

Recognizing Suicide Potential in Women

When to suspect, how to screen, what to do

DOUGLAS G. JACOBS, MD and NANCY L. DEUTSCH, BA

Of all persons who complete suicide, 75% have seen a physician within 6 months of their deaths; 60% have seen a physician within 1 month.¹⁻³ Although some studies have suggested that young people may be less likely to seek help, a 1996 study found that persons younger than age 35 who committed suicide did, in fact, make an increased number of visits to general practitioners in the 3 months before their deaths.⁴ The rate of increase in office visits in the week before death was greater for women than for men. In both sexes, most final visits to a clinician were for psychologic reasons.⁴

The implication of these findings is that persons considering suicide appreciate that something is troubling them and make the effort to see a clinician, but do not or cannot communicate their suicidal tendencies. Thus, it is all the more important that primary care clinicians be able to recognize suicide potential in their patients. Suicidal ideation is generally a symptom of an underlying, treatable disorder—usually depression. Identifying suicidal ideation can facilitate treatment of the underlying depression and reduce the risk of com-

ABSTRACT: One in every 5 women suffers from depression, and women are more likely to attempt suicide than men are. Since both depression and previous suicide attempts are risk factors for suicide, it is important that clinicians who work with women screen for depression and be alert for signs of suicidal intent. At least half the patients who receive mental health care do so through their primary care provider; the primary care provider is also often given the role of deciding which patients require specialized mental health care. Primary care clinicians should be familiar with the attributes of a woman who may be considering suicide, feel comfortable speaking with patients about suicide, and know the correct procedures for patients at risk. (*Women Health Primary Care* 1998;1(7):560-570)

pleted suicide, as well as the risk of morbidity resulting from the suicide attempt. Therefore, clinicians must be aware of the risk factors for suicide, should be comfortable speaking about suicide with patients, must know how to elicit information regarding suicidal intent, and should be familiar

with the management and/or disposition of a suicidal patient (see “Suicide in women: What primary care clinicians can do,” page 561).

RECOGNIZING SUICIDE POTENTIAL

Suicide itself is not a disease but rather occurs as an outcome in persons suffering from a variety of diagnoses. Psychologic autopsy studies reveal that 90% to 93% of persons who commit suicide are suffering from a major psychiatric disorder: either depression, alcoholism, or schizophrenia.⁵ More than 50% of persons who complete suicide have a related physical illness; coexisting disorders are particularly common among elderly persons.⁶

For a primary care clinician to recognize suicide potential, he or she must have a high index of suspicion for depression and other risk factors. Women have a higher rate of depression than men do, and they are 3 times more likely to attempt (but not to complete) suicide than men are. Thus, it is especially important that clinicians who treat female patients (and particularly those who do so predominantly) be aware of the

Dr. Jacobs is an associate clinical professor of psychiatry at Harvard Medical School, Boston, Massachusetts; he is also the executive director of the National Mental Illness Screening Project and the editor of the new book, The Harvard Medical School Guide to Suicide Assessment and Intervention. Ms. Deutsch is an associate at the Suicide Research and Education Division of the National Mental Illness Screening Project.

risk factors for and signs of both depression and suicidality.

SUICIDE IN WOMEN

In 1995, the suicide rate for women was 4.4 per 100,000.⁷ Adolescent females are almost twice as likely as adolescent males to report suicidal ideation, and they are more likely

to attempt suicide or engage in nonfatal suicidal behavior than are their male counterparts.⁸ Although women commit the majority of suicide attempts in all age groups, only about 20% of completed suicides are made by women.⁹

Women often use pills as a method of suicide and self-destructive behavior.

Recent studies reveal that anywhere from 70% to 90% of suicide attempts by women are drug overdoses.⁹ However, the vast majority of completed suicides by women involve firearms or self-poisoning (including carbon monoxide inhalation).⁷

Although the risk factors for

Suicide in women: What primary care clinicians can do

Primary care clinicians can serve a pivotal role in recognizing suicide potential in their patients.²⁸ Research indicates that at least half the patients who receive mental health care do so through their primary care provider.³¹ In addition to addressing a patient's immediate concerns, primary care clinicians must often also act as gatekeepers, deciding when the patient needs to be referred to a psychiatrist or other mental health professional. As the responsibility and opportunity for diagnosing mental illness come increasingly under the domain of primary care, it becomes all the more important for these clinicians to work together with mental health care providers to share resources and information.

