



AMERICAN ASSOCIATION OF SUICIDOLOGY

Dedicated to the Understanding and Prevention of Suicide

Facts about Suicide and Depression

FACTS ABOUT SUICIDE

In 2005, suicide was the eleventh leading cause of death in the U.S., claiming 32,637 lives. Suicide rates among youth (ages 15-24) have increased more than 200% in the last fifty years. The suicide rate is highest for the elderly (ages 65+) than for any other age group.

Four times more men than women complete suicide, but three times more women than men attempt suicide.

Suicide occurs across all ethnic, economic, social and age boundaries.

Many suicides are preventable. Most suicidal people desperately want to live; they are just unable to see alternatives to their problems. Most suicidal people give definite warning signals of their suicidal intentions, but those in close contact are often unaware of the significance of these warnings or unsure what to do about them.

Talking about suicide does not cause someone to become suicidal.

Surviving family members not only suffer the loss of a loved one to suicide, but are also themselves at higher risk for suicide and emotional problems.

WHAT IS DEPRESSION?

Major Depressive Disorder (MDD) is the most prevalent mental health disorder. In the U.S., the lifetime risk for MDD is 16.6% according to a recent study (Kessler et al., 2005). According to the National Institute of Mental Health (NIMH), 9.5% or 18.8 million American adults suffer from a depressive illness in any given year.

The symptoms of depression (listed below) interfere with one's ability to function in all areas of life (work, family, sleep, etc).

Common symptoms of depression, occur almost every day for a period of two weeks or more:

- o Depressed mood (e.g. feeling sad or empty)
- o Lack of interest in previously enjoyable activities
- o Significant weight loss or gain, or decrease or increase in appetite
- o Insomnia or hypersomnia
- o Agitation, restlessness, irritability
- o Fatigue or loss of energy
- o Feelings of worthlessness, hopelessness, guilt
- o Inability to think or concentrate, or indecisiveness
- o Recurrent thoughts of death, recurrent suicidal ideation, suicide attempt or plan for completing suicide

A family history of depression (e.g., a parent) increases the chances (11-fold) that a child in that family will also have depression.

The treatment of depression is effective 60 to 80% of the time. However, according to the World Health Organization (WHO), less than 25% of individuals with depression receive adequate treatment.

Depression often is accompanied by co-morbid (co-occurring) mental disorders (such as alcohol or substance abuse) and, if left untreated, can lead to higher rates of recurrent episodes and higher rates of suicide.

THE LINK BETWEEN DEPRESSION AND SUICIDE

Suicide is the major life-threatening complication of depression.

Major Depressive Disorder (MDD) is the psychiatric diagnosis most commonly associated with completed suicide. Lifetime risk of suicide among patients with untreated MDD is nearly 20% (Gotlib & Hammen, 2002). About 2/3 of people who complete suicide are depressed at the time of their deaths.

In a study conducted in Finland, of 71 individuals who completed suicide and who had Major Depressive Disorder, only 45% were receiving treatment at the time of death and only a third of these were taking antidepressants (Isometsa et al., 1994).

About 7 out of every 100 men and 1 out of every 100 women who have been diagnosed with depression at some time in their lifetime will go on to complete suicide.

The risk of suicide in people with Major Depressive Disorder is about 20 times that of the general population.

Individuals who have had multiple episodes of depression are at greater risk for suicide than those who have had one episode.

People who have a dependence on alcohol or drugs in addition to being depressed are at greater risk for suicide.

Individuals who are depressed and exhibit the following symptoms are at particular risk for suicide:

- o Hopelessness
- o Rage, uncontrolled anger, seeking revenge
- o Acting reckless or engaging in risky activities, seemingly without thinking
- o Feeling trapped – as if there's no way out
- o Increasing alcohol or drug use
- o Withdrawing from friends, family and society
- o Anxiety, agitation, inability to sleep or sleeping all the time
- o Dramatic mood changes
- o Expressing no reason for living; no sense of purpose in life

TREATMENT

The most commonly used treatments for depression are:

- o Pharmacology (i.e. antidepressants)
- o Psychotherapy
- o Electroconvulsive Therapy (ECT)

The best treatment for depression is the combination of antidepressants and psychotherapy. A meta-analysis of 16 studies (Pampallona et al., 2004) demonstrated the advantages of combined treatment versus pharmaceutical treatment alone. One hypothesis is that therapy increases adherence to the antidepressant treatment.

Treatments are effective 60 to 80% of the time. The Collaborative Depression Study indicates that after a first episode, 70% recovered within 5 years (National Institute of Mental Health).

In summary...

