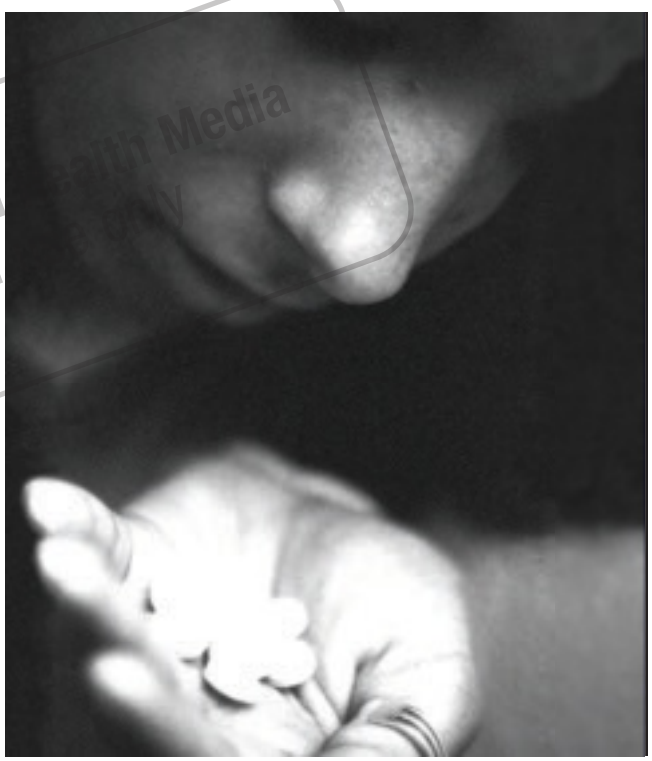
Current PSYCHIATRY

Will my patient attempt suicide again?

Risk factors help you identify patients who need immediate hospitalization for safety

Ms. J, age 32, comes to our mental health clinic seeking treatment for depression and anxiety. She reports she has attempted suicide 3 times. Ms. J describes the first 2 attempts—both of which occurred when she was in her 20s after the end of a relationship—as "cries for attention" that were relatively innocuous. Her third suicide attempt, however, was an acetaminophen overdose approximately 1 year ago that resulted in hospitalization and irreversible liver damage.

Ms. J acknowledges that over the last several weeks she has been thinking about suicide almost constantly, especially as the anniversary of her fiancé's death approaches. She says she has a nearly full bottle of zolpidem in her medicine cabinet and fantasizes about taking all of them and just "going to sleep."



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Elizabeth L. Jeglic, PhD
Associate professor
Department of psychology
John Jay College of Criminal Justice
New York, NY

Many patients—especially those with depression—experience recurrent thoughts of death or a wish to die, but only about 10% attempt suicide.[1] To identify those who are at highest risk and warrant hospitalization, it is vital to assess how a history of suicidal behavior and other factors impact the risk for future suicide attempts. This article:

- examines research on patients who have attempted suicide and risk factors for repeat suicide attempts
- describes characteristics of patients with multiple attempts
- explores the link between a history of self-injurious behavior and suicide attempts.

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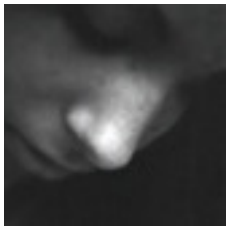

Suicide attempts

Clinical Point

Persons with a previous suicide attempt are 38 times more likely to commit suicide than those with no past attempts

Table 1

Repeated suicidal behavior: Factors that increase risk

History of ≥1 suicide attempts
Feelings of hopelessness
Presence of an Axis I or II disorder
High levels of perceived stress
History of physical or sexual abuse

Source: References 7,8

A strong predictor

A previous suicide attempt is among the strongest predictors of future suicide attempts.[2-4] In a sample of clinically referred European adolescents, those who had attempted suicide were 3 times more likely to try again during the 1-year follow-up compared with those who had never attempted suicide.[5] In addition, Harris et al[6] found that patients with a previous suicide attempt were 38 times more likely to eventually commit suicide than those with no past attempts.

Other risk factors

Other factors might help predict which individuals will continue to engage in suicidal behavior after a first attempt (***Table 1***).[7,8] Spirito et al[7] followed 58 adolescent suicide attempters for 3 months after their initial attempt. Seven (12%) made a subsequent attempt, and 26 (45%) reported continued suicidal ideation. Depressed mood was the strongest predictor of subsequent suicidal behavior, followed by poor family functioning, affect regulation difficulty, and hopelessness.

