

Risk factors for fatal and nonfatal repetition of suicide attempts: a literature review

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Objectives: This review aimed to identify the evidence for predictors of repetition of suicide attempts, and more specifically for subsequent completed suicide.

Methods: We conducted a literature search of PubMed and Embase between January 1, 1991 and December 31, 2009, and we excluded studies investigating only special populations (eg, male and female only, children and adolescents, elderly, a specific psychiatric disorder) and studies with sample size fewer than 50 patients.

Results: The strongest predictor of a repeated attempt is a previous attempt, followed by being a victim of sexual abuse, poor global functioning, having a psychiatric disorder, being on psychiatric treatment, depression, anxiety, and alcohol abuse or dependence. For other variables examined (Caucasian ethnicity, having a criminal record, having any mood disorders, bad family environment, and impulsivity) there are indications for a putative correlation as well. For completed suicide, the strongest predictors are older age, suicide ideation, and history of suicide attempt. Living alone, male sex, and alcohol abuse are weakly predictive with a positive correlation (but sustained by very scarce data) for poor impulsivity and a somatic diagnosis.

Conclusion: It is difficult to find predictors for repetition of nonfatal suicide attempts, and even more difficult to identify predictors of completed suicide. Suicide ideation and alcohol or substance abuse/dependence, which are, along with depression, the most consistent predictors for initial nonfatal attempt and suicide, are not consistently reported to be very strong predictors for nonfatal repetition.

Keywords: suicide, deliberate self-harm, suicide attempt, repetition, predictors

Introduction

In recent years, suicide-attempt (SA) rates have been widely studied. A World Health Organization community survey reported the lifetime prevalence of SAs at 0.4%–4.2%.¹ Female sex, young age, marital status (divorced or widowed), and having a personality disorder have been associated with an increased risk of attempting suicide.

The incidence rate for completed suicide (S) is 11.2/100,000,² increases with age, and is three times higher in males than in females.³ Suicide accounts for about 1% of all deaths and is the ninth-leading cause of death in the US and the third in ages 15–24 years.^{3,4} Rates in Caucasians are twice those of non-Caucasian populations, and married people are less likely than single, divorced, or widowed to commit suicide.² For those in bereavement, the risk is higher in the first year after loss. Rates are higher in Protestants (31.4/100,000) than in Catholics (10.9/100,000) or Jews (15.5/100,000). Unemployment increases the rate of suicide by 50%.³

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The suicide risk is higher in psychiatric patients compared to nonpsychiatric populations. More specifically, lifetime risk of suicide has been reported as high as 15% for affective disorders, 10% for schizophrenia, and 2%–3% for alcohol abuse.⁴ With respect to affective disorders, the risk is higher with increasing severity of depression. Suicides occur more often in patients with a family history of suicide, mood disorders, and alcohol abuse.⁴ Suicidality tends to emerge early in the course of a mood disorder, and increases in association with melancholia and agitation.⁴

Despite these many variables having been associated with suicidal behavior, their usefulness in predicting future suicidal behavior remains undemonstrated. The prospective prediction of later suicide remains difficult.^{5,6} A need exists, as underlined by Hughes and Owens,⁶ for more effective monitoring of people who contact hospitals because of SAs, and for more information on patients who carry out SAs but do not attend hospital. The likelihood of a repeated attempt after a first SA has been investigated less extensively. An episode of self-harm is a strong predictor of later suicide, with the risk peaking in the first 6 months after a self-harming episode, but risk persists for many decades.

A recent review estimated the 1-year incidence of repetition at 16% and fatal repetition at 2% of attempters.⁷ After 9 years, the suicide-fatality rate increased to more than 5%. Both fatal and nonfatal repetition rates were reported to be lower in Mediterranean than in Northern European countries.⁸

However, despite the potential importance of studies investigating the risk factors involved in repetition of SA, no systematic reviews of the issue have been reported. Accordingly, the aim of this review was to identify the evidence for predictors of repetition of SA, and more specifically for subsequent S.

