suicidal experiences (5%, $p = 0.05$).

4 | DISCUSSION

This study set out to investigate the occurrence and correlates of suicidal experiences in adults seeking outpatient psychotherapy. We found that 19% of the patients presented with suicidal thoughts and 6% with suicide attempts. This is a large proportion, more than in the

TABLE 2 Correlates of suicidal thoughts

		Model 1				Model 2				Model 3			
		Demographic				Demographic + biography				Demographic + biography + self-destructive behaviour			
		OR	CI	p	OR	CI	p	OR	CI	p			
Gender	Female	Ref			Ref			Ref					
	Male	1.5	[1.0 2.1]	0.05	1.6	[1.1 2.4]	0.03	1.7	[1.1 2.6]	0.01			
Age	<30 years	Ref			Ref			Ref					
	30–39 years	0.8	[0.5 1.4]	0.47	0.8	[0.4 1.3]	0.29	0.9	[0.5 1.6]	0.67			
	40–49 years	1.0	[0.6 1.5]	0.88	0.8	[0.5 1.4]	0.44	1.0	[0.6 1.8]	0.97			
	50–59 years	0.5	[0.3 0.9]	0.03	0.4	[0.2 0.7]	0.01	0.5	[0.2 1.0]	0.04			
	60+ years	0.5	[0.2 1.3]	0.14	0.3	[0.1 1.3]	0.11	0.4	[0.1 1.5]	0.19			
School education	College	Ref			Ref			Ref					
	Post-compulsory	2.3	[1.4 3.8]	<0.01	1.9	[1.1 3.2]	0.02	1.8	[1.1 3.2]	0.03			
	Compulsory or below	2.2	[1.2 4.1]	0.01	1.9	[1.0 3.6]	0.04	1.7	[0.9 3.4]	0.10			
	Unknown/not mentioned	1.9	[1.1 3.1]	0.02	1.4	[0.8 2.5]	0.19	1.3	[0.7 2.3]	0.40			
Vocational training	University or higher vocational	Ref			Ref			Ref					
	Apprenticeship/other	0.9	[0.6 1.5]	0.70	0.9	[0.5 1.4]	0.62	0.9	[0.5 1.5]	0.65			
	None (yet)	1.7	[0.9 3.2]	0.09	1.5	[0.7 2.9]	0.28	1.5	[0.7 3.1]	0.25			
	Unknown/not mentioned	0.6	[0.3 1.2]	0.14	0.5	[0.2 1.0]	0.07	0.5	[0.3 1.1]	0.11			
Country of birth	Global North	Ref			Ref			Ref					
	Global South	1.6	[0.3 1.2]	0.14	1.5	[0.5 4.3]	0.50	1.1	[0.3 3.5]	0.89			
	Unknown/not mentioned	0.8	[0.6 4.6]	0.36	0.7	[0.5 1.1]	0.10	0.7	[0.5 1.0]	0.05			
Experienced violence	No or not mentioned				Ref			Ref					
	(Only) outside family				0.7	[0.2 2.4]	0.60	0.7	[0.2 2.2]	0.49			
	(Only) from partner				1.4	[0.5 4.3]	0.51	1.3	[0.4 3.9]	0.66			
	(Only) within family				1.4	[0.9 2.1]	0.13	1.1	[0.7 1.7]	0.68			
	In >1 area				2.4	[1.3 4.6]	0.01	2.1	[1.1 4.1]	0.03			
Parents' death	Both still alive or one alive/one not mentioned				Ref			Ref					
	At least one parent ... died after age 18 years				1.1	[0.7 1.8]	0.70	1.1	[0.6 1.8]	0.84			
	... died at age 12–18 years				0.6	[0.2 1.8]	0.35	0.5	[0.1 1.6]	0.23			
	... died at age 5–11 years				1.8	[0.7 5.0]	0.26	2.1	[0.7 5.7]	0.16			
	... died at age < 5 years				3.4	[1.1 10.9]	0.04	3.3	[1.0 10.7]	0.05			
	Unknown/not mentioned				Ref			Ref					
Parents' separation	Not separated				1.5	[0.9 2.3]	0.09	1.4	[0.9 2.2]	0.17			
	Separated after age 11 years				0.7	[0.3 1.5]	0.34	0.7	[0.3 1.6]	0.39			
	Separated at age 5–11 years				0.7	[0.3 1.6]	0.45	0.6	[0.3 1.4]	0.21			
	Separated at age < 5 years				1.5	[0.8 2.7]	0.17	1.2	[0.6 2.3]	0.57			
	Unknown/not mentioned				1.2	[0.8 1.8]	0.43	1.3	[0.8 2.0]	0.33			
Employment	At least half-time or in training				Ref			Ref					
	Age pension				1.1	[0.2 6.2]	0.93	1.2	[0.2 7.1]	0.84			
	Early retirement				3.0	[1.5 6.1]	<0.01	2.9	[1.4 6.0]	<0.01			
	Homemaker				1.1	[0.5 2.1]	0.85	1.1	[0.6 2.3]	0.76			
	Unemployed				1.1	[0.6 1.9]	0.74	1.0	[0.6 1.8]	0.96			
	Unknown				1.4	[0.8 2.3]	0.24	1.4	[0.9 2.5]	0.17			