Because women are more likely to suffer from depression and more prone to attempt suicide than men are, it is especially important that primary care clinicians who work with women screen for depression and be alert for signs of suicidal intent. The first step in this process is a high index of suspicion for depression and suicide.

Clinicians should be aware of warning signs when taking a patient's history or reviewing symptoms, and they should not hesitate to perform a suicide inquiry when they feel it is appropriate. This inquiry need not be detailed; a few simple questions can suffice.

Clinicians should have access to referral resources for suicidal patients and know how to contact the appropriate mental health providers in an emergency. Communication with, and a referral to, a

mental health specialist are also important if a primary care clinician has any questions about the assessment.

Primary care clinicians should also be familiar with mental health statutes in their states. Most states have provisions that allow clinicians to authorize involuntary evaluations in cases in which the patient appears to be at high risk for suicide but refuses to seek help. Basically, these provisions authorize the police or an ambulance crew to take the patient (against her will, if necessary) to an emergency room for further evaluation. Your local department of mental health can provide information about your local statutes on involuntary commitment.

It is also important that diagnosis, treatment plan, prescription size, and communication with family or with other health care providers be documented whenever a suicide inquiry is conducted. This is especially true in cases of involuntary evaluation or commitment.

Clinicians who are interested in becoming more involved in screening their patients for depression can participate in the nonprofit National

Depression Screening Day's Primary Care Outreach program. This program, which will take place for the first time in conjunction with the National Depression Screening Day on October 8, 1998, provides clinicians with a free depression screening kit that includes copies of a 10-question depression screening test, scoring instructions, educational brochures, and a video.

For more information about the primary care outreach program or to order a FREE depression screening kit, contact:

National Mental Illness Screening Project

One Washington Street, Suite 304
Wellesley Hills, MA 02481-1703

Phone: 781-239-0071

Fax: 781-431-7447

suicide in women are similar to those in men, there are some important differences. The risk factors for suicide in women are listed in Table 1.^{3,9-12} In addition, certain personality traits are associated with suicide attempts in young women. These include:

- ◆ Impulsiveness.
- ◆ A low tolerance for frustration.
- ◆ A tendency to externalize aggression.
- ◆ High affiliative, succorant, or nurturant needs.¹³
- ◆ Histrionic behavior.¹⁴

Some have theorized that a particular risk factor for suicide in women is a disruption or disappointment in the woman's relationships with others. One model of women's self-development posits that women achieve meaning and

Table 1. Risk factors for suicide in women

- ◆ A history of depression, another psychiatric or addictive disorder (including substance abuse), or physical or sexual abuse
- ◆ Previous suicide attempts
- ◆ A family history of suicide or mental disorders (including depression)
- ◆ A disrupted family environment
- ◆ Living alone
- ◆ The absence of young children in the home
- ◆ Coexisting physical illness
- ◆ Unemployment, either voluntary or forced
- ◆ The presence of a firearm in the house

value in their sense of self through their relations with, and connectedness to, other people. According to this model, what sustains women are "opportunities to experience themselves in a context of ongoing mutual relationships."¹² Thus, women who experience a lack of connectedness to others or who fear abandonment are more at risk for suicide. A suicide attempt is seen as a method for reengaging with another person.

For clinicians, this theory implies that particular attention should be paid to the home situations of female patients, for whom family stress or violence could play an especially important role in the decision to attempt suicide. Although in men more attention is generally paid to level of independence and/or work situations, the relational development theory indicates that evaluation of a woman's psychologic state should focus not on independence or work status, but on current interpersonal situations.¹²

This provides an explanation for why women are more prone to self-destructive behavior, including suicide, during times of interpersonal loss. A tendency toward self-destructive behavior may also manifest itself in self-mutilation (see the sidebar at left).

