SUICIDE IN THE ELDERLY

It must first be determined when assessing suicide in the elderly, what is meant by "elderly"? While most accepted definitions use either 60 or 65 as the beginning of "old age," it would seem important to expand that criteria based upon the person being assessed. While the American Association of Suicidology provides statistics for ages 65 to 85, to narrow the focus of preventive treatment to those ages only would seem a disservice to one's client population.

A 55-year-old, brought to treatment by a concerned adult child, who lives an isolated life, is unkempt, and presents with flat affect, exhibiting little interest in life, can certainly seem more "elderly" than a 75-year-old who is healthy and vital and socially connected and who may present with a circumstantial concern that would not appear to be something that a clinician would feel a suicide evaluation would be appropriate for. It's important, however, to assess them all.

Demographics

The American Association of Suicidology has produced a fact sheet which refers to suicide demographics and risk factors of those 65 and older.

- The elderly made up 13.0% of the population in the last census and these rates are definitely climbing as Baby Boomers come of age.
- The elderly accounted for almost 15.6% of all suicides. There was one elderly suicide every 90 minutes.

- There were about 16 elderly suicides each day resulting in 5,994 per annum suicides among those 65 and older.
- Elderly white men were at the highest risk with a rate of approximately 29.0 suicides per 100,000 each year. White men over the age of 85, who are labeled “old-old”, were at the greatest risk of all age-gender-race groups. In 2010, the suicide rate for these men was 47.33 per 100,000. That was 2.37 times the current rate for men of all ages (19.94 per 100,000).
- 84.0% of elderly suicides were male; the rate of male suicides in late life was 5.25 times greater than for female suicides.
- The suicide rate for the elderly reached a peak in 1987 at 21.8 per 100,000 people. Since 1987, the rate of elderly suicides has declined 28% (down to 14.9 in 2010). This is the largest decline in suicides rates among the elderly since the 1930’s.
- The rate of suicide for women typically declines after age 60 (after peaking in the middle adulthood, ages 45-49).
- Although older adults attempt suicide less often than those in other age groups, they have a higher completion rate. For all ages combined, there is an estimated 1 suicide for every 100-200 attempts. Over the age of 65, there is one estimated suicide for every 4 attempted suicides.
- Firearms were the most common means (71.3%) used for completing suicide among the elderly. Men use firearms more often than women.

- Alcohol or substance abuse plays a diminishing role in later life suicides compared to younger suicides. One of the leading causes of suicide among the elderly is depression, often undiagnosed and/or untreated.

More Facts about Suicide in the Elderly

According to the Administration on Aging (AoA) an estimated 8,618 older Americans (ages 60+) died from suicide in 2010. Although the rate of suicide for women typically declines in older age, it increases with age among men. Older men die by suicide at a rate that is more than seven times higher than that of older women. The incidence of suicide is particularly high among older, white males (30.3 suicides per 100,000). Notably, the rate of suicide in the oldest group of white males (ages 85+) is over four times higher than the nation's overall rate of suicide. While these figures tend to somewhat parallel those published by the American Association of Suicidology, they are considerably higher in many instances--possibly because they include statistics from age 60 vs. from age 65.

Suicide attempts are often more lethal in older adults than in younger adults. Older people who attempt suicide are often more frail, more isolated, more likely to have a plan, and are more determined than younger adults. These factors suggest that older adults are less likely to be rescued, and are more likely to die from a suicide attempt than younger adults. Firearms are the most common means of suicide in older adults (67%), followed by poisoning (14%) and suffocation (12%).

Of note, older adults are nearly twice as likely to use firearms as a means of suicide as are people under age 60. The lethality of older adult suicide attempts suggests that interventions must be aggressive and that multiple prevention methods should be used. Given

the enormity of the statistics and the fact that the elderly are the fastest growing segment of the population, it is absolutely imperative that clinicians be vigilant in order to recognize and address elder suicidality in a psychotherapy practice.

Why Is Suicidality in Elders Often Missed?

According to the American Association for Marriage and Family Therapy, (AAMFT) the elderly are most often likely to be seen in a community agency--and community agencies are more likely to serve elderly women. The suicide rate for elderly women is far below even the national average, so these agencies don't tend to assess for suicide. Most of these agencies tend to encourage self-sufficiency in terms of individual capability and safety. This encouragement for independence may cause the agencies to let the client control information, such as informing relatives or involving other available services. Leaving the patient in full control can allow him to filter and edit how much information about suicidal intent gets disclosed to others who might be able to help.