Hopelessness. Beck et al[9] found that patients who scored ≥9 on the Beck Hopelessness Scale (BHS)—the most common self-report measure of hopelessness—were approximately 11 times more likely to commit suicide than patients who scored ≤8. A study of hospitalized suicide attempters found that BHS scores were unique predictors of future suicide attempts.[10] Several studies have found that persons who remain consistently hopeless are more likely to kill themselves compared with those who have fluctuating hopelessness levels.[11,12]

Psychiatric diagnoses. More than 90% of persons who eventually commit suicide have a diagnosable mental disorder.[8] Although almost all Axis I and II disorders can increase the likelihood of a suicide attempt, certain disorders—including major depression, bipolar disorder, schizophrenia, substance use disorders, eating disorders, borderline personality disorder, and antisocial personality disorder—increase risk more than others.[8]

History of abuse—specifically sexual abuse—is associated with suicidal behavior. A study of depressed women age >50 found that among those who were sexually abused before age 18, 83% reported 1 suicide attempt and 67% made multiple attempts.[13] Among women who had not experienced childhood sexual abuse, 58% reported a past suicide attempt and 27% made multiple attempts.[13]

In a separate study of psychiatric inpatients, those who had been physically or sexually abused were more likely to have made a suicide attempt than patients with no such history.[14] This study did not find a difference in reported abuse between single and multiple suicide attempters.

Stressors. In many cases suicide attempts are precipitated by acute or chronic stressors, including:

- job stress
- chronic illness
- financial problems
- relationship discord
- retirement and declining physical health (especially for older men)
- death of a loved one.[15]

Anniversaries of the death of a loved one or other difficult life events can increase the risk for suicide attempts.[16]

Risk is not necessarily cumulative—and not all risk factors are weighted equally. In general, however, the more risk factors a patient has, the greater the likelihood that he or she may attempt suicide.[17]

continued on page 27

continued from page 20

Red flag: Multiple attempts

When assessing a patient's suicide history, ask about the number of attempts. A person who makes >1 suicide attempt—a multiple attempter—has a significantly higher chance of making subsequent attempts compared with those with 1 or no attempts.[18,19]

Persons who make multiple attempts share certain characteristics (***Table 2***).[19-21] Rudd et al[19] compared 68 multiple attempters with 128 single attempters and found that multiple attempters had higher levels of:

- suicide ideation
- depression
- hopelessness
- perceived stress.

Multiple attempters also had more Axis I disorders and poorer social problem-solving skills and experienced their first psychiatric disorder at an earlier age than single suicide attempters.

Similarly, Foreman et al[20] found that compared with single suicide attempters, multiple attempters had higher levels of depression, hopelessness, and suicidal ideation and met criteria for more Axis I diagnoses. Multiple attempters also were more likely to be:

- diagnosed with substance use disorders, psychotic disorder, or borderline personality disorder
- unemployed and have relationship difficulties, a history of emotional abuse, and a family history of psychiatric problems and suicide.

Miranda et al[21] found that compared with single suicide attempters and suicide ideators, multiple attempters had Axis I disorders more often and had a stronger wish to die during the attempt. In this study, multiple suicide attempts increased by more than 4 times the likelihood that a person with a history of suicidal thoughts and/or behaviors would make another attempt.

Among 326 individuals in a military medical setting treated for suicidal behavior or severe suicidal ideation, multiple suicide attempters reported higher levels of ongoing distress that was unrelated to specific life stressors.[22] This suggests these patients may not respond well to psychological interventions that focus on problem-solving.

Table 2

Common characteristics of multiple suicide attempters

History of Axis I disorder (major depressive disorder, bipolar disorder, schizophrenia, substance use disorders, eating disorders)
High levels of perceived stress
High levels of depression
Symptoms of borderline personality disorder
Poor problem-solving skills
Family history of psychiatric illness

Source: References 19-21

Self-harm and suicidal behavior

Patients who engage in nonsuicidal self harm—also called self-injurious behavior (SIB)—may be mistaken for suicide attempters. Although differences exist between suicide attempters and those who engage in SIB, evidence suggests that a history of SIB increases risk for suicidal behavior.[23,24] In a retrospective study of 4,167 self-harmers, females who engaged in ≥4 acts of SIB were more likely to die from suicide than those who engaged in ≤3 acts.[25] A cross-sectional analysis of data from 3,069 students responding to a random Web-based survey found that an increased incidence of SIB significantly increased the odds of suicidal behavior.[26]