TABLE 2 (Continued)

		Model 1			Model 2			Model 3		
		Demographic			Demographic + biography			Demographic + biography + self-destructive behaviour		
		OR	CI	<i>p</i>	OR	CI	<i>p</i>	OR	CI	<i>p</i>
Partner	Without partner				Ref			Ref		
	Stable partner				0.8	[0.5 1.1]	0.17	0.8	[0.5 1.1]	0.18
	Changing partners				1.3	[0.7 2.5]	0.43	1.4	[0.7 2.7]	0.36
	Unknown/not mentioned				1.6	[0.8 3.3]	0.17	1.8	[0.9 3.7]	0.10
Partner's death	Yes, partner died				1.1	[0.4 2.9]	0.83	1.2	[0.5 3.2]	0.71
Parenthood	Has children				1.0	[0.7 1.5]	0.92	1.1	[0.7 1.6]	0.77
Somatic comorbidity	Somatic comorbidity				1.1	[0.8 1.6]	0.61	1.2	[0.8 1.8]	0.32
Chronic pain	Yes, at present or previously				1.2	[0.7 1.8]	0.50	1.2	[0.8 1.9]	0.42
Self-harm behaviour	Yes, at present or previously							7.9	[4.1 15.3]	<0.01
Alcohol misuse	Yes, at present or previously							1.7	[0.9 3.2]	0.09
Drug misuse	Yes, at present or previously							1.0	[0.5 1.9]	0.92

Abbreviations: CI, confidence interval; OR, odds ratio; Ref, Reference.

general population (Kessler et al., 1999; Richardson et al., 2022) where 10% report suicidal ideation and 2% suicide attempts in Germany (Nock et al., 2008). This is not surprising because poor mental health is a known risk factor for suicidal ideation (Cavanagh et al., 2003; Franklin et al., 2017; Schechter et al., 2022a; Zheng et al., 2021). Among people with schizophrenia, 34% have suicidal thoughts at least once in their life, according to a meta-analysis (Bai et al., 2021). Even in countries where suicidal behaviour is stigmatized, like Morocco, 31% of the patients with severe psychiatric disorders reported a history of suicide attempts (Barrimi et al., 2022). In a hospital in Beijing, China, the medical records of 12% of the patients with one or more of five types of mental disorders contained indications of suicidal ideation (Zhu et al., 2021). In psychiatric hospitals in Germany, 5% of the inpatients require 1:1 care because of acute suicidality, according to documented data from 47 hospitals (Nienaber et al., 2016). It is also known that people thinking about taking their own life more often seek help from health care professionals (Litman et al., 1963), which is important because this opens a window of opportunity to prevent suicides. Knowing about this proportion of patients with suicidal experiences in community-based psychotherapy practices is helpful to inform clinical practice and training.

