Consensus Discussion

Dr. Jamison: We want to try to achieve some consensus about what works, does not work, or has yet to be evaluated in suicide prevention. Then we will proceed to more specific questions about a general sense of the evidence regarding acute and long-term prevention of suicide with each class of treatment. We will start with the antidepressants to get a general sense of what we know and what has been presented to date.

Dr. Lenox: I am interested in the prophylactic effect of lithium in the treatment of patients with both bipolar and unipolar depression. This is a most important question to those of us who use pharmacologic strategies in order to understand molecular targets. We need data looking at suicide events during long-term antidepressant treatment of patients with recurrent major depressive disorder. We need to ask whether antidepressant treatment in this population is conclusively more effective than lithium treatment. Dr. Sackeim pointed out that lithium was less effective in the first 6 months after ECT than later. Lithium may turn out to be as effective as antidepressants in that population after that critical period of time.

Dr. Jamison: What do we know about the combined use of lithium with antidepressants? We have many studies assessing the effectiveness of lithium alone but not many studies of a drug that seems to be most effective in preventing suicides in combination with antidepressants, antipsychotics, or anticonvulsants.

Participant: Antianxiety agents should be part of the armamentarium in the treatment of acute depression. Their appearance might address other issues such as the value of using a sedative antidepressant and whether the combination of an antianxiety agent and an antidepressant should be considered as treatment in patients in the early stages of acute depressive disorders with suicidality.

Dr. Jamison: This is an important issue. Patients and doctors should be educated about the symptoms of agitation and insomnia, for example. Such difficult symptoms should be treated aggressively with p.r.n. medications early on in the illness when patients are relatively naive.

Dr. Müller-Oerlinghausen: Such a documented presentation should target long-term treatment, which is vital to suicide prevention. We should emphasize appropriate continuous treatment emphatically. When we change treatments weekly, we push the patient into an oscillating course of disease, which definitely increases the risk of suicidality.

Dr. DePaulo: In the United States we now change doctors as frequently as we change antidepressants.

Dr. Jamison: It is important to note that the first year of depressive illness represents a high risk of suicidality. Noncompliance is also problematic in that early period. What are the implications for treatment early in the course of the illness? What drugs or combination of drugs and what kinds of education are appropriate?

Dr. Angst: The early course of an illness is not the time to generalize. Be aware that, in an acute episode, suicidality will continue to play a major role for about a year. When an episode recurs, perhaps 2 or 3 years later, suicidality will again be a problem. The course of the episode itself, not just the beginning, is important. After treating a patient to lower the risk of suicidality, be aware of a regression of risk, but know that it will progress again. The recurrence of suicidal risk should be emphasized. If we assume that high risk is a onetime phenomenon, we become careless about the future. If we recognize that risk continues over decades, over a lifetime, we will be more vigilant and continually aware that the patient is always at risk.

Dr. Jamison: It is also important to stress the recurrence of illness in the clinical environment. We probably all see young men who, after a manic episode, stop their medication. It is important to keep them in treatment long enough for them to relapse, to see that this illness has a course over a lifetime. We should also recognize, however, that there is a significant risk of suicide during the first year of illness. We must educate patients and doctors about that risk.

Dr. Baldessarini: The issue of this early risk motivates early screening, interventions, and case recognition. We need to do a better job of recognizing mood disorders. What recommendations can we make about public and professional educational and interventional efforts? Dr. Shaffer has raised the possibility that certain forms of educational interventions may actually lower the threshold for suicidality rather than increase it.

Dr. Jamison: Many studies of suicide prevention in the school systems reveal that such efforts fail when they focus on suicide rather than on the recognition of treatment for depression, which is a very different issue.

Dr. Nilsson speculated that many patients who refuse to take lithium are not responsive to lithium. Many of these patients who do not take lithium probably would be responsive, but they experience euphoric and expansive manias early in the illness and hence are unwilling to take lithium and endure its side effects. Noncompliance should be treated aggressively as a dual problem, not just as an affective illness problem.

Dr. Baldessarini: In the Sardinian data *[Tondo L, Baldessarini RJ, Hennen J, et al. J Clin Psychiatry 1999; 60(suppl 2):63–69]*, the main reason for terminating treatment was that the patient was doing well. Patients experience mania and assume that they no longer need lithium.

Dr. DePaulo: One could make a case that these patients changed their risk state by stopping lithium treatment. The issue is more problematic in somebody who stopped lithium treatment because of a manic episode, which certainly is another reason that many patients stop taking lithium.

Dr. Müller-Oerlinghausen: A high proportion of patients stop taking lithium on advice of the doctor, apparently because of a misunderstanding of side effects. In one shocking case a patient was withdrawn because of the perceived risk of cirrhosis of the liver; the patient committed suicide 3 months later. It is worth the effort to convince patients, doctors, and families of the importance of lithium maintenance. Compliance means more than the patient's obeying the doctor's orders; it means constant communication between the patient and the doctor.