One hypothesis suggests that some persons use SIB as a coping mechanism, and SIB and suicide are on the same continuum of behaviors. Others postulate that suicide attempters may use SIB to habituate themselves to suicidal behavior. Joiner[27] suggests that individuals who commit suicide have rehearsed the suicidal behavior, thus

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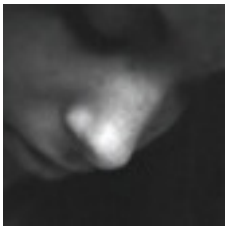
Clinical Point

Assess for self-injurious behavior (SIB) because a history of SIB may increase risk for suicidal behavior



Suicide attempts

Clinical Point

Perform a suicide inquiry to determine if a patient requires hospitalization, but be aware patients may lie about their suicidal intent

Table 3

Hospitalize? 4 questions to guide your decision

Are you having thoughts of hurting or killing yourself? *If yes:* What are you thinking/planning to do?
Do you have access to lethal means?
What is the likelihood that you will hurt yourself?
Have you ever done something to hurt yourself (either suicide attempt or self-injurious behavior)? *If yes:* How many times?

rendering it less foreign and enabling increased lethality.

Although the link between SIB and suicide attempts remains unclear, evidence suggests SIB is a risk factor for suicidal behavior and therefore should be assessed when evaluating a patient's suicide risk.

CASE CONTINUED

At high risk

Ms. J has several risk factors for making another suicide attempt. She has 3 previous attempts, and because her last attempt caused liver damage we know she is capable of lethal behavior. In addition, the anniversary of the death of her fiancé is approaching. Ms. J also reports almost constant suicidal ideation, with a specific plan (to overdose). Her fantasies of taking pills could be interpreted as mental rehearsal and desensitization to the behavior.

Because we believe Ms. J is at high risk for a serious, if not lethal, suicide attempt we conduct a 4-question suicide inquiry. It is clear that Ms. J had suicidal thoughts and a plan. Her answer to "How likely is it that once you leave my office you will do something to hurt yourself?" is the key to determining whether or not she requires hospitalization. Ms. J states that she is "pretty certain she will hurt herself" once she leaves the office, so we hospitalize her.

To determine if a patient requires immediate hospitalization, perform a specific suicide inquiry. Although there is no surefire way to determine if a patient will kill himself or herself, asking specific questions can help you gauge risk. Based on evidence[28] and my clinical experience, I focus on patients' answers to 4 questions (***Table 3***). Affirmative answers to these questions are a strong indication that a patient requires hospitalization.

Occasionally, patients are not truthful when asked about their suicidal intent. If you suspect a patient is lying, clinical judgment and the patient's history guide the decision on hospitalization.

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Bottom Line

A past suicide attempt is a strong predictor of a future attempt. In your clinical assessment of suicidal patients, ask about their history of suicide attempts—including the number of attempts—and self-injurious behaviors. The risk of suicide increases with the number of past suicide attempts.