Methods

One of the authors (MB) searched both PubMed and Embase systematically for studies carried out between January 1, 1991 and 31 December, 2009 in English, using the keywords repetition/repeated suicide attempt, repetition/repeated self-harm, recurrence/recurrent self-harm, recurrence/recurrent suicide attempt, repetition/repeated self-poisoning, and recurrence/recurrent self-poisoning. Suicides in most primary studies included those that were definite (by verdict of a coroner or equivalent authority) or probable (open verdict or equivalent judgment); definitions were too variable for us to discriminate further, and we have included them all and used this broad definition of suicide. With the terms “suicide

attempt” or “SA,” any nonfatal act in which the patient causes self-harm (self-mutilation, poisoning, jumping from high places, firearm shots, hanging, asphyxiation) was considered. The nomenclature has been taken from Silverman et al; we considered all suicidal acts, despite the degree of suicidal intent. With the term “SA” we mean a not-completed suicide (with or without injuries), while with the term “S” we mean a completed suicide.^{9,10}

For the aim of this study, we included cohort studies, case-control studies, and cross-sectional studies. Since our review focused on environmental risk factors and not on management, we excluded studies investigating self-harm management and/or care. Moreover, some of these studies investigated selected populations at risk, and others had very small samples. Thus, we decided to exclude studies investigating selected populations (childhood/adolescence, elderly, males/females only, minorities only, patients with a specific personality disorder), studies with small samples (fewer than 50), or prospective studies with a follow-up shorter than 6 months. We decided to exclude special populations because the aim of the review was the prospective prediction of later suicide in the whole population referring to the emergency room.

Studies on self-poisoning only were included because the self-poisoning method encompasses 80% of females’ and 64% of males’ SAs.⁸ For the same reason, we decided to include studies on adults only.

Data extraction

After a first screening, 211 papers satisfied our inclusion criteria. Six were useful for the introduction and for the discussion. The majority of them were carried out in Europe. Since designs, the variables studied, and the length of follow-up were different among these studies, a formal meta-analysis or direct comparison was not possible. After excluding 53 studies for not fulfilling the scope of the review, five studies for small sample size, 72 studies for a selected sample (37 childhood/adolescence, ten elderly, three females only, one males only, 19 patients with a psychiatric diagnosis, two minorities), we were left with 76 studies: 13 (17%) with a cohort analysis, 45 (59%) with a case-control analysis, and 18 (24%) with a cross-sectional analysis (Figure 1).

Sixty of them (79%) were carried out in Europe, more specifically, 24 in the UK, 20 in Scandinavian countries, five in Ireland, two in France, one in Spain, one in the Netherlands, one in Belgium, and six in three or more countries. The other studies were done in the US (five), Australia (four), Canada (two), the People’s Republic of China (two), Iran (one),

Brazil (one), and Uganda (one). SA was investigated in 64, while S was investigated in 18 studies.

All the risk factors investigated in the studies were inserted and then selected by a consensus-based process (by all the authors).

Results

Nonfatal repetition

The strongest predictor for nonfatal repetition was a history of SA, a finding reported as significant in 13 of 16 multivariate analyses and 13 of 14 univariate analyses (Table 1). Also significant were being a victim of a sexual abuse (multivariate 5/9, univariate 4/5), poor global functioning (multivariate 3/4, univariate 4/4), having a psychiatric disorder (multivariate 5/11, univariate 6/11), undergoing psychiatric treatment (multivariate 2/7, univariate 7/8), depression (multivariate 3/10, univariate 8/12), anxiety (multivariate 2/6, univariate 4/5), or alcohol abuse or dependence (multivariate 4/10, univariate 4/8). There were weaker associations for having a personality disorder, repetition for young adult age, unmarried status, alcohol abuse or dependence, psychiatric morbidity or treatment, and unemployment status. For many variables (Caucasian ethnicity, having a criminal record, having any mood disorders, bad family environment, and impulsivity) there are indications for a correlation, but data are very scarce. The results of analyses are in Table 1.

