Discussion

Depression Screening and Suicide Risk

Dr. Manji: I want to address issues raised by Jack Kevorkian, M.D. The level of acceptance that he has gained, even in the health care profession, is surprising. Dr. Kevorkian is relatively flamboyant and aggressive. He appears on television and presents himself as an advocate for individual rights. Does the American Foundation for Suicide Prevention have any plans to address some of these issues?

Dr. Hendin: We have tried to address the problem socially. We were involved in making a presentation to the Supreme Court when they ruled on assisted suicide. We are also trying to work with doctors in Oregon who are confronted with an assisted suicide law in place. In Michigan, the supporters of a law legalizing assisted suicide have not been able to gather the requisite signatures; they do not seem to be able to enact a law. Essentially, Dr. Kevorkian appeared when the public had not yet been educated about these matters. Medicine was only beginning to address the problem, and he was seen as the only answer; Dr. Kevorkian became the spokesperson for people who were seriously or terminally ill, despite the fact that he lacked background or training in these matters. Citizens of Michigan rallied around him, though, and no one believes he will be convicted of any wrongdoing in Michigan. Doing so would just make him more of a martyr. The medical profession should do more to implement the program of palliative care that the American Medical Association has recently introduced. They are training doctors to educate the public about viable alternatives to assisted suicide for the seriously ill, and we should move in that direction. Oregon is a much harder problem. They have a law on physician-assisted suicide, but fortunately it does not look as if most states want to copy Oregon in that respect. The states that have considered a similar law, even when passage seemed likely, have ended up passing laws prohibiting assisted suicide. The more the public is educated, the less inclined they are to pass such a law. The fight against assisted suicide is not a hopeless endeavor.

Dr. Angst: Dr. Hendin, the curve you showed illustrating the Netherlands suicide figures *[Hendin H. Seduced by Suicide: Doctors, Patients, and Assisted Suicide. New York, NY: WW Norton; 1998]* decreased from 1983 to 1992 continuously by about a third. When was euthanasia introduced or legalized in the Netherlands? Interpreting such a curve without this information is impossible.

Dr. Hendin: Assisted suicide and euthanasia became accepted in the Netherlands through a series of court rulings on cases in the 1970s and 1980s. The practices appear to have become widespread in the 1980s. We do not have accurate figures for that period, because the Dutch did not conduct a formal study until 1990. Eventually assisted suicide and euthanasia were supported by statute. Although they remained formally illegal, they were permitted under specifically defined circumstances.

Dr. Shaffer: How is an assisted suicide classified as a cause of death?

Dr. Hendin: It is not classified as a suicide but as a separate medical category.

Dr. Jamison: Is assisted suicide advantageous in terms of insurance payments, for example?

Dr. Hendin: I do not know.

Dr. Goodwin: Dr. Hendin, you mentioned that only 2% to 4% of assisted suicides occur in patients with a terminal illness. Do 2% to 4% of patients have a medical illness only, or might there be a comorbid psychiatric illness?

Dr. Hendin: We do not know. Studies such as that conducted by Robins et al. *[Robins E, Murphy G, Wilkenson RH. Am J Public Health 1959;49:888–889]*, from which these figures are taken, did not address this question.

Dr. Goodwin: Dr. Shaffer, have you found any difference between the psychiatric/psychological profiles of adolescents who have committed suicide and those of adults who have committed suicide?

Dr. Shaffer: Adolescents who commit suicide are predominantly aggressive and bad tempered. They drink heavily and get into trouble repeatedly. These young people experience difficulties in their relationships and consequent difficulties with the law and school. These patients account for 66% to 75% of teenage suicides. But there is another profile, less common but fairly typical—a perfectionist, a very good high-achieving young person who was often thought to be without problems. When a systematic psychological autopsy is performed, the child has anxiety disorders and great anticipatory anxiety over events. Such a person often commits suicide shortly before a much-feared event, but there is no history of impulsivity, aggressivity, or relationship difficulties that would help to explain the suicide.

Dr. Goodwin: There is no formal study, then, that compares adolescents who have committed suicide with adults who have committed suicide?

Dr. Shaffer: No. The closest existing study used so few adolescents that it is not easy to derive useful data.

Dr. Jacobs: Our data reveal a significant percentage of people not in treatment who register "severe" scores on the Zung Self-Rating Depression Scale.

Dr. Goodwin: Do the screening data provide any figures about suicide prevention?

Dr. Jacobs: No. I am convinced from anecdotal evidence that we have prevented some suicides. Approximately 20% of the people we have screened over a 6-year period have had severe depression, and those people have gone into treatment. I would like to look at suicide rates in the last quarter of a particular year to assess the impact of getting more people into treatment and of media attention focused on the awareness of depression that usually occurs during that period of time.

Dr. Shaffer: We know of 3 suicides in over 3000 adolescents screened for depression. These deaths all point to the great problem of the difference between identifying depression and actually getting depressed people into treatment. The first teenager was already in long-standing psychotherapy, without medication despite a diagnosis of major depression, suicide ideation, and substance abuse. His parents didn't want to change his therapist. The second was a young person who was absent on the screening day. The third was a young man who was reported as a high risk to the father. His father replied, "Well, we'll deal with him ourselves." One can identify the adolescents who are going to commit suicide. How one deals with them consequently requires more ingenuity.

Dr. DePaulo: Dr. Shaffer, your educational program had as its goal the destigmatization of suicide.

Dr. Shaffer: Yes. The designers of these programs often fear that suicide is seen as a crazy behavior. Therefore, as long as suicidal young people think that they are crazy, they will not come forward to tell anybody. The programs are designed to spread the message that it is all right to feel suicidal.

Dr. DePaulo: So you think that there is an opportunity here to modify existing programs?

Dr. Shaffer: I think there are wonderful opportunities to educate high school students.

Dr. DePaulo: The impact of existing programs can be very negative, and I want to make sure that we are not doing the wrong thing.

Dr. Goodwin: Has your research changed any of those programs?

Dr. Shaffer: For a while, their numbers dropped drastically. A number of states stopped advocating them. Unfortunately, such efforts never last very long.

Dr. DePaulo: Shouldn't the goal of such programs be to stigmatize suicide attempts as opposed to treatment?

Dr. Shaffer: Yes. There have been various attempts to stigmatize suicide attempts. Some programs have focused on the survivors of suicide and show the great distress that they experience. Some programs in Colorado have taken students into the morgue and showed them bodies of the young people. There is a lot of evidence indicating that, for the most part, going into high schools and telling young people that drugs are not good for them increases drug use, if anything. But behaviorally oriented programs that teach young people how to say no in the face of high pressure to take drugs have been shown to be successful. We must have a strategy beyond simply telling young people that suicide is bad for them.