Dr. Lenox: There may be a neurobiology of compliance. Patients who accept treatment may be substantially different from patients who do not. We should worry about ascertainment bias. We need to understand the difference between a response of the system, a response of the disease, and an outcome variable. We may be altering the pathophysiology of the disorder, and compliance may imply a lower neurobiological risk for suicide.

Dr. Jamison: Nonadherence is not the same thing as nonresponsiveness; we can do something about nonadherence, which is an issue that is not addressed aggressively enough.

Dr. Baldessarini: Doctors are being deprived of opportunities to work as educators. They used to spend large amounts of time training the patient: "You'll experience a lot of side effects, and you won't believe the medication is helping you. You'll be the last one to see an effect. If you stop medication, you'll feel better only because the side effects will go away, and you won't want to stay in treatment. I know all this."

Dr. Jamison: With the abundance of information on media like CD-ROMs, there is no excuse for education being restricted to oral communication.

Dr. Jacobs: Continuity of care is another problem. If managed care does not permit follow-up examinations for more than a week during the posthospitalization period, we have to devise another treatment strategy, such as using ECT rather than waiting for a follow-up.

Dr. Jamison: How many doctors distribute educational materials to their patients and follow through with patient education? Without this information we lose our patients, because they believe that they are getting well.

Dr. Roy: Specialty clinics could provide this sort of education. In other fields of medicine, patients with particular diseases are sent to specialty clinics.

Dr. Müller-Oerlinghausen: For a long time, it has been argued wrongly that data from specialized clinics cannot be generalized. Specialized lithium clinics simply provide optimal care. We should make a point of having these kind of specialized institutions for depression; they could also could give necessary education to patients and doctors.

Dr. Baldessarini: Among unipolar patients in this country, only about 33% to 40% of people with major depression receive some kind of professional attention and diagnostic formulation. Of those, the most optimistic numbers I have seen indicate that one quarter to one third are actually treated in some minimally appropriate fashion. A University of Southern California study *[McCombs JS, Nichol MB, Stimmel GL, et al. J Clin Psychiatry 1990;51(6, suppl):60–69]* found that only 2% to 5% of those diagnosed were appropriately treated even by minimal criteria. We have a big educational job. We should collaborate with anybody who encounters depressed persons—ministers, rabbis, social workers, mothers, anyone. We certainly cannot do it alone.

Dr. Wyatt: In classical psychiatry and probably in the rest of mental health, most of us see patients in our own offices without the support of social workers, nurses, and other ancillary professionals. There are exceptions, but we cannot practice medicine that way.

Dr. Jamison: Dr. Roy, do you know what percentage of primary care doctors ever ask family history questions about depression, other psychiatric disorders, and suicide?

Dr. Roy: I have no figures, but such inquiries are rare. In fact, it is not common among psychiatric residents to ask such questions, even though a family history of attempted or completed suicide is an indication of increased risk, particularly in a patient with previous attempts. Such patients are at long-term risk for suicide if they relapse into depression.

Dr. Baldessarini: We deal with these problems every day and are used to talking comfortably with patients about these very difficult issues. A primary care physician might see a suicidal patient once a year, and there is still an enormous shame factor in our society. Part of our educational effort must be to medicalize suicide and treat it as a more routine phenomenon.

Dr. Goodwin: Something like the CAGE Questionnaire, an instrument for rating alcoholism and substance abuse, could be imbedded among many medical questions. With a self-report instrument, patients do not feel as much shame writing it down and talking about it.

Dr. Simpson: In a family study of bipolar disorder *[Simpson SG, Folstein SE, Meyers DA, et al. Am J Psychiatry 1992;149:1660–1665]* we found, amazingly, that people failed to make a connection between affective disorder and suicide. Early in the study, I would ask each relative about a family history of depression or affective disorders. Relatives would deny any such history, but when I asked if there were any suicides, they would often produce them.

Dr. Jamison: In terms of pharmacotherapy, we know that lithium works. Almost as impressive in the findings, there is little evidence that any other agent does.

Dr. Goodwin: That we have few data does not mean that another agent has been shown not to work. Anticonvulsants have not been used long enough for us to have accumulated the amount of data we have for lithium.

Dr. Sackeim: Antidepressants have been around long enough; surprisingly, we lack even that information. Is lithium better as a prophylaxis for the illness, or does it have a specific effect?

Dr. Jamison: Or does lithium have some anti-aggressivity/anti-impulsivity effect as well?

Dr. Müller-Oerlinghausen: Some lithium data favor some specificity *[Müller-Oerlinghausen B, Müser-Causemann B, Volk J. J Affect Disord 1992;25:261–269]*. Even patients who did not respond, who continued to experience episodes, did not commit suicide in spite of severe relapses. Data from the prospective MAP study show the same phenomenon *[Ahrens B, Müller-Oerlinghausen B., unpublished data.]*

Dr. Manji: What other treatments have such an impact on mortality? The data presented here suggest a specific antisuicidal affect of lithium. Dr. Müller-Oerlinghausen has stated that even patients who do not show an adequate mood-stabilizing effect with lithium appear to have a reduction in suicide. If these effects on suicidality are also observed at slightly lower (and therefore better tolerated) plasma levels, perhaps low-dose lithium should be a part of every bipolar patient's treatment, irrespective of the primary mood stabilizer. There are exciting new preclinical studies that show neuroprotective effects of lithium. Thus, this monovalent cation appears to have some hitherto underappreciated and unique long-term biochemical actions that may be very important for its mortality-lowering —both suicidal and cardiovascular—effects.