Completed suicide

The strongest predictors of S are older age (multivariate 9/16, univariate 2/5), a high suicide ideation (multivariate 5/9, univariate 1/2), a history of SA (multivariate 7/11, univariate 1/5). Living alone, male sex, and alcohol abuse are weaker predictors. There is a correlation (but supported by very scarce data) for poor impulsivity and having a somatic diagnosis. There are no data available for sexual and physical abuse during childhood or for the family environment. The syntheses of the available results are in Table 2.

Discussion

At present, there is no psychological test, clinical technique, or biological marker sensitive and specific enough to predict either short-term suicide or repetition. In line with Appleby et al,³ there is a north–south gradient in the repetition rate of suicide. A study by Pokorny⁵ illustrates how a method to predict suicide based on recognized risk factors will not only lead to a better identification of individuals at risk but also to a higher number of lost-to-follow-up or undetected cases. In this study, the authors attempted to identify which

of 4,800 consecutive patients would commit suicide. On the basis of 21 risk factors, they identified 803 patients having increased risk of suicide. Thirty of 803 (3.7%) committed suicide in a 5-year follow-up. None of these risk factors was detected in 37/67 suicides. These results are confirmed by a review of twelve studies conducted by Diekstra in 1985.⁸⁵ About 50% of suicidal people had committed at least one previous attempt. Also in this review, it is shown that it is easier to detect a nonfatal SA than a fatal one. This means that S is multifactorial, and involves not only medical but also philosophical aspects, eg, life is or is not worth living, and it is often a difficult but aware choice. The goal of a suicide assessment is not to predict suicide, but to place a person along a putative risk continuum to evaluate suicidality, especially in the period immediately following the attempt, and allow for a more informed intervention. In fact, according to Reulbach and Bleich,⁸⁶ up to 45% of people who deliberately harm themselves leave accident and emergency departments without receiving an adequate psychiatric assessment; after the discharge, the patients should not be lost in aftercare, especially if they suffer from depression, bipolar disorder, or schizophrenia.⁸⁶

In fact, after adjustment for baseline demographic and clinical characteristics and hospital differences, being referred for specialist follow-up was associated with reduction in repetition rate.⁸⁷

Synthesis of the available results

It is difficult to identify risk factors for repetition of nonfatal SA, and even more for repetition ending in S. The studies evaluated in this review had different designs and follow-up, so they are not comparable for a systematic review with meta-analysis of the available data. However, some intriguing results are available. Alcohol/substance abuse or dependence and suicide ideation, which are, along with depressed mood, the most consistent predictors for self-harm and suicide,⁴ do not seem as strong for nonfatal repetition. The presence of a previous SA is a more consistent finding for nonfatal repetition than for S, but it is the best risk factor for both and persists for many decades. The presence of a personality disorder, depression, sexual abuse in childhood, alcohol dependence, or unemployed or unmarried status are more consistently significant in nonfatal than in fatal SAs, while in nonrepeated SA, having a personality disorder increased rates among both fatal and nonfatal attempts.⁴ Impulsivity seems to be correlated with SA and inversely correlated with suicide completion. On the other hand, having a suicide ideation, (older) age, and (male) sex are thought to be

more consistently found in fatal repetition, although the role of sex is not very clear. Female sex and younger age, in contrast with data on nonfatal SA, are not likely to predict repetition. This means that once a first SA has been made (an event more frequent in females and younger people), the risk for a second attempt does not appear increased in these two categories.

Other variables, such as family environment, problem-solving, and global functioning, have a positive correlation with fatal and/or nonfatal SA repetition, but data available are not sufficient to identify them as “predictors” of repetition. Further studies are needed to confirm this correlation.

Methodological pitfalls

Many other variables have been studied, eg, Caucasians commit suicide twice as frequently as other races, and Protestants are more likely to commit suicide than Catholics or Jews.⁴ A nonheterosexual orientation carries an increased risk for attempted but not for completed SAs.⁴ In all these cases, data on SA repetition are inconsistently reported.

Moreover, since a previous SA is the best risk factor for both fatal and nonfatal repetition, most findings presented here might not be specific to repetition. Only three studies in our group investigated the risk factors in first attempters for future attempts,^{38,45,78} and only one⁴⁵ studied it prospectively.