DEPRESSION AND SUICIDE

Depression is a common illness, affecting approximately 17 million Americans each year. It is estimated that at least 1 in every 5 women will suffer from depression at some point during her lifetime. The costs of depression are high. If left untreated, depression can become chronic and impair personal relationships as well as a person's ability to function socially and at work.¹⁵⁻¹⁷ Chronic depression is also associated with increased mortality.¹⁸

The link between depression and suicide is strong. Roughly 50%

Self-mutilation

Although attempted suicide is a strong risk factor for completed suicide, not all people who injure themselves do so with the intent to die.⁹ Some persons may attempt suicide with the intent of being discovered and "saved," while others may self-mutilate, often secretly, with no thoughts of attempting suicide.

Favazza,³² a leading expert on self-mutilation, describes this latter disorder as a "morbid form of self-help"—an attempt to cope with and rid oneself of negative thoughts and feelings. The behavior is triggered by events, thoughts, or feelings that the individual attempts to cope with through self-abuse.³³ Self-mutilation may serve as:

- ◆ A way to feel something.
- ◆ A self-punishment.
- ◆ A way to get attention.
- ◆ A means to obtain vengeance.
- ◆ An emotional escape.

There appears to be a strong association between self-mutilation and a history of physical or sexual abuse. Women are particularly prone to this disorder.

If a primary care clinician notices lacerations on a woman's wrists or other self-inflicted injuries, the first step is to perform a suicide inquiry. If the result is negative, questions should be asked about physical or sexual abuse. The woman should also be given an appropriate referral to a mental health specialist, regardless of whether the injuries result from self-mutilation or abuse at another's hands.

of persons who commit suicide are depressed at the time of death.¹⁹ Even brief, recurrent episodes of depression have been found to be associated with suicidal behavior and attempts.¹⁴

Although fewer women than men successfully complete suicide, one study has shown that among psychiatric patients, the female-to-male ratio is nearly equal.²⁰ This demonstrates the need for clinicians to be aware of depression and other psychiatric disorders in their patients.

Depression is an organic illness that manifests with both physical and emotional symptoms (Table 2). The physical symptoms of depression include lack of energy, changes in appetite and sleep patterns, vague complaints (such as headaches and gastrointestinal problems), and fatigue. The emotional symptoms include difficulty making decisions, hopelessness, and feelings of sadness; in addition, patients may report that they do not enjoy the things they used to enjoy doing, and that they have thoughts of death or suicide. Some of these symptoms, especially the physical ones, may reveal themselves in the course of a regular medical appointment. However, others may need to be elicited by more in-depth questioning or screening.

Any primary care clinician who makes a diagnosis of depression should ask about suicide, because suicidal thoughts are one of the symptoms of depression. In addition, a variety of factors must be considered when an initial pre-

scription for antidepressants is written. We will describe each of these steps—the depression screen, the suicide inquiry, and antidepressant administration—below.

POSTPARTUM DEPRESSION

One condition unique to women leaves them at increased risk of depression: childbirth. Among women who have given birth, the incidence of postpartum depression ranges from 10% to 15%^{21,22}; as many as 50% of women experience some type of postnatal “blues.”²²

shown that regular screening can help detect postpartum depression in women who may otherwise not voice their complaints.²¹⁻²³ Most cases of postpartum depression should be treated.

SCREENING FOR DEPRESSION

The presence of the somatic symptoms of depression can be ascertained during a complete health history and review of systems. For example, changes in appetite may be uncovered during an inquiry into gastrointestinal symptomatology; changes in energy may become evident during the endocrine examination. For persons with clear-cut, well-defined physical symptoms of depression (eg, “I wake up at 3 AM and can’t fall back to sleep. I’m tired all the time and have lost 7 pounds in the last 3 weeks—I just don’t seem to want to eat as much as I used to.”), a review of systems may be all that is necessary to alert the examiner to the possible diagnosis, especially if the person appears depressed and has a sad affect.

When a patient has even a couple of the traditional physical symptoms of depression, it is extremely important to ask about emotional symptoms, which may be harder to uncover. Patients may be reluctant to report that they are sad, no longer enjoy life, have lost interest in sexual activity, or have recurrent thoughts of death or suicide. The fear of being labeled “crazy” is deeply felt and may inhibit the examination. In addition, many of the symptoms of depression—such as feeling worthless, guilty, and not needed—may pre-

Table 2. DSM-IV criteria for major depressive episode

- ◆ Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (note: in children or adolescents this could be an irritable mood)
- ◆ Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
- ◆ Significant weight loss when not dieting, weight gain, or decrease or increase in appetite nearly every day
- ◆ Insomnia or hypersomnia nearly every day
- ◆ Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
- ◆ Fatigue or loss of energy nearly every day
- ◆ Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- ◆ Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or observed by others)
- ◆ Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*.³⁴

Although people with children are less likely to commit suicide, some women become psychotic following childbirth, putting them at higher risk for suicide. It is important, therefore, to address postpartum depression in patients.