Regarding correlates of suicidal thoughts and attempts, we first looked at demographic variables alone because these data are usually already available at the time of the first contact with the practice. These results thus can give the clinicians hints for who might be at increased risk before they can explore in more depth. In contrast to data from the general population (Richardson et al., 2022), we found that men had a higher probability of suicidal thoughts than women. One explanation for this difference could be that our results are based

on data from clinical practice, not on surveys. It might be that men do not disclose suicidal thoughts as openly in a questionnaire compared to when they are asked about that by a therapist. Another explanation could be that men have more reservations about contacting doctors or therapists for mental health issues, leading to delayed treatment and thereby worsened symptoms (Bayer et al., 2020; Curry et al., 2002; Doherty & Kartalova-O'Doherty, 2010). Men were also more likely to have attempted to take their own life, which is in line with findings from the general population and clinical samples (Nock & Kessler, 2006; O'Connor & Pirkis, 2016; Richardson et al., 2022; Śmigielski et al., 2021). Lower education was another correlate, which is in accordance with data from other settings (Borges et al., 2010; Kessler et al., 1999; Śmigielski et al., 2021).

However, these demographic variables are most likely not causes of suicidal ideation but merely indicators for it. Much more important are the experiences the patients had, especially during childhood (Richardson et al., 2022). Our findings show that the loss of parents (due to separation or death) before the age of 5 especially increases the risk for suicidal thoughts. This can be explained by developmental psychology theories and the role of early deprivation (Spitz, 1951). The loss of important others can, in the minds of the young person, leave a trace of experiences of being abandoned, which can stay until adulthood. This can result in feelings of loneliness and being unconnected, which increases the likelihood of suicidal actions according to the Three-Step Theory of suicide (Klonsky & May, 2015). We found in our study that among ideators, those whose parents separated during childhood had a higher probability of attempting suicide.

Another important risk factor for suicide attempts, most likely causal, was experienced violence, especially when the patients had

TABLE 3 Correlates of suicide attempts

		Model 1				Model 2				Model 3			
		Demographic			Demographic + biography			Demographic + biography + self-destructive behaviour					
		OR	CI	p	OR	CI	p	OR	CI	p			
Gender	Female	Ref			Ref			Ref					
	Male	2.6	[1.4 4.7]	<0.01	3.8	[1.9 7.7]	<0.01	5.6	[2.6 12.1]	<0.01			
Age	<30 years	Ref			Ref			Ref					
	30–39 years	1.0	[0.4 2.4]	0.99	1.0	[0.4 2.8]	0.95	1.6	[0.5 5.1]	0.39			
	40–49 years	1.1	[0.5 2.4]	0.86	1.0	[0.4 2.9]	0.98	1.7	[0.5 5.4]	0.38			
	50–59 years	0.4	[0.1 1.2]	0.10	0.4	[0.1 1.6]	0.21	0.7	[0.2 2.9]	0.60			
	60+ years	0.8	[0.2 3.8]	0.74	1.5	[0.2 11.1]	0.68	2.4	[0.3 19.6]	0.42			
School education	College	Ref			Ref			Ref					
	Post-compulsory	3.3	[1.3 8.3]	0.01	2.3	[0.8 6.3]	0.12	2.3	[0.8 6.7]	0.14			
	Compulsory or below	5.0	[1.9 13.1]	<0.01	4.6	[1.6 13.4]	0.01	4.2	[1.4 12.8]	0.01			
	Unknown/not mentioned	2.0	[0.8 5.1]	0.15	1.6	[0.6 4.5]	0.36	1.3	[0.4 3.9]	0.65			
Vocational training	University or higher vocational	Ref			Ref			Ref					
	Apprenticeship/other	1.3	[0.5 3.1]	0.61	1.3	[0.5 3.5]	0.57	1.3	[0.5 3.7]	0.58			
	None (yet)	2.5	[0.9 7.4]	0.08	2.1	[0.6 7.0]	0.24	2.6	[0.7 9.7]	0.15			
	Unknown/not mentioned	1.0	[0.3 3.4]	0.98	0.8	[0.2 2.8]	0.68	0.8	[0.2 3.1]	0.72			
Country of birth	Global North	Ref			Ref			Ref					
	Global South	0.6	[0.1 5.4]	0.67	0.9	[0.1 7.8]	0.89	0.3	[0.0 4.1]	0.38			
	Unknown/not mentioned	1.0	[0.5 1.7]	0.90	1.1	[0.6 2.1]	0.77	1.0	[0.5 1.9]	0.91			
Experienced violence	No or not mentioned				Ref			Ref					
	(Only) outside family				–			–					
	(Only) from partner				4.1	[0.9 17.9]	0.06	3.5	[0.7 18.4]	0.14			
	(Only) within family				1.3	[0.6 2.9]	0.46	0.9	[0.4 2.1]	0.84			
	In >1 area				9.2	[3.8 22.3]	<0.01	9.5	[3.7 24.1]	<0.01			
Parents' death	Both still alive or one alive/one not mentioned				Ref			Ref					
	... died after age 18 years				1.3	[0.6 3.0]	0.51	1.3	[0.5 3.1]	0.56			
	... died at age 12–18 years				–			–					
	... died at age 5–11 years				–			–					
	... died at age < 5 years				–			–					
	Unknown/not mentioned				Ref			Ref					
Parents' separation	Not separated				1.8	[0.9 4.0]	0.12	1.7	[0.8 4.0]	0.18			
	Separated after age 11 years				0.6	[0.1 2.8]	0.48	0.6	[0.1 3.5]	0.59			
	Separated at age 5–11 years				2.0	[0.7 5.6]	0.21	1.3	[0.4 4.3]	0.64			
	Separated at age < 5 years				1.7	[0.6 4.3]	0.30	1.2	[0.4 3.5]	0.68			
	Unknown/not mentioned				0.6	[0.3 1.4]	0.25	0.6	[0.3 1.5]	0.27			
Employment	At least half-time or in training				Ref			Ref					
	Age pension				–			–					
	Early retirement				2.2	[0.8 6.7]	0.15	2.1	[0.7 6.7]	0.19			