According to Owens et al,⁷ the median proportion of patients repeating nonfatal SA is 16% at 1 year and 23% in studies lasting longer than 4 years. For a subsequent suicide, after a longer follow-up, the suicide rate increases from less than 2% at 1 year to more than 5% in studies lasting over

9 years. However, as most prospective studies lasted 1 year, the risk factors for S in subsequent years may differ from those detected at early follow-up.

Future perspectives

Further studies would ideally examine a well-defined inception cohort (ie, patients at time of first SA) identified and followed prospectively. A long-term follow-up (at least 4 years) is recommended. Standard definitions of risk and prognostic factors should be determined when planning the study. Interacting factors such as previous attempts or selected samples should be controlled for at the planning or the analysis stage. Some variables, like sexual child abuse, family environment, problem-solving, and global functioning, should be included, to evaluate their role for a repeated episode. Ideally, a study would compare different ethnicities and religions and investigate the differences in suicide repetition between immigrants and nonimmigrants. Sexual orientation should be investigated as well.

Conclusion

SA repetition (whether fatal or nonfatal) is a common event in developed countries. Prediction of recurrent SA in a patient who committed a first SA is an important task for the psychiatrist. However, it is hard to find independent predictors out of all the many variables associated with repeated and especially with S. Based on the available evidence, only a previous SA, depression, sexual abuse in childhood, and personality disorders have been found to predict nonfatal SA, while previous SA and older age were found to predict fatal SA. Suicidal ideation, which is one of the most consistent

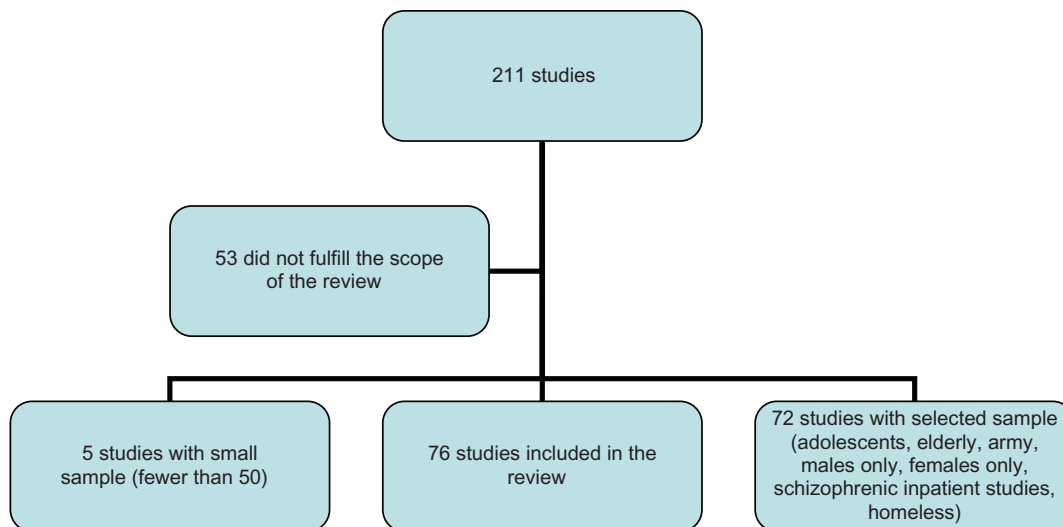


Figure 1 Literature review.