continued on page 31

treatment and consider tapering Effexor XR in the third trimester. **Labor, Delivery, Nursing**—The effect on labor and delivery in humans is unknown. Venlafaxine and ODV have been reported to be excreted in human milk. Because of the potential for serious adverse reactions in nursing infants from Effexor XR, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use**—Safety and effectiveness in the pediatric population have not been established (see **BOX WARNING** and **WARNINGS: Clinical Worsening and Suicide Risk**). No studies have adequately assessed the impact of Effexor XR on growth, development, and maturation of children and adolescents. Studies suggest Effexor XR may adversely affect weight and height (see **PRECAUTIONS-General**, *Changes in Height* and *Changes in Weight*). Should the decision be made to treat a pediatric patient with Effexor XR, regular monitoring of weight and height is recommended during treatment, particularly if long term. The safety of Effexor XR for pediatric patients has not been assessed for chronic treatment >6 months. In studies in patients aged 6-17, blood pressure and cholesterol increases considered to be clinically relevant were similar to that observed in adult patients. The precautions for adults apply to pediatric patients. **Geriatric Use**—No overall differences in effectiveness or safety were observed between geriatric and younger patients. Greater sensitivity of some older individuals cannot be ruled out. SSRIs and SNRIs, including Effexor XR, have been associated with cases of clinically significant hyponatremia in elderly patients, who may be at greater risk for this adverse event (see **PRECAUTIONS: Hyponatremia**). **ADVERSE REACTIONS**: ***Associated with Discontinuation of Treatment***—The most common events leading to discontinuation in MDD, GAD, SAD, and PD trials included nausea, anorexia, anxiety, impotence, dry mouth, dizziness, insomnia, somnolence, hypertension, diarrhea, paresthesia, tremor, abnormal (mostly blurred) vision, abnormal (mostly delayed) ejaculation, asthenia, vomiting, nervousness, headache, vasodilatation, thinking abnormal, decreased libido, and sweating. ***Commonly Observed Adverse Events in Controlled Clinical Trials for MDD, GAD, SAD, and PD***—Body as a Whole: asthenia, headache, flu syndrome, accidental injury, abdominal pain. Cardiovascular: vasodilatation, hypertension, palpitation. Digestive: nausea, constipation, anorexia, vomiting, flatulence, diarrhea, eructation. Metabolic/Nutritional: weight loss. Nervous System: dizziness, somnolence, insomnia, dry mouth, nervousness, abnormal dreams, tremor, depression, hypertonia, paresthesia, libido decreased, agitation, anxiety, twitching. Respiratory System: pharyngitis, yawn, sinusitis. Skin: sweating. Special Senses: abnormal vision. Urogenital System: abnormal ejaculation, impotence, orgasmic dysfunction (including anorgasmia) in females. ***Vital Sign Changes***: Effexor XR was associated with a mean increase in pulse rate of about 2 beats/min in depression and GAD trials and a mean increase in pulse rate of 3 beats/min in SAD trials. (see **Sustained Hypertension** and **Elevations in Systolic and Diastolic Blood Pressure** sections of **WARNINGS**). ***Laboratory Changes***: Clinically relevant increases in serum cholesterol were noted in Effexor XR clinical trials. Increases were duration dependent over the study period and tended to be greater with higher doses. ***Other Events Observed During the Premarketing Evaluation of Effexor and Effexor XR***—N=7,212. "Frequent"=events occurring in at least 1/100 patients; "infrequent"=1/100 to 1/1000 patients; "rare"=fewer than 1/1000 patients. **Body as a whole** - Frequent: chest pain substernal, chills, fever, neck pain; Infrequent: face edema, intentional injury, malaise, moniliasis, neck rigidity, pelvic pain, photosensitivity reaction, suicide attempt, withdrawal syndrome; Rare: appendicitis, bacteremia, carcinoma, cellulitis, granuloma. **Cardiovascular system** - Frequent: migraine, tachycardia; Infrequent: angina pectoris, arrhythmia, extrasystoles, hypotension, peripheral vascular disorder (mainly cold feet and/or cold hands), postular hypotension, syncope; Rare: aortic aneurysm, arteritis, first-degree atrioventricular block, bigeminy, bundle branch block, capillary fragility, cerebral ischemia, coronary artery disease, congestive heart failure, heart arrest, hematoma, cardiovascular disorder (mitral valve and circulatory disturbance), mucocutaneous hemorrhage, myocardial infarct, pallor, sinus arrhythmia, thrombophlebitis. **Digestive system** - Frequent: increased appetite; Infrequent: bruxism, colitis, dysphagia, tongue edema, eructation, esophagitis, gastritis, gastroenteritis, gastrointestinal