The symptoms of postpartum depression mirror those of general depression and surface most often between 3 and 9 months postpartum.²² A number of studies have

vent patients from mentioning their emotional state, even when they are very aware that something feels wrong. Recent studies indicate that the 5 most common symptoms of depression are emotional, not physical, which underscores the need to probe for emotional disturbances.²⁴

The use of a simple, self-rating screening form can help clinicians quickly and easily detect the emotional symptoms of depression. There are several self-rating depression scales available. However, 3 of them—the Center for Epidemiological Studies–Depression Scale,²⁵ the Beck Depression Inventory,²⁶ and the Zung Self-Rating Depression Scale²⁷—are particularly helpful in the primary care setting because they are easy to use and sensitive to depressive symptoms.^{28,29} Among the other advantages of these scales:

- ◆ The scales take little time to administer (most people can fill one out while sitting in the waiting room).
- ◆ The questions probe a patient's affective state, routine life behaviors, and cognitive abilities.
- ◆ Because the scores are easy to calculate, a staff member (eg, nurse, assistant, secretary) can determine the patient's results immediately.
- ◆ The scores have cutoff values denoting the severity of depression.
- ◆ Most important, the results are reliable.

When any of these scales are used, it is imperative to remember that its results alone are not sufficient for a diagnosis of depression. However, a positive score indicates the need for a thorough examination for the symptoms of depression listed in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (Table 2).

It may be inefficient for primary care clinicians to administer a screening test to each patient at every visit.²⁸ However, certain

groups at increased risk for depression can be targeted for routine screening. For example, screening may be particularly pertinent for women who:

- ◆ Have experienced a recent loss or are undergoing severe stress.
- ◆ Report vague somatic symptoms.
- ◆ Express any of the expected somatic or emotional symptoms of depression.
- ◆ Have a family history of depression, suicide, or mental illness.
- ◆ Have a history of self-medicating behavior, including alcohol abuse,

Table 3. Drugs that have been associated with depression

Alcohol
Amphetamine (withdrawal from)
Anabolic steroids
Baclofen
Cimetidine
Clonidine
Cocaine (withdrawal from)
Corticotropin/glucocorticoids
Cycloserine
Digitalis
Disulfiram
Ethambutol
Guanethidine
Hallucinogens
Inhalants
Levodopa
Methyldopa
Metoclopramide
Nonsteroidal anti-inflammatory drugs
Opioids
Oral contraceptives
Propranolol
Ranitidine
Reserpine
Sedative-hypnotics
Sulfonamides
Thiazide diuretics

Data extracted from Miller MC, Paulsen RH. Suicide assessment in the primary care setting. In: Jacobs DG, ed. *The Harvard Guide to Suicide Assessment and Intervention*. 1998.³⁵

or use of stimulants (diet pills), nicotine,³⁰ or antianxiety agents (benzodiazepines or barbiturates).

- ◆ Have a history of self-destructive behavior.
- ◆ Are currently taking certain medications, particularly antihypertensives, hormones, histamine-2 receptor blockers, anticonvulsants, or levodopa.²⁸ These drugs, as well as others, increase the risk of depression (Table 3).
- ◆ Are suffering from a major illness, such as stroke, coronary artery disease, cancer, or diabetes.²⁸
- ◆ Have chronic pain.
- ◆ Are in the postpartum period.²¹⁻²³
- ◆ Have a history of diagnosed depression.

By identifying and addressing depression in their patients, clinicians may be helping to also identify suicidal thoughts and behavior.

INQUIRING ABOUT SUICIDE

Clinicians who have not been trained in psychiatry may be uncomfortable asking a patient about suicide for a number of reasons. They may not be aware of the risk factors for suicide nor know how to evaluate suicidal patients. Furthermore, clinicians may be anxious about dealing with suicidal patients and fear the patient will react negatively to the topic because of the stigma attached to mental illness.² Primary care practitioners often do not have the time to perform crisis intervention during their daily appointments, and they may not be aware of changes in the patient's mental state, or of the onset of symptoms of depression or anxiety.