Table 1 Summary of available factors correlated with suicidality

| Variable | Number of risk-factor-significant references in multivariate analysis (significant/total) (S) | Number of risk-factor-significant references in multivariate analysis (significant/total) (SA) | Number of risk-factor-significant references in univariate analysis (significant/total) (S) | Number of risk-factor-significant references in univariate analysis (significant/total) (SA) |
|-------------------------|---|--|---|--|
| Age | 9 older/16 | 3 medium age/23 3 young/23 | 2 older/5 | 3 older/28 7 young-medium age/28 |
| Sex | 4 M/15 | 4 F/22 | 1 M/5 | 4 F/26 |
| Ethnicity | 0/1 | 3 M/22 | 0/1 | 1 M/26 |
| Marital status | 1 married or widowed/5 | 1 Caucasian/3 2 not married/182 divorced/18 | 1 not married/2 | 2 Caucasian/4 2 divorced/22 4 not married/22 2 married/22 |
| Employment status | 3 not employed/7 | 3 not employed/14 | 0/4 | 9 unemployed/18 1 not student/18 1 retired/18 |
| Social class | 0/2 | 0/5 | 0/1 | 1 low/4 |
| Education | 0/2 | 1 low/10 | | 2 low/9 |
| Housing status | 2 alone/4 | 0/8 | 1 alone/2 | 3 alone/7 |
| Psychiatric morbidity | 2/7 | 5/11 | 1/4 | 6/11 |
| Psychiatric treatment | 1/3 | 2/7 | 0/2 | 7/8 |
| Psychosis | 2/7 | 2/7 | 1/2 | 2/7 |
| Mood disorders | 1/7 rev | | | |
| Depression | 2/3 | 3/4 | | 0/1 |
| Anxiety | 0/5 | 3/10 | 1/2 | 8/12 |
| Alcohol misuse | 0/3 | 2/6 | 0/1 | 4/5 |
| Substance misuse | 2/9 | 4/10 | 1/4 | 4/8 |
| Somatic diagnosis | 1/7 | 0/7 | 0/3 | 2/8 |
| Family history of S | 3/4 | 1/41 rev/4 | 1/2 | 1/3 |
| Personality disorders | 0/1 | 1/2 | | 2/4 |
| History of sexual abuse | 0/7 | 2/6 | | 3/6 |
| Method | 7/11 | 5/9 | | 4/5 |
| Suicidal ideation | 1 rev/11 1 less poison/4 | 13/16 | 1/5 | 13/14 |
| Hopelessness | 5/9 | 2 penetrating/9 | 0/2 | 2 more poison/8 |
| Circumstances | 0/2 | 1/13 | 1/2 | 6/14 |
| Family environment | 0/3 | 1 rev/13 | | |
| Criminal record | 0/2 | 2/8 | | 5/6 |
| Global functioning | 0/3 | 0/6 | 0/2 | 2/8 |
| Impulsivity | 1 low/2 1 rev/1 | 1 bad/1 1/4 | | 2 bad/3 2/3 |
| | | 3 low/4 1/1 | 1 low/1 1 rev/1 | 4 low/4 2/2 |

Abbreviations: F, female; M, male; SA, suicide attempt(s); rev, reverse correlation; S, completed suicide.

Table 2 Factors correlated with suicide attempts (SAs) and completed suicide (S)

