Antidepressant-Induced Suicidality: What It Is and What You Should Do

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Do antidepressants actually cause children to be suicidal? If so, how do we detect it, and what should we do about it? In this article, we'll give you a brief review of the most recent findings on antidepressant-induced suicidality (AIS) in children and adolescents, and then move on to some practical tips for how to evaluate and prevent this problem.

Review of data on antidepressant-induced suicidality

In 2004, the FDA required a black box warning about suicidality in children and adolescents for all antidepressants. This was based on a meta-analysis of 23 antidepressant clinical trials with a total of 4,300 children and adolescents. While no actual suicides occurred in these trials, suicidal thinking was reported by 4% of kids taking medication vs 2% on placebo (Hammad TA, *Arch Gen Psychiatry* 2006;63(3):332–339). Although the difference was not statistically significant, the FDA mandated the black box warning in 2004, extending it to young adults (ages 18–24) in 2007. After the warning, there was a precipitous drop in antidepressant prescription rates and in diagnoses of depressive

disorders in youth, and some reports emerged of increasing suicide rates. For example, one retrospective study published in 2014 found a reduction of 31% in the use of antidepressants in adolescents in the second year after the warning, and the authors estimated 2 additional suicide attempts per 100,000 adolescents and 4 per 100,000 young adults (Lu CY et al, *BMJ* 2014;348:g3596).

While the FDA's actions may have had the unintended negative consequence of discouraging effective medication treatment, the preponderance of data indicate that AIS is a real issue in some patients and that it is an important potential side effect to monitor.

How to prevent AIS

Before you start antidepressants in children, check for common risk factors for suicidality. These include substance abuse, conduct disorder, prior suicidal ideation (SI) or attempts, and guns in the home. Because bipolar disorder is associated with SI, carefully assess whether the patient has symptoms and/or a family history of bipolar disorder. There are also some standardized screening instruments that are useful when assessing for SI: the Suicidal Ideation Questionnaire (SIQ-Jr) (for purchase information, see: https://www.parinc.com/Products/PKey/413) and the Patient Health Questionnaire (PHQ-A) (see: http://uacap.org/uploads/3/2/5/0/3250432/phq-a.pdf).

Choosing medications

Unless the depression is quite severe, it's best to begin treatment with psychotherapy. Address stressors and dynamic issues in school and family, as well as lifestyle factors such as sleep, exercise, and behavior activation strategies. While good psychotherapy is effective for depression, medication can be life-saving when a child is severely depressed, and particularly when there is suicidal thinking present.

Fluoxetine has the best data for antidepressant efficacy and may be the safest as well. Cipriani and colleagues looked at 34 randomized clinical trials of acute MDD, totaling 5,260 participants (ages 9–18) on 14 different antidepressants (Cipriani A et al, *Lancet* 2016;388(10047):881–890). Only fluoxetine was significantly more effective than placebo, and only venlafaxine was associated with an increased risk of SI. Fluoxetine was also more tolerable than duloxetine and imipramine. The researchers noted that when SI is present, it tends to occur early, particularly within the first month. Be sure to have close follow-up early on, asking about SI with questions such as, "Have you had any thoughts of hurting yourself?" and, "Have you had any thoughts of not wanting to live?"

Start low, go slow

The commonsense approach of "starting low and going slow" is supported by a large population study indicating that deliberate self-harm (DSH) can be dose-related (Miller M et al, *JAMA Intern Med* 2014;174(6):899–909). This study looked at 162,625 patients ages 10–64. It compared those who had dosages of fluoxetine 20 mg, sertraline 50 mg, or

citalopram 20 mg vs people on higher dosages of those antidepressants. The overall rate of DSH in the patients on the higher dosages was 1 in 136 in the first 3 months of treatment, but patients ages 10–24 on those higher dosages had twice that rate of DSH.

How to talk to family about AIS

Ask about family history of antidepressant use and outcomes to learn what might work for your patient and what challenges and concerns family members might have. Tell families that antidepressants can be very helpful, reducing suicidal ideas and behavior, and although their risk of causing self-harm is low, watchfulness is advised just in case. Ask family members to alert you right away if self-harm occurs, and to watch for other possible side effects of antidepressants, including trouble sleeping, increased activity, or impulsivity —these can lead to patients feeling worse or acting on suicidal thoughts.

Evaluating SI or self-harm

If a child has made concerning statements, assess them carefully. Passive SI is common in children, and you might hear statements such as, “I wish I were dead” or, “I wish I were not here.” If a child is indeed thinking about self-harm, follow up by asking if the child has thought of ways to possibly do so. Ask specifically if the child has actually done anything to prepare for an attempt, such as securing a knife, pills, or a rope, or looking for places to jump. Remember that asking gradually and sequentially about suicidal ideas and plans is extremely unlikely to “give the child dangerous ideas.” It is far worse to have failed to ask.

Try to figure out how likely it is that the antidepressant is contributing to SI. Was the medication started within about 3 weeks of the SI onset? While 3 weeks or sooner is common, suicidality can emerge at any time. Are there other side effects, such as agitation or insomnia, which might have preceded and caused the SI? Are there other contributors that probably have nothing to do with the medication, such as family turmoil, bullying, or school stress? Often the only way to be certain that the medication is the culprit is to reduce the dosage and see if the suicidal thinking abates.

CCPR: When children are depressed, start with therapy. Add antidepressants if symptoms are severe, and partner with family members to watch for new or increased suicidal thinking or behavior.

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