Taking action to help can include getting the word out (that someone is in danger of committing suicide) into the stream of communication, letting others know about it, breaking what could be called a fatal secret, talking to the person, talking to others, offering help, getting loved ones interested and responsive, creating action around the person, showing response, indicating interest, and showing deep concern.

Risk Factors

The act of completing suicide is rarely preceded by only one cause or one reason. In the elderly, these are some of the common risk factors:

- Increasing age

- Being a white male
- Being divorced
- The recent death of a loved one; loss and grief
- Physical illness
- Misuse of alcohol, especially in combination with a psychiatric disorder
- Uncontrollable pain or the fear of a prolonged illness
- Family discord
- Financial trouble
- Perceived poor health, unrelieved pain
- Social isolation and loneliness
- Major changes in social roles (e.g. retirement)

Elderly adults have often grown up with the belief that it is admirable to "suffer in silence." It may take considerable skill on the part of the clinician to get the full story as to what is actually going on for them physically, emotionally, circumstantially, etc. Trust may not be freely given to the therapist, especially if the client has never been in therapy before or if they are not accustomed to looking beyond the surface of life, which is true more often than not in the elderly.

Another thing that can impede the trust-building process could be the age of the therapist. If the therapist appears to be young and have little life experience, the task at communicating one's ability to be helpful can be daunting at best. Listening, even if nothing much is being said is probably the best approach vs. trying to let the client know how much the therapist believes he or she knows about the client's life and about how to help them. Everyone

wants to be heard and understood; however even saying "I understand" can seem shallow or insincere to a non-trusting, suspicious client. How could a therapist possibly understand, who might be only half the age of the client--or even less? Some behaviors that the therapist can cultivate would be to lean in while listening; be gentle, even without verbally responding; let the process unfold--even if it seems to take forever. If the client doesn't *experience* that he or she can trust the therapist, then there will be little hope of getting to the basis for what may be causing stress and/or creating a risk of suicide in the elderly client.

Warning Signs

When the therapist observes or is provided information about any of the following changes in behavior of an elderly client, then it is highly likely that this person is making plans for committing suicide and appropriate intervention is imperative.

- Loss of interest in things or activities that are usually found enjoyable
- Cutting back social interaction, self-care and grooming
- Breaking medical regimens (such as going off diets, prescriptions)
- Experiencing or expecting a significant personal loss (spouse or other)
- Feeling hopeless and/or worthless
- Putting affairs in order, giving things away, or making changes in wills
- Stock-piling medication or obtaining other lethal means
- Other clues are a preoccupation with death or a lack of concern about personal safety. Remarks such as "This is the last time that you'll see me" or "I won't need anymore appointments" should raise concern.
- The most significant indicator is an expression of suicidal intent.

While the risk factors and warning signs presented in the above lists may seem relatively obvious, there are several others that may not be as apparent or that have not been mentioned but are nonetheless critical in our assessment for suicidal risk.

Dementia

Because life expectancy is dramatically increasing, the "oldest old" or those in their 80's and 90's and even above are the fastest growing segment of the population. Results of two recent studies show that both the incidence and prevalence of dementia continue to rise in a linear fashion among this population, whereas it was once thought that between 65 and 90, the incidence of dementia began to taper off.

So what does this mean for suicide risk? Patients who are first diagnosed with dementia are usually cognizant that something is "off" with their memory and/or thought process. One can only imagine the fear, the dread, the panic that must take over when a patient has these moments of lucidity and realization of where their life is headed with the continual degeneration as the dementia consumes more and more of their rational mind. Not wanting to be a burden to others, or an embarrassment to themselves and their families, it would seem that before they have lost their basic rational cognition, suicide might be a viable option.

Depression

Undiagnosed late-life mood disorders are a major problem. Often the public sees depression and suicide as normal aspects of aging. Many people view youth suicide as a greater tragedy than late-life suicide. This type of thinking can thwart the effective outreach to the elderly and efforts to understand and treat their conditions. The health care system is not

meeting the needs of many elderly patients, and discriminatory coverage and reimbursement policies for mental health care are significant barriers to treatment.

An assessment for depression *must* undergird all of the other risk factors. Even if the depression is more situational, stemming from some of the risk factors listed above, it definitely needs to be taken into account. Sometimes, addressing ways to alleviate some of the challenges, the depression can shift as well without it becoming a major depressive disorder. However, if the depression is a deep-seated major depression or a chronic dysthymia or bipolar disorder, then it will need to be assessed and addressed from a clinical perspective, perhaps with medication in addition to in-depth psychotherapy.