| Study | Year | Design | Number of patients | Factors significantly associated with SA |
|--|------|---|--|---|
| Appleby et al ³ | 1999 | Case-control (S) | 149 P, 149 C | Care reduced, history of SA, suicidal thoughts during aftercare, most recent admission at first illness |
| Asnis et al ¹¹ | 1993 | Cross-sectional | 74 repeaters, 90 first attempters | No variables associated |
| Batt et al ¹² | 1998 | Cross-sectional | 158 multirepeaters, 164 first repeaters, 310 first attempters 773 | Married status, not a student, not living alone, alcohol dependence, anxiety |
| Bille-Brahe and Jessen ¹³ | 1994 | Case-control | | Self-poisoning, living alone, less hanging/cutting, divorced, unemployment |
| Boyes ¹⁴ | 1994 | 5-year follow-up, retrospective cohort (male, female) | 1,597 | No differences |
| Brådvik ¹⁵ | 2003 | Case-control (S) | 98 S, 89 C | No differences |
| Brezo et al ¹⁶ | 2008 | Case-control (previous SA) | Not known | History of SA, compulsivity, anxiety |
| Carter et al ¹⁷ | 1999 | Case-control | 1,238 | Female sex, single or divorced/widowed/separated, retired, age classes 25–34 or 35–44 years, length of stay |
| Carter et al ¹⁸ | 2002 | Case-control | 1,317 | History of SA, personality disorders, low social class |
| Carter et al ¹⁹ | 2005 | Case-control (S) | 31 P, 93 C | Increased number of drugs ingested, increased dose ingested, drug/alcohol abuse/dependence |
| Cedereke and Ojehagen ²⁰ | 2005 | Case-control | 178 | History of SA, history of psychiatric treatment, lower global functioning, suicide ideation |
| Chandrasekaran and Gnanaselane ²¹ | 2008 | Case-control | 293 (67 repeated) | Hopelessness: history of psychiatric treatment, major depression, lower global functioning |
| Christiansen and Jensen ²² | 2007 | Case-control (S and SA) | 2,614 P, 39,210 C | SA method (self-poisoning), age class 15–24 years, psychiatric morbidity, S, history of SA, method (jumping from high places), ages 15–24 and 25–59 years |
| Coakley et al ²³ | 1994 | Cross-sectional | 122 repeaters, 179 first attempters | Older age, history of depression, schizophrenia, or alcohol dependence |
| Colman et al ²⁴ | 2004 | Case-control | 369 (92 repeaters) | History of SA, history of depression, history of schizophrenia, and poor physical health |
| Conner et al ²⁵ | 2007 | Case-control | 277 P 277 C | Depression, acute stress, poor quality of life |
| Cooper et al ²⁶ | 2005 | Case-control (S) | 7,968 | S: not living with a close relative, avoiding discovery, alcohol abuse/dependence, method (cutting), history of psychiatric treatment, physical health problem, high risk management at ER, history of SA |
| Cooper et al ²⁷ | 2006 | 5-year follow-up, prospective cohort (ethnicity) | 299 South Asians, 6,884 Caucasians | Caucasian ethnicity |
| Corcoran et al ²⁸ | 2004 | Case-control | 1,256 | History of SA, age class 45–49 years |
| Crane et al ²⁹ | 2007 | Cross-sectional | 323 repeaters, 285 first attempters | Suicidal ideation, male sex, depression, hopelessness |
| da Silva Cais et al ³⁰ | 2009 | Cross-sectional | 101 repeaters, 102 first attempters | Female sex, suicide ideation, unemployment status or being a housewife, history of emotional, physical, or sexual abuse, criminal record, hopelessness, depression |
| De Moore and Robertson ³¹ | 1996 | Case-control (S) | 223 | History of SA, planned attempt, narcotic overdose, mental illness (dementia, depression, psychosis) |
| Ekeberg et al ³² | 1991 | Case-control (S) | 934 | Older age, suicide ideation |
| Evans et al ³³ | 1996 | Cross-sectional | 185 | Impulsiveness |