ulcer, gingivitis, glossitis, rectal hemorrhage, hemorrhoids, melena, oral moniliasis, stomatitis, mouth ulceration; Rare: abdominal distension, biliary pain, cheilitis, cholecystitis, cholelithiasis, esophageal spasms, duodenitis, hematemesis, gastroesophageal reflux disease, gastrointestinal hemorrhage, gum hemorrhage, hepatitis, ileitis, jaundice, intestinal obstruction, liver tenderness, parotitis, periodontitis, proctitis, rectal disorder, salivary gland enlargement, increased salivation, soft stools, tongue discoloration. **Endocrine system** - Rare: galactorrhoea, goiter, hyperthyroidism, hypothyroidism, thyroid nodule, thyroiditis. **Hemic and lymphatic system** - Frequent: ecchymosis; Infrequent: anemia, leukocytosis, leukopenia, lymphadenopathy, thrombocythemia; Rare: basophilia, bleeding time increased, cyanosis, eosinophilia, lymphocytosis, multiple myeloma, purpura, thrombocytopenia. **Metabolic and nutritional** - Frequent: edema, weight gain; Infrequent: alkaline phosphatase increased, dehydration, hypercholesteremia, hyperglycemia, hyperlipidemia, hypokalemia, SGOT increased, SGPT increased, thirst; Rare: alcohol intolerance, bilirubinemia, BUN increased, creatinine increased, diabetes mellitus, glycosuria, gout, healing abnormal, hemochromatosis, hypercalcinuria, hyperkalemia, hyperphosphatemia, hyperuricemia, hypocholesteremia, hypoglycemia, hyponatremia, hypophosphatemia, hypoproteinemia, uremia. **Musculoskeletal system** - Infrequent: arthritis, arthrosis, bone spurs, bursitis, leg cramps, myasthenia, tenosynovitis; Rare: bone pain, pathological fracture, muscle cramp, muscle spasms, musculoskeletal stiffness, myopathy, osteoporosis, osteosclerosis, plantar fasciitis, rheumatoid arthritis, tendon rupture. **Nervous system** - Frequent: amnesia, confusion, depersonalization, hypesthesia, thinking abnormal, trismus, vertigo; Infrequent: akathisia, apathy, ataxia, circumoral paresthesia, CNS stimulation, emotional lability, euphoria, hallucinations, hostility, hyperesthesia, hyperkinesia, hypotonia, incoordination, libido increased, manic reaction, myoclonus, neuralgia, neuropathy, psychosis, seizure, abnormal speech, stupor, suicidal ideation; Rare: abnormal/changed behavior, adjustment disorder, akinesia, alcohol abuse, aphasia, bradykinesia, buccoglossal syndrome, cerebrovascular accident, feeling drunk, loss of consciousness, delusions, dementia, dystonia, energy increased, facial paralysis, abnormal gait, Guillain-Barré syndrome, homicidal ideation, hyperchlorhydria, hypokinesia, hysteria, impulse control difficulties, motion sickness, neuritis, nystagmus, paranoid reaction, paresis, psychotic depression, reflexes decreased, reflexes increased, torticollis. **Respiratory system** - Frequent: cough increased, dyspnea; Infrequent: asthma, chest congestion, epistaxis, hyperventilation, laryngismus, laryngitis, pneumonia, voice alteration; Rare: atelectasis, hemoptysis, hypoventilation, hypoxia, larynx edema, pleurisy, pulmonary embolus, sleep apnea. **Skin and appendages** - Frequent: pruritus; Infrequent: acne, alopecia, contact dermatitis, dry skin, eczema, maculopapular rash, psoriasis, urticaria; Rare: brittle nails, erythema nodosum, exfoliative dermatitis, lichenoid dermatitis, hair discoloration, skin discoloration, furunculosis, hirsutism, leukoderma, miliaria, petechial rash, pruritic rash, pustular rash, vesiculobullous rash, seborrhea, skin atrophy, skin hypertrophy, skin striae, sweating decreased. **Special senses** - Frequent: abnormality of accommodation, mydriasis, taste perversion; Infrequent: conjunctivitis, diplopia, dry eyes, eye pain, otitis media, parosmia, photophobia, taste loss; Rare: blepharitis, cataract, chromatopsia, conjunctival edema, corneal lesion, deafness, exophthalmos, eye hemorrhage, glaucoma, retinal hemorrhage, subconjunctival hemorrhage, hyperacusis, keratitis, labyrinthitis, miosis, papilledema, decreased pupillary reflex, otitis externa, scleritis, uveitis, visual field defect. **Urogenital system** - Frequent: albuminuria, urination impaired; Infrequent: amenorrhea, cystitis, dysuria, hematuria, kidney calculus, kidney pain, leukorrhea, menorrhagia, metrorrhagia, nocturia, breast pain, polyuria, pyuria, prostatic disorder (prostatitis, enlarged prostate, and prostate irritability), urinary incontinence, urinary retention, urinary urgency, vaginal hemorrhage, vaginitis; Rare: abortion, anuria, balanitis, bladder pain, breast discharge, breast engorgement, breast enlargement, endometriosis, female lactation, fibrocystic breast, calcium crystalluria, cervicitis, orchitis, ovarian cyst, prolonged erection, gynecomastia (male), hypomenorrhea, kidney function abnormal, mastitis, menopause, pyelonephritis, oliguria, salpingitis, urolithiasis, uterine hemorrhage, uterine