- o Risk benefit ratio clearly resides on the side of treatment as opposed to no treatment for depression.
- o The best treatment is combined pharmacology and psychotherapy.
- o Most suicides in individuals with Major Depressive Disorder are among those who do not receive treatment.
- o We still know too little about those who don't improve despite adequate treatment.
- o More clinical research is needed.

ANTIDEPRESSANTS and SUICIDE RISK

In short-term studies, there has been some evidence that children and adolescents taking antidepressants exhibit a risk of increased suicidal ideation and/or suicidal behaviors (suicidality). Given this, the concern is that antidepressants could potentially lead to completed suicides.

The U.S. Food and Drug Administration (FDA) analyzed 24 trials that included over 4400 patients and concluded that the risk of suicidality in children and adolescents who were prescribed antidepressants was 4%, twice the placebo risk of 2% (www.fda.gov). None of the children in these studies died by suicide.

As with any new prescription in children and adolescents, careful monitoring of symptoms and side-effects should be observed by an adult. Any changes in symptomatology should be reported to the prescribing physician.

More research is required to determine if antidepressants are related to suicidality in children, adolescents and adults.

FDA 'BLACK BOX' WARNINGS

The Food and Drug Administration (FDA) is now requiring manufacturers of antidepressants to add a 'black box' warning label describing the potential risks of suicidality and the need for close monitoring of anyone prescribed this type of pharmacotherapy.

The FDA also developed a Patient Medication Guide (MedGuide), a user-friendly guide intended to educate patients and their caregivers about their prescription.

A joint meeting of the Psychopharmacologic Drugs Advisory Committee and the Pediatric Drugs Advisory Committee in September 2004 analyzed the short-term placebo-controlled trials of nine antidepressant drugs. The results demonstrated “a greater risk of suicidality during the first few months of treatment of those receiving antidepressants, the average risk of such events on drug was 4%, twice the placebo risk of 2%. No suicides occurred in these trials” (www.fda.gov). Based on these findings, the FDA issued the following warnings (the ‘black box’ warnings) regarding antidepressants:

- o Antidepressants increase the risk of suicidal thinking and behavior (suicidality) in children and adolescents with MDD (Major Depressive Disorder) and other psychiatric disorders.
- o Anyone considering the use of an antidepressant in a child or adolescent for any clinical use must balance the risk of increased suicidality with the clinical need.
- o Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.
- o Families and caregivers should be advised to closely observe the patient and to communicate with the prescriber.

All patients being treated with antidepressants should be closely monitored for any changes in symptoms especially at the beginning of treatment or when the dose is adjusted up or down.

For more information on the FDA warnings, please visit their website (<http://www.fda.gov>).

BE AWARE OF FEELINGS, THOUGHTS, AND BEHAVIORS

Nearly everyone at some time in his or her life thinks about suicide. Most everyone decides to live because they come to realize that the crisis they are experiencing is temporary, but death is not. On the other hand, people in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control. Frequently, they:

Can't stop the pain

Can't think clearly

Can't make decisions

Can't see any way out

Can't sleep, eat, or work

Can't get out of the depression

Can't make the sadness go away

Can't see the possibility of change

Can't see themselves as worthwhile

Can't get someone's attention

Can't seem to get control

If you experience any of these feelings, get help!

If you know someone who exhibits these feelings, offer help!

If you are experiencing any of these warning signs, please call 1-800-273-TALK

TALK TO SOMEONE -- YOU ARE NOT ALONE. CONTACT:

- o A community mental health agency
- o A school counselor or psychologist
- o A suicide prevention/crisis intervention center
- o A private therapist
- o A family physician
- o A religious/spiritual leader

American Association of Suicidology

The goal of the American Association of Suicidology (AAS) is to understand and prevent suicide. AAS promotes research, public awareness programs, education, and training for professionals, survivors, and all interested persons. AAS serves as a national clearinghouse for information on suicide. AAS has many resources and publications which are available to its membership and the general public. For membership information, please contact:

References

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- Isometsa, E. T., Aro, H. M., Henriksson, M. M., Heikkinen, M. E., & Lonnquist, J. K. (1994). Suicide in major depression in different treatment settings. *Journal of Clinical Psychiatry*, 55 (12), p. 523-527.
- Kessler, E. C., Berglund, P., Demler, O., Jin, R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, p. 593.
- Pampallona, S., Bollini, P., Tibaldi, G., Kupelnick, B., & Munizza, C. (2004). Combined pharmacotherapy and psychological treatment for depression: A systematic review. *Archives of General Psychiatry*, 61 (7), p. 714-719.

Websites:

- National Institute of Mental Health (<http://www.nimh.nih.gov/>)
U.S. Food & Drug Administration (<http://www.fda.gov/>)

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