| | | | | |
|------------------------------------|------|---|--|---|
| Evans et al ⁴⁴ | 2000 | Cross-sectional | 421 | No differences |
| Forman et al ⁴⁵ | 2004 | Cross-sectional | 114 repeaters, 39 first attempters | Unemployment, child emotional abuse, family mental illness, family suicide attempt, depression, hopelessness, psychosis, substance abuse, less problem-solving |
| Gilbody et al ⁴⁶ | 1997 | Case-control | 1,576 P (36% previous SA) | History of SA |
| Harriss et al ⁴⁷ | 2005 | 2–6 years' follow-up, prospective cohort study (suicidal ideation) (S and SA) | 2,489 | S: suicidal ideation SA: no correlation |
| Haukka et al ⁴⁸ | 2008 | Case-control (S and SA) | 18,199 | S: psychosis, mood disorders SA: female sex, age-group 30–40 years, any psychiatric disorder, alcohol abuse/dependence |
| Haw et al ⁴⁹ | 2003 | 12–16 months' prospective cohort (suicidal ideation) | 118 | No correlation |
| Haw et al ⁴⁰ | 2007 | Cross-sectional | 4,167 (3 groups: first attempters, <4 episodes repeaters, ≥4 repeaters; M and F calculated separately) | M with ≥4 episodes more aged 25–34 years, history of SA, current psychiatric disorders, personality disorders, psychiatric treatment, alcohol/drug abuse, being a victim of violence, criminal record, history of SA less in nonrepeaters |
| Hawton et al ⁴¹ | 2003 | Case-control | 150 | Psychiatric disorders |
| Henriques et al ⁴² | 2005 | 5–10 years' follow-up, prospective cohort | 393 | Suicidal ideation |
| Heyerdhal et al ⁴³ | 2009 | Case-control | 2,032 | Deep coma, age class 30–49 years, use of sedative drugs and opiate agents |
| Hjelmeland et al ⁴⁴ | 1998 | Case-control (S and SA) | 654 | S: older age class SA: history of SA, lower suicidal intent |
| Hjelmeland and Polit ⁴⁵ | 1996 | Case-control | 1,012 (507 first attempters, 509 repeaters) | In first attempters: history of sexual abuse, psychiatric disorder |
| Johnston et al ⁴⁶ | 2006 | Case-control | 4,743 | In repeaters: alcohol abuse and suicide among relatives |
| Kapur et al ⁴⁷ | 2006 | Case-control (S and SA) | 7,723 | History of SA, history of psychiatric treatment, employment status, unmarried, Caucasian ethnicity |
| Keeley et al ⁴⁸ | 2003 | Case-control | 2,287 | S: longer period since the first act, male sex, older age, single status SA: age class 25–34 years, single status, Caucasian ethnicity, unemployed |
| Kinyanda et al ⁴⁹ | 2005 | Cross-sectional | 25 repeaters, 75 first attempters | SA: current or previous psychiatric treatment, history of SA, alcohol abuse/dependence, psychiatric diagnosis Male sex, history of SA, dysfunctional family of origin, history of sexual abuse, criminal record |
| Kiankhooy et al ⁵⁰ | 2009 | Case-control | 156 | Single status, have children, live alone or with parents, sexual problems as major precipitant for SA, had more negative life events in childhood and fewer negative life events in the past year |
| Lilley et al ⁵¹ | 2008 | 18-month prospective cohort (method) | 7,344 | Self-inflicted injury, penetrating mechanism of injury, length of stay, male sex |
| McAuliffe et al ⁵² | 2006 | Case-control | 836 | Self-poisoning |
| McAuliffe et al ⁵³ | 2007 | Cross-sectional (suicide ideation) | 84 repeaters, 52 first attempters | Repeaters scored higher on the passive avoidance factor and on the negative expression factor and lower on the active handling factor on Utrecht coping list |
| McAuliffe et al ⁵⁴ | 2008 | Case-control | 152 | No differences Older age, history of SA |

(Continued)

Table 2 (Continued)