TABLE 3 (Continued)

		Model 1			Model 2			Model 3		
		Demographic			Demographic + biography			Demographic + biography + self-destructive behaviour		
		OR	CI	<i>p</i>	OR	CI	<i>p</i>	OR	CI	<i>p</i>
	Homemaker				0.6	[0.1 2.3]	0.42	0.6	[0.1 2.8]	0.50
	Unemployed				0.7	[0.3 2.0]	0.56	0.7	[0.2 2.0]	0.51
	Unknown				1.3	[0.5 3.2]	0.62	1.3	[0.5 3.6]	0.55
Partner	Without partner				Ref			Ref		
	Stable partner				0.6	[0.3 1.3]	0.18	0.7	[0.3 1.4]	0.29
	Changing partners				0.8	[0.2 3.0]	0.71	1.1	[0.3 4.8]	0.85
	Unknown/not mentioned				1.7	[0.5 6.1]	0.39	2.5	[0.7 9.6]	0.17
Partner's death	Yes, partner died				0.3	[0.0 3.0]	0.33	0.4	[0.0 3.7]	0.40
Parenthood	Has children				0.8	[0.4 1.5]	0.43	0.8	[0.4 1.7]	0.59
Somatic comorbidity	Somatic comorbidity				1.5	[0.8 2.9]	0.20	1.8	[0.9 3.6]	0.10
Chronic pain	Yes, at present or previously				1.5	[0.7 3.2]	0.26	1.8	[0.8 3.9]	0.14
Self-harm behaviour	Yes, at present or previously							15.0	[6.0 38.0]	<0.01
Alcohol misuse	Yes, at present or previously							1.7	[0.6 4.8]	0.28
Drug misuse	Yes, at present or previously							0.5	[0.1 1.6]	0.22

Abbreviations: CI, confidence interval; OR, odds ratio; Ref, Reference.

been repeatedly traumatized, which is in line with existing literature (Beryn & Tanner-Smith, 2022; Mars et al., 2019). The findings support the assumption that continued or repeated experience of fear, death or pain results in an 'acquired capability' to act on the suicidal ideation (Klonsky & May, 2015). A consequence for the clinical practice is that patients with such experiences should be monitored especially carefully for suicidal ideation, even if they themselves do not actively bring this topic up. It should be mentioned that words like 'capability' or 'capacity' should not be used in such a way that people reaching out for help are denied help. It seems that, sadly, this sometimes happens, maybe because of a misconception about what capacity means (Aves, 2022).