spasm, vaginal dryness. **Postmarketing Reports**: agranulocytosis, anaphylaxis, aplastic anemia, catatonia, congenital anomalies, CPK increased, deep vein thrombophlebitis, delirium, EKG abnormalities such as QT prolongation; cardiac arrhythmias including atrial fibrillation, supraventricular tachycardia, ventricular extrasystoles, and rare reports of ventricular fibrillation and ventricular tachycardia, including torsades de pointes; toxic epidermal necrolysis/Stevens-Johnson syndrome, erythema multiforme, extrapyramidal symptoms (including dyskinesia and tardive dyskinesia), angle-closure glaucoma, hemorrhage (including eye and gastrointestinal bleeding), hepatic events (including GGT elevation; abnormalities of unspecified liver function tests; liver damage, necrosis, or failure; and fatty liver), interstitial lung disease, involuntary movements, LDH increased, neuroleptic malignant syndrome-like events (including a case of a 10-year-old who may have been taking methylphenidate, was treated and recovered), neutropenia, night sweats, pancreatitis, pancytopenia, panic, prolactin increased, renal failure, rhabdomyolysis, serotonin syndrome, shock-like electrical sensations or tinnitus (in some cases, subsequent to the discontinuation of venlafaxine or tapering of dose), and SIADH (usually in the elderly). Elevated clozapine levels that were temporally associated with adverse events, including seizures, have been reported following the addition of venlafaxine. Increases in prothrombin time, partial thromboplastin time, or INR have been reported when venlafaxine was given to patients on warfarin therapy. **DRUG ABUSE AND DEPENDENCE**: Effexor XR is not a controlled substance. Evaluate patients carefully for history of drug abuse and observe such patients closely for signs of misuse or abuse. **OVERDOSAGE**: The most commonly reported events in overdosage include tachycardia, changes in level of consciousness (ranging from somnolence to coma), mydriasis, seizures, and vomiting. Electrocardiogram changes (eg, prolongation of QT interval, bundle branch block, QRS prolongation), ventricular tachycardia, bradycardia, hypotension, rhabdomyolysis, vertigo, liver necrosis, serotonin syndrome, and death have been reported. Published retrospective studies report that venlafaxine overdosage may be associated with an increased risk of fatal outcomes compared to that observed with SSRI antidepressant products, but lower than that for tricyclic antidepressants. Epidemiological studies have shown that venlafaxine-treated patients have a higher pre-existing burden of suicide risk factors than SSRI-treated patients. The extent to which the finding of an increased risk of fatal outcomes can be attributed to the toxicity of venlafaxine in overdosage as opposed to some characteristic(s) of venlafaxine-treated patients is not clear. Treatment should consist of those general measures employed in the management of overdosage with any antidepressant. Ensure an adequate airway, oxygenation and ventilation. Monitor cardiac rhythm and vital signs. General supportive and symptomatic measures are also recommended. Induction of emesis is not recommended. Gastric lavage with a large bore orogastric tube with appropriate airway protection, if needed, may be indicated if performed soon after ingestion or in symptomatic patients. Activated charcoal should be administered. Due to the large volume of distribution of this drug, forced diuresis, dialysis, hemoperfusion, and exchange transfusion are unlikely to be of benefit. No specific antidotes for venlafaxine are known. In managing overdosage, consider the possibility of multiple drug involvement. Consider contacting a poison control center for additional information on the treatment of overdose. Telephone numbers for certified poison control centers are listed in the Physicians' Desk Reference® (PDR). **DOSAGE AND ADMINISTRATION**: Consult full prescribing information for dosing instructions. **Switching Patients to or From an MAOI**—At least 14 days should elapse between discontinuation of an MAOI and initiation of therapy with Effexor XR. At least 7 days should be allowed after stopping Effexor XR before starting an MAOI (see **CONTRAINDICATIONS** and **WARNINGS**).

This brief summary is based on Effexor XR, Prescribing Information W10404C036 ET01, revised February 2008.

continued from page 28

Related Resources

- Joiner TE. *Why people die by suicide*. Cambridge, MA: Harvard University Press; 2005:46-93,203-22.
- American Foundation for Suicide Prevention. www.afsp.org.
- SAVE: Suicide Awareness Voices of Education. www.save.org.

Drug Brand Name

Zolpidem • Ambien

Disclosure

The author reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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