| Study | Year | Design | Number of patients | Factors significantly associated with SA |
|------------------------------------|------|--|--|---|
| McEvedy ⁵⁵ | 1997 | Case-control | 628 | Married status, older age |
| Neeleman et al ⁵⁶ | 1998 | Cross-sectional | 120 natural-cause death, 36 accidental death, 11 suicide death | Adolescent emotional instability, conduct problems |
| Nordentoft et al ⁵⁷ | 1993 | Case-control (S) | 974 | Older age, living alone, history of SA, no respirator treatment |
| Nordstrom et al ⁵⁸ | 1995 | 5-year follow-up, prospective cohort | 1,573 | Male sex, older age female |
| Ojehagen et al ⁵⁹ | 1991 | Cross-sectional | 46 repeaters, 33 first attempters | Unemployed status, disability pension, psychiatric disorder, psychiatric treatment, psychiatric inpatient |
| Ostamo and Lönnqvist ⁶⁰ | 2001 | Case-control (S) | 2,782 | Male sex, married, widowed or divorced status, older age class |
| Osváth et al ⁶¹ | 2003 | Cross-sectional | 549 first attempters, 609 repeaters | Psychiatric disorders (personality disorders, mood disorders, and alcohol abuse), divorced status, unemployed status, low education status, age-groups 20–35 and 35–44 years |
| Owens et al ⁶² | 1991 | 1-year follow-up, prospective cohort (admission) | 687 admitted to a ward, 305 discharged from ER | No differences |
| Owens et al ⁶³ | 1994 | Case-control | 992 | Ingestion of more than one drug, history of SA, age class 25–54 years, psychiatric disorder, unemployed status, psychiatric admission, expression of a threat to another person or written a note |
| Owens et al ⁶⁴ | 2005 | Case-control (S) | 1,091 | Older age, male sex, impairment of consciousness, psychiatric disorders, admission during the daytime, discharge from accident and emergency after psychiatric assessment, no history of SA |
| Petit et al ⁶⁵ | 2004 | Case-control | 123 | Suicidal ideation, presuicidal crisis |
| Platt et al ⁶⁶ | 1992 | Case-control | Not specified | Age class 15–34, female sex |
| Schmidtke et al ⁶⁸ | 1996 | Cross-sectional | 16,394 (repeaters 42% of M and 45% of F) | Divorced |
| Scollier's et al ⁶⁷ | 2009 | Case-control | 361 | History of SA, female sex, age classes 20–29, 30–39, and 40–49 years, education, suicide ideation, medium Buglass and Horton risk, anxiety, depression, psychiatric disorder |
| Sheikholeslami et al ⁶⁸ | 2008 | Cross-sectional | 35 repeaters, 49 first attempters | Not married status, psychiatric disorder, personality disorder, depression, hopeless, suicide ideation, impulsiveness, less satisfaction, negative events |
| Sidley et al ⁶⁹ | 1999 | Case-control | 66 | History of SA, hopelessness |
| Sinclair et al ⁷⁰ | 2007 | Case-control | 68 | Sexual abuse, mood disorder |
| Stenager et al ⁷¹ | 1994 | Case-control (S and SA) | 139 | S: older age SA: no somatic diseases |
| Suokas et al ⁷² | 2001 | 5-year follow-up, prospective cohort (history of SA) (S) | 1,018 P | SA |
| Suominen et al ⁷³ | 2000 | Retrospective cohort (personality disorders) | 114 with personality disorders, 65 without | Personality disorder |
| Suominen et al ⁷⁴ | 2004 | Case-control | 224 | Suicide ideation |
| Taylor et al ⁷⁵ | 1994 | Cross-sectional | 53 repeaters, 47 first attempters | Panic disorder, psychiatric disorder, history of SA, history of sexual abuse, PTSD |

| | | | | |
|----------------------------------|------|--|---|--|
| Tejedor et al ⁷⁶ | 1999 | Case-control (S and SA) | 150 | S: low global functioning SA: history of SA, low global functioning |
| Tidemalm et al ⁷⁷ | 2008 | Case-control (S and SA) | 27,004 | S: psychosis, mood disorder, depressive disorder, anxiety disorder, alcohol abuse/dependence, personality disorder SA: psychosis, mood disorder |
| Townsend et al ⁷⁸ | 2001 | Case-control | 1,719 | Single drug used |
| Trémeau et al ⁷⁹ | 2005 | Retrospective cohort (family history of S) | 480 | Family history of S |
| Verkes et al ⁸⁰ | 1997 | 1-year follow-up, prospective cohort (serotonergic parameters) | 220 | Serotonergic parameters |
| Wang and Mortensen ⁸¹ | 2006 | Case-control | 48,000 | Age class <40 years, being a newcomer, alcohol influence, suicide letter |
| Westling et al ⁸² | 2004 | Case-control (CSF leptin) | 78 | No differences |
| Ystgaard et al ⁸³ | 2004 | Cross-sectional | 58 repeaters, 77 first attempters | History of sexual abuse, history of physical abuse |
| Zahl and Hawton ⁸⁴ | 2004 | Case-control (S and SA) | 8,879 first attempters, 2,704 repeaters | S: history of SA SA: younger age, female sex |

Abbreviations: M, male; F, female; PTSD, posttraumatic stress disorder; CSF, cerebrospinal fluid; S, completed suicide; SA, suicide attempt(s); P, patients; C, controls; ER, emergency room.

predictors for SA and S, does not seem as strong for repeated SA, while it remains consistent for S. In several cases, no apparent risk factor was detected, and it makes it difficult to prevent fatal and nonfatal attempts.

A large multicenter prospective investigation of first SAs should be undertaken comparing different countries and differing social and cultural backgrounds and settings within each country.

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Disclosure

The authors report no conflicts of interest in this work.

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