Unemployment, a risk factor for suicide in the general population (Voss et al., 2004), did not appear to be a correlate of suicidal thoughts in our sample of psychotherapy patients. Early retirement, however, was. A possible explanation for this could be that retired patients feel their life lacks meaning because they cannot contribute to society as much as their peers, in addition to the prospect that this will not change—in contrast to unemployment, which usually is transient. It is also possible that early retirement and suicidal thoughts have a common cause, namely, poor mental health (Singer et al., 2014), making this a confounding factor. This has clinical implications as patients might urge therapists and doctors to support their desire to retire, thinking retirement will alleviate their mental health problems; however, having their retirement application granted

ultimately does not make them feel better. On the contrary, suicidal thoughts are more common.

Suicide is the ultimate form of self-destruction, and therefore, it is not surprising that self-injurious thoughts and behaviours are more common in people with suicidal ideation (Litman et al., 1963; Ribeiro et al., 2016). This also includes self-destructive behaviour in a more general sense, such as alcohol consumption or dangerous driving (Farberow, 1980). Our findings are in line with that. Alcohol also reduces ego functioning and thereby can increase the risk for suicide attempts if ideation is present (Richardson et al., 2021). As such, it is a factor on the causal pathway.

Another important result of our study is that patients with suicidal experiences who seek outpatient psychotherapy had used mental health care in the past more often than other patients, underlining the importance of support by medical personnel who are often sought out as potential rescuers (Litman et al., 1963). They more often applied for short-term therapy probably because this can in most cases be provided by the therapist without prior approval by the health insurance and therefore can be offered faster than long-term therapy. Another explanation is that one of the aims of consultations in such situations could be to explore whether the patients can make use of outpatient psychotherapy. Long-term treatment would then only be offered if this could be confirmed. Third, it is also possible that therapists are afraid of the legal and emotional consequences of having a suicidal patient in treatment, therefore offering them fewer

TABLE 4 Factors associated with suicide attempts among people with suicidal ideation