Dr. Roy: The key to suicide prevention lies in the education of doctors. Medical students should be taught about the risk factors for suicide, the diagnosis and treatment of depression, and the other common psychiatric disorders associated with suicide.

Dr. Jacobs: The experience of suicidal ideation is usually the symptom of an illness—most often depression—that is treatable. We should emphasize to the public that if they or a family member experience suicidal ideation or attempt suicide, they should obtain a psychiatric evaluation.

Dr. Baldessarini: The treatment of special populations—including age groups, gender factors, racial groups, and ethnic groups—for depression and suicidality is important. These groups should each be treated differently. Mood disorders in children, young adults and the elderly are often substantially different and have a different prognosis, course, and treatment response.

Dr. Hendin: Medical students are not educated to look for mood disorders in patients who are physically ill. Neither are they trained to care for patients they cannot cure. The concept of palliative care is relatively new to them. Doctors often walk away from such patients. We are only beginning to address the education of medical students in this area.

Dr. Roy: Psychological autopsy studies, from Robins et al. in the 1950s *[Robins et al. Am J Psychiatry 1959; 115:724–733]* to the Finnish suicide studies in the 1990s *[Isometsä ET, Henriksson MM, Aro HM, et al. Am J Psychiatry 1994;151:530–536]* show that most suicide victims had seen a medical practitioner in the last few weeks and months of their lives. Most of them are found not to have been prescribed psychotropic medications at suicide or to have been prescribed such medications in inadequate dosages.

Dr. Wyatt: In our Department of Defense study we found 250 suicides a year—more deaths than those due to acts of war in this country—and this has been the case for the last 10 or 15 years. None of these people ever sees a psychiatrist after becoming suicidal. We have some sense of who they are. They are going through conflicts with their wives or are going through a divorce. Unfortunately, they have access to firearms.

Dr. Jacobs: This behavior is a signal of the acute onset of a treatable depressive illness.

Dr. Goodwin: Do we have a consensus on the percentage of suicides that relate to the major psychiatric illnesses?

Dr. Roy: Psychological autopsy studies show unanimously that 90% to 95% of suicide victims have a psychiatric disorder at the time of suicide. Ninety percent of these are Axis I disorders. Other diagnoses that contribute to that 95% are schizophrenia, alcohol abuse, and drug abuse. These people kill themselves, not directly because of schizophrenia, alcohol abuse, or drug abuse but because of secondary depression.

Dr. Goodwin: How many of that group would be accounted for by primary depression?

Dr. Roy: Primary depression would usually account for 50% to 75%.

Dr. DePaulo: Yes, but in some very small populations, that figure may vary depending on the prevalence of other factors that contribute to suicide.

Dr. Jacobs: We should communicate to the Department of Defense that these suicides were symptoms of an undiagnosed and treatable illness.

Dr. Goodwin: The first study of serotonin and aggression was done in a military population. We found that these were people who apparently needed no psychiatric intervention but who had a lot of suicide attempts associated with violence, essentially.

Dr. DePaulo: The military might constitute a good population in which to redo something like the Lundby study, an impossible task in most American communities because the population would have changed completely 25 years later.

Dr. Goodwin: Are we ready to go back to research standards? We all agreed that reporting the number of

prior attempts, age at first attempt, and age of onset of illness would be important. For example, the Fawcett study *[Fawcett J, Scheftner WA, Fogg L, et al. Am J Psychiatry 1990;147:1189–1194]* incorporates descriptions of terms like anxiety, hopelessness, anhedonia, and substance abuse. These items should certainly be included in a clinical study.

Dr. Sackeim: There is no standardization, no Schedule for Affective Disorders and Schizophrenia (SADS) for suicide, no Research Diagnostic Criteria (RDC), no Diagnostic and Statistical Manual of Mental Disorders (DSM). Comparison across settings is hopeless; data are not used in the same way.

Dr. Goodwin: Previous attempts to set standards generated instruments like RDC and SADS. In our own case, it often is a matter of using data that is collected but that goes unreported.

Dr. Baldessarini: We should ask, at least, for a family history of mood disorder and suicidal behavior.

Dr. Hendin: Within the general category of depression, clearly defining the affective state of depressed patients—do they feel hopeless, desperate, or guilty?—will help us to distinguish depressed patients who are suicidal from those who are not.

Dr. Baldessarini: The fact that meetings like this are occurring with some regularity is a step forward. Suicide has been a taboo subject in our society for too long. Too much shame, guilt, and blame have been connected with it. Suicide has not received the scientific attention that it deserves, but that is changing.