Depression is very prevalent among MS patients, and is a major risk factor for suicidal ideation and suicide. Depression can decrease the functional level of patients, thereby increasing their level of disability. Fortunately, depression in MS patients is usually treatable. Patient suicide can often be prevented by screening for and treating depression.

Suicide is a major public health problem in the US, taking about 30,000 lives per year, and constituting the fourth leading cause of death for ages 25-44. MS is usually diagnosed within this age group. Chronic illness is thought to be a motivating factor in 25% of suicides. Chronic pain has also been linked to suicide.

MS patients have an increased rate of suicide as compared to the general population and matched populations. Sadovnik, et al. found that suicide accounted for 15% of all deaths in an MS clinic population. Feinstein studied 140 patients in an MS clinic, and found that 28.6% had experienced suicidal intent, and that 9 of the 140 had actually attempted suicide. He also discovered there was no increase risk of suicide for age, sex, duration of disease or cognitive impairment. Feinstein also found that the presence and severity of depression, alcohol abuse, and social isolation had an 85% predictive accuracy for suicidal intent in the MS patients studied.

Depression in MS patients has long been observed. Lifetime prevalence of depression has been reported to be well over 50%. If other depressive disorder diagnoses are also considered, rates would likely be much higher. In Minden’s 1987 sample, where one-third of the MS patients met the criteria for major depression, 64% were reported to have low mood. We found that even in patients with a first demyelinating event or new diagnosis, 32% of patients were experiencing depression.

It is unclear why MS patients have such a high rate of depressive disorders, but it is thought to be related both to organic changes in the brain, as well as a response to the psychosocial stressors which come with chronic illness and disability. Some studies have noted that treatment with the beta interferons is a cause of depression, but that finding has not been consistent in subsequent studies. We have encountered a small number of patients who seem to have an intense depressive reaction to beta interferon, with associated suicidal ideation. These symptoms subsided with withdrawal of the medication.

Fortunately, depression in MS is treatable. The optimal treatment for depression is the combination of psychotherapy and anti-depressant medication. Depression in MS patients is under-diagnosed, and untreated. For example, in Feinstein’s sample, one third of the patients with depression had never received medication or counseling from any professional.

Screening for depression and suicidality can be done during each brief office visit. This is important because depression among MS patients fluctuates over time.

### DSM IV Criteria for Major Depression (abbreviated)

Five or more of the following symptoms which are present during a two week period, constitute a change from previous functioning, occur nearly every day, and include either depressed mood and/or loss of interest or pleasure.

1. Depressed mood experienced by patient or by observer
2. Diminished interest or pleasure in almost all activities
3. Significant weight loss or gain when not dieting
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive/inappropriate guilt
8. Diminished ability to think or concentrate, indecisiveness
9. Recurrent thoughts of death, or suicidal thoughts/plans
Minden and colleagues (8) have noted that in depressed MS patients, irritability, discouragement, and the experience of frustration often accompany low mood. Although an MS patient may not meet the criteria for major depression, their depressive disorder may still impact and limit their lives. A health care professional should at least inquire about the presence of depression by simply asking, “Are you feeling depressed? Do your family or friends think you are depressed?”

Bipolar disorder is twice as prevalent in people who have MS than in the general population (10). Bipolar disorder is characterized by periods of elevated, expansive mood, with inflated self-esteem, reduced need for sleep, pressured or excessive speech, and excessive pursuit of pleasurable activities. Manic periods often alternate with periods of major depression. Suicide is a significant risk for patients with bipolar disorder: 10-15% of patients with bipolar disorder are lost through completed suicide (7). If a patient has a history of mania or hypomania, she or he should be referred to a psychiatrist for treatment, as SSRIs can sometimes induce mania in these patients.

It is also important to ask patients who report depressive symptoms if they have considered taking their own lives. Many MS patients, in the course of adapting to chronic illness, have given suicide some thought, as a possibility for them in the distant future. This can be an attempt to attain a feeling of ultimate control over what patients experience as a process beyond their control.

It is essential for clinicians to screen for acute (active in the present) thoughts about suicide, and if the patient has any plans as to how they might go about (active in the present) thoughts about suicide, and if the patient has any plans as to how they might go about achieving self-harm raises concern about the patient’s safety. When there is any concern whatsoever about a patient’s safety, she or he should be evaluated immediately at the nearest emergency room. It is not advisable to release such a patient to family members, who may be unaware or unable to keep the patient safe, or to wait for an appointment with a mental health professional.

It is also very important to screen patients for alcohol abuse and social isolation. These factors are also predictors of suicide in MS patients, when accompanied by depression (6). Unemployment has also been found to be a risk factor in the general population (13).

Where many neurologists are comfortable prescribing antidepressant medication, few have the time or expertise to provide psychotherapy. The Central New England Chapter of the National MS Society maintains a referral list for mental health professionals. In non-acute cases, the psychologists, social workers, and psychiatrists can assess risks of suicide and treat underlying depression.


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