		Model 1			Model 2			Model 3		
		Demographic			Demographic + biography			Demographic + biography + self-destructive behaviour		
		OR	CI	<i>p</i>	OR	CI	<i>p</i>	OR	CI	<i>p</i>
Gender	Female	Ref			Ref			Ref		
	Male	1.5	[0.7 3.4]	0.34	2.5	[0.9 7.1]	0.08	3.3	[1.0 10.9]	0.05
Age	<30 years	Ref			Ref			Ref		
	30–39 years	1.1	[0.4 3.2]	0.80	1.4	[0.4 5.4]	0.62	1.8	[0.4 7.9]	0.42
	40–49 years	0.9	[0.3 2.5]	0.86	0.9	[0.2 3.8]	0.84	1.1	[0.2 5.9]	0.88
	50–59 years	0.5	[0.1 1.9]	0.32	0.6	[0.1 4.3]	0.65	0.7	[0.1 6.2]	0.78
	60+ years	1.5	[0.2 12.9]	0.69	5.3	[0.1 202.4]	0.37	5.7	[0.0 713.2]	0.48
School education	College	Ref			Ref			Ref		
	Post-compulsory	2.5	[0.8 7.8]	0.13	1.7	[0.4 7.4]	0.46	1.6	[0.3 7.6]	0.58
	Compulsory or below	5.8	[1.6 20.4]	0.01	7.2	[1.5 34.0]	0.01	8.1	[1.5 42.8]	0.01
	Unknown/not mentioned	1.8	[0.6 6.0]	0.31	1.9	[0.4 8.2]	0.38	1.7	[0.3 8.0]	0.53
Vocational training	University or higher vocational	Ref			Ref			Ref		
	Apprenticeship/other	1.3	[0.4 3.8]	0.66	1.6	[0.4 5.8]	0.48	1.7	[0.4 7.1]	0.48
	None (yet)	1.5	[0.4 5.6]	0.58	1.9	[0.3 9.9]	0.47	2.7	[0.4 17.4]	0.29
	Unknown/not mentioned	1.2	[0.3 5.2]	0.84	1.7	[0.2 12.2]	0.60	1.8	[0.2 16.9]	0.60
Country of birth	Global North	Ref			Ref			Ref		
	Global South	0.3	[0.0 4.0]	0.39	0.5	[0.0 7.5]	0.63	0.4	[0.0 5.9]	0.48
	Unknown/not mentioned	0.9	[0.4 2.0]	0.85	1.6	[0.6 4.7]	0.37	1.7	[0.5 5.4]	0.41
Experienced violence	No or not mentioned				Ref			Ref		
	(Only) outside family				-			-		
	(Only) from partner				7.9	[0.6 101.1]	0.11	8.1	[0.6 119.6]	0.13
	(Only) within family				0.9	[0.3 2.6]	0.78	0.5	[0.1 1.8]	0.29
	In >1 area				4.7	[1.1 19.1]	0.03	5.2	[1.1 24.8]	0.04
Parents' death	Both still alive or one alive/one not mentioned				Ref			Ref		
	... died after age 18 years				2.8	[0.8 10.0]	0.11	3.2	[0.8 12.4]	0.09
	... died at age 12–18 years				-			-		
	... died at age 5–11 years				-			-		
	... died at age < 5 years				-			-		
	Unknown/not mentioned				Ref			Ref		
Parents' separation	Not separated				1.1	[0.4 3.3]	0.85	1.3	[0.4 4.2]	0.67
	Separated after age 11 years				4.0	[0.5 32.2]	0.19	5.5	[0.6 51.0]	0.13
	Separated at age 5–11 years				8.2	[1.2 54.5]	0.03	5.7	[0.8 41.6]	0.08
	Separated at age < 5 years				1.6	[0.4 7.4]	0.52	1.1	[0.2 6.0]	0.88
	Unknown/not mentioned				0.7	[0.2 2.0]	0.47	0.6	[0.2 1.9]	0.35
Employment	At least half-time or in training				Ref			Ref		
	Age pension									
	Early retirement				0.5	[0.1 2.5]	0.38	0.4	[0.1 2.6]	0.31
	Homemaker				0.6	[0.1 4.1]	0.59	0.6	[0.1 5.6]	0.67
	Unemployed				0.7	[0.2 3.1]	0.65	0.6	[0.1 2.8]	0.54
	Unknown				1.0	[0.2 4.1]	0.99	0.7	[0.1 3.1]	0.59

TABLE 4 (Continued)

		Model 1			Model 2			Model 3		
		Demographic			Demographic + biography			Demographic + biography + self-destructive behaviour		
		OR	CI	<i>p</i>	OR	CI	<i>p</i>	OR	CI	<i>p</i>
Partner	Without partner				Ref			Ref		
	Stable partner				0.8	[0.3 2.2]	0.69	1.0	[0.3 3.0]	0.98
	Changing partners				0.6	[0.1 3.5]	0.59	1.1	[0.2 7.0]	0.94
	Unknown/not mentioned				1.3	[0.2 7.5]	0.77	2.6	[0.4 16.8]	0.33
Partner's death	Yes, partner died				0.5	[0.0 7.2]	0.62	0.4	[0.0 6.3]	0.49
Parenthood	Has children				1.0	[0.3 2.8]	0.93	1.1	[0.3 3.9]	0.86
Somatic comorbidity	Somatic comorbidity				1.8	[0.6 5.0]	0.29	2.2	[0.7 6.7]	0.17
Chronic pain	Yes, at present or previously				2.5	[0.8 7.5]	0.11	3.7	[1.1 12.2]	0.03
Self-harm behaviour	Yes, at present or previously							8.4	[2.5 28.6]	<0.01
Alcohol misuse	Yes, at present or previously							1.8	[0.5 6.5]	0.40
Drug misuse	Yes, at present or previously							0.4	[0.1 2.3]	0.30

Abbreviations: CI, confidence interval; OR, odds ratio; Ref, Reference.