Many clinicians may also be under the misconception that asking about suicide will somehow introduce the idea into someone's mind. In fact, the opposite is often true. Many patients are relieved when they are asked about suicide, because it gives them an opportunity to discuss it and makes them

feel that they are not “crazy.” Indeed, broaching the subject of suicidal intent, if gradually and tactfully done, can allow the patient to reveal specific suicidal plans; it can then lead to a discussion of alternatives, which the doctor may be able to encourage the patient to consider.¹¹

A suicide inquiry should be conducted whenever the clinician is concerned that a patient may be considering suicide because of the severity of depression, references to hopelessness, or references to lack of a future. The following steps are recommended in conducting a suicide inquiry: Question the patient about her suicidal intent. Ask about her current and past thoughts about life and death, access to particular methods of suicide, and any specific plans she may have (Table 4). The questioning should be done thoughtfully and tactfully, encouraging the patient to be honest. Be careful to avoid attaching a negative stigma to suicidal thoughts or behaviors.

The point of the questioning is to determine the specificity of planning that has been done and to begin a conversation about alternative solutions. Appropriate documentation of the questions, including positive and negative responses, is useful.

Positive responses to the questions should indicate to the primary care clinician that the patient is at risk for suicide and should be referred to a mental health specialist or that a consultation should be obtained immediately.

ADMINISTERING ANTIDEPRESSANTS

Whenever antidepressants are prescribed initially, a number of factors must be considered:

- ◆ Suicide tends to occur early in the course of a depressive illness. Thus, a follow-up visit must be scheduled to take place within a few days or weeks; this visit must include a repeat suicide inquiry.

Table 4. Questions to ask during a suicide inquiry

- ◆ Have you ever felt so bad that you thought life was not worth living?
- ◆ Have you ever thought about how you would act on these thoughts?
- ◆ Do you have access to . . . (the particular method that is referred to in the prior question)?
- ◆ Do you plan to obtain . . . (the method)?
- ◆ Have you ever tried to hurt yourself (kill yourself) in the past?
- ◆ Do you know what would happen to you if you . . . (used the method referred to)?
- ◆ Do you have a plan as to a particular time of day?
- ◆ Are you thinking about whether or not other people will be at home?
- ◆ Do you have a particular location picked out?
- ◆ Have you rehearsed your suicide in any way (eg, tied a noose)?

- ◆ Although there may be economic pressures to write large prescriptions, it is advisable that the initial prescription for antidepressants include only enough medication for the time until the follow-up visit (with no refill).
- ◆ The clinician should ask about other medications the patient is currently taking, as well as whether the patient is currently in psychotherapy. Some medications may interact with antidepressants. Furthermore, if another clinician is currently treating the patient with psychopharmacotherapy, the primary care practitioner should be informed of the new prescription.
- ◆ If toxicity is a concern, the new antidepressants (the selective serotonin reuptake inhibitors) are good choices. These drugs are reported to be less lethal when taken as an overdose.
- ◆ Patients and/or their families should be told that suicidal thoughts can accompany depres-

sion. If the patient experiences any such thoughts, the clinician should be contacted immediately and/or the patient should go to an emergency room.

A CAVEAT

Although screening for signs of depression and suicidal intent is important in helping to identify at-risk patients, we must always remember that it is not possible to predict which patients will actually commit suicide. We clinicians should do our best to be educated about suicide risk and assessment, but we must also accept the fact that suicides will occur, despite our best efforts at prevention. ❁

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Recognizing Suicide Potential

- The use of a simple, self-rating screening form can help clinicians quickly and easily detect the emotional symptoms of depression and assist in diagnosing the illness.
- A suicide inquiry should be conducted whenever the clinician is concerned about the patient's suicidal intent because of the severity of depression, references to hopelessness, or references to lack of a future.
- Particular attention should be paid to the home situations of female patients, for whom family stress or violence could play a particularly important role in the decision to attempt suicide.
- Patients who are diagnosed with depression and/or their families should be told that suicidal thoughts can occur with depression and that if the patient experiences any such thoughts, the clinician should be immediately contacted and/or the patient should go to an emergency room.