TABLE 5 Frequency of mental health conditions according to the International Classification of Diseases, 10th version (ICD-10)

Chapter	Among those with suicidal thoughts		Among those with suicide attempts		Among all	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
F0x Organic, including symptomatic, mental disorders	0	0%	0	0%	0	0%
F1x Mental and behavioural disorders due to psychoactive substance use	10	5%	2	4%	30	3%
F2x Schizophrenia, schizotypal and delusional disorders	1	1%	1	2%	12	1%
F3x Mood [affective] disorders	134	73%	47	85%	641	65%
F4x Neurotic, stress-related and somatoform disorders	96	52%	25	45%	536	55%
F5x Behavioural syndromes associated with physiological disturbances and physical factors	21	11%	10	18%	87	9%
F6x Disorders of adult personality and behaviour	41	22%	17	31%	172	18%
F7x Mental retardation	2	1%	1	2%	2	0.2%
F8x Disorders of psychological development	1	1%	0	0%	2	0.2%
F9x Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	1	1%	1	2%	7	1%

Note: Multiple diagnoses per patient possible.

sessions (Conrad et al., 2021; Dorrman, 2021; Levi-Belz et al., 2020; Yulis & Kiesler, 1968).

We would like to mention some important limitations of our study. First, we do not know about the proportion of patients with suicidal experiences who were not accepted by the therapist in the first place and therefore no application was sent to the health insurances. It is likely that those with acute suicidal ideation were more often referred to a hospital and thus declined outpatient psychotherapy compared to those without such thoughts. This cannot be

checked because we lack the data for this. If, however, this was the case, then the true proportion of suicidal experiences in patients seeking outpatient psychotherapy is even higher than what we found in our study.

Second, this was not a study about correlates of suicidal ideation in general, because a certain proportion of individuals will not seek mental health care despite a clear need for it, for example, the elderly (Boehlen et al., 2019). We thus can only draw conclusions for those contacting a psychotherapist for help.

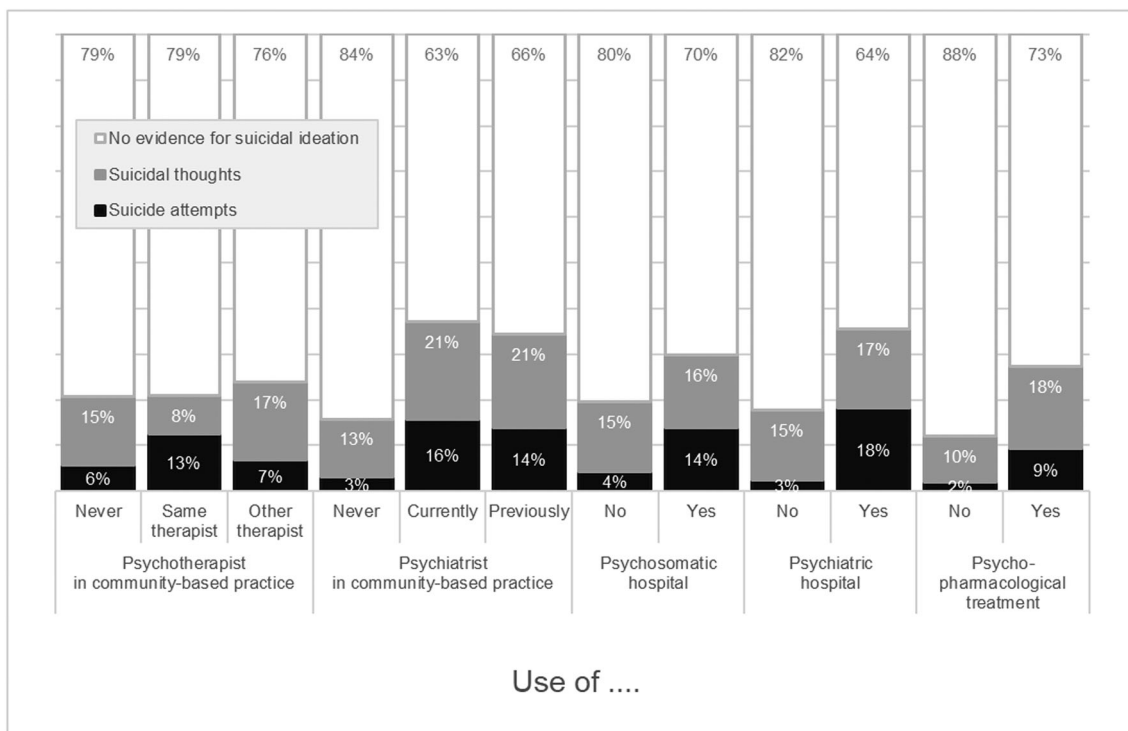


FIGURE 1 Previous and concurrent mental health treatment in patients with and without suicidal experiences

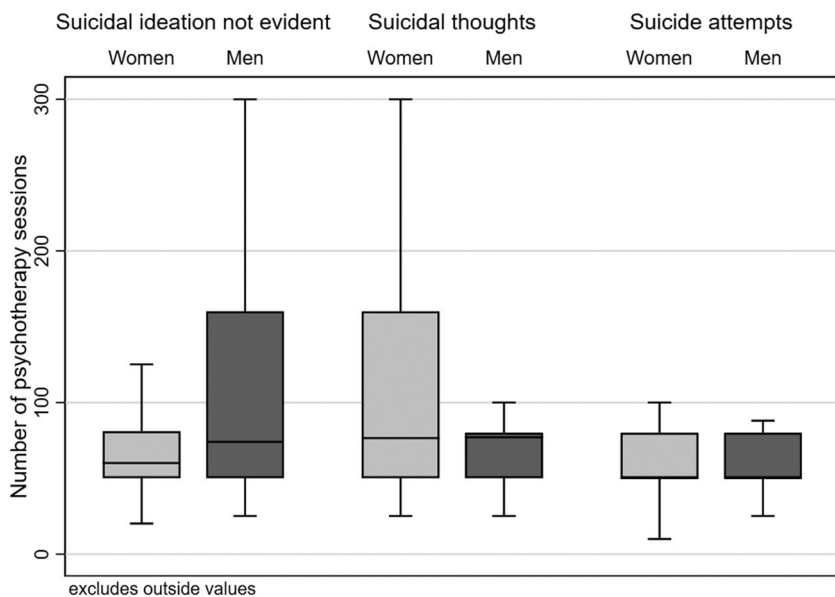


FIGURE 2 Number of psychotherapy sessions applied for by patients with and without suicidal experiences

Third, we have no (or only indirect) self-reports from the patients. They did or did not tell the psychotherapist about their suicidal experiences and the therapist did or did not include this in the report (although it is officially a requirement to explore suicidality in all cases and to write down the results in the report). Usually, one can assume that if suicidality is present, it is reported. However, it is also possible that a therapist decides to conceal this issue out of fear that otherwise the therapy would not be reimbursed. This implies the results might even underestimate the prevalence of suicidal experiences.

Another limitation is related to the cross-sectional design of the study, which precludes investigating causal relationships. Even if variables are strongly associated, it could be due to confounding or to reverse causality. We can thus only speak about increased risk for suicidal experiences if certain factors are present, but these are not determinants or causal factors. Our assumptions about causality can only draw on theory.

A strength of our study is that it was not based on a survey but rather on clinical data, because some patients may reveal suicidal

thoughts or attempts only in front of a professional who will help them. This is in contrast to collecting this information directly from the patient within the framework of a specific study; patients may not be as inclined to be honest about suicidal ideation in that context, or they may not participate in a study at all.

The distribution of age, gender, education, marital status and psychiatric diagnoses is similar to other psychotherapy practice studies in Germany (Albani et al., 2009; Henkel et al., 2019), supporting the assumption that our sample is representative for this clinical population.

In conclusion, we found a high proportion of suicidal experiences in patients seeking outpatient psychotherapy. It should therefore be a central topic in the training of psychotherapists (Mackelprang et al., 2014; Pope & Tabachnick, 1993). Biographic data can provide important information of who is at increased risk and should therefore be explored in detail. Attention should be given to experiences of loss of a parent at an early age, of violence and of early retirement.

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CONFLICTS OF INTEREST

None.

ETHICS APPROVAL

Approval was obtained from the responsible ethics board of the state of Rhineland-Palatinate (# 2018-13321). The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

AUTHOR CONTRIBUTIONS

SS, LS, IS, JB and LM formulated the research question. SS and LS designed the study. SS, LS, IS and LM did data extraction. SS performed data analysis. SS wrote the first draft of the article. All authors wrote the article and did critical review.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author (SS) in an aggregated form.

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