It's important to keep in mind that many in the older generation are not used to asking for help, sharing their emotional pain or admitting to having "problems." This is why the assessment process is so critical--a therapist may not always get straight answers so reading body language, facial expressions and trusting one's own intuitive sensibilities as a therapist are important in this process. It can also be helpful if the patient is willing to involve a family member or close friend, at least for the initial evaluation. This type of third party can often provide objective information that the patient isn't cognizant of or isn't willing to initially talk about.

There are many depression rating scales available, including a Geriatric Depression Scale (GDS) that is designed specifically for rating depression in the elderly. The 100-item questionnaire has been tested and found to be a reliable and valid self-rating depression scale for elderly populations. Using such a scale in conjunction with an interview process could be helpful in ferreting out the often missed diagnoses of depression in an elderly client. However,

it is imperative to keep in mind that shame and fear of stigma may lead to underreporting of symptoms in self-administered scales.

Some Subtleties of Assessment for Depression

A study in the Journal of Applied Gerontology revealed some interesting criteria when it comes to elders having an understanding of depression, which can make it difficult for a clinician to make a diagnosis of depression. Many senior adults believe that depression is marked by crying and sadness. When presented with an anecdote of a 70-year-old having lost interest in her usual activities and suffering from sleep disturbance, fatigue, loss of appetite, lack of concentration, etc., less than half of the participants, who were themselves in their 70's, identified these as symptoms of depression.

This makes it clear that as a clinician it will be imperative to do some educating along with assessing the client's possible depression. Unless the patient can understand that he is presenting symptoms of depression he will be unlikely to seek and/or accept help. There is likely to be considerable denial on the client's part as well a lack of understanding. No amount of "therapy" will be effective if the patient hasn't "bought in" to the understanding that they are exhibiting signs of clinical depression or even a bipolar depression.

Whereas, younger people are more likely to experience dysphoria, depression with sadness, the older population presents more often with a lack of interest in formerly pleasurable activities, or anhedonia. And, they are very unlikely to see this as depression. In fact, more often than not, they will probably mention it to their family physician as not quite feeling like their usual self, and, unless the physician is particularly savvy, she may not suggest that the patient see a mental health professional.

Evidence shows that most elderly suicide victims visit their physician shortly before dying. In fact, over 70% of older patients who die by suicide visit their primary care physician within a month of their death. Unfortunately, most of these clients are not diagnosed with a psychiatric disorder and do not seek mental health services. These are but some of the ways that depression can be overlooked in an elderly client. Incidentally, older clients are just as likely to respond to standard treatment--talk therapy and antidepressants--as their younger counterparts so it is certainly critical that they be appropriately diagnosed.

Medications

While it's found that alcohol or substance abuse plays a diminishing role in later life suicides compared to younger suicides, it's still important to assess for the elderly client's use of not only alcohol and street drugs, but also of their medications. Not only can a combination of meds if not properly monitored be a source of depression and confusion, but some of the meds can also serve as possible overdose resources if someone is determined to take his life. These events are often seen as accidental overdoses and not labeled as suicide. And, of course, it's important to be aware of the fact that older patients often see multiple doctors for different problems and one doctor may not know what another one has prescribed.

According to New York Times health writer, Jane Brody:

Over-medication of the elderly is a public health crisis that compromises the well-being of growing number of older adults. Many take fistfuls of prescription and over-the-counter medications on a regular basis, risking serious and sometimes fatal side effects and drug interactions.

These reactions can cause confusion, depression and other side effects--all of which could trigger a sense of hopelessness and helplessness which could lead to thoughts and/or actions of suicide.

Caregiver Burnout

Elderly people are often called upon to care for an ailing spouse. This incident was described in the Journal of the American Medical Association (JAMA) in March 2012:

> *Mrs. D, at 84 years of age, was the primary caregiver for her functionally impaired 86-year-old husband and shot herself 3 times in a suicide attempt. Mrs. D's family did not perceive the severity of the caregiver burden as a family picnic was planned for the day of her attempted suicide. Mrs. D did not leave a note and later stated she fully intended to kill herself. While recovering in the hospital, she expressed relief at not having caregiver responsibilities. Two months later, her husband died, which Mrs. D described as a release for her.*

Once again, the elderly are not likely to ask for help. They often believe it's their responsibility to "stand by your man," or woman, as the case may be, "till death do us part," which often means that they take on care giving responsibilities that are far too taxing and consuming--even for a younger professional. But if someone is feeling trapped in this role and they believe it has no foreseeable end, they can lose perspective and begin to see no way out other than the possibility of ending one's own life. A part of the assessment of the elderly patient then is to ask whether or not they are taking care of anyone and then to assess the extent of their responsibility and how much of a toll it may be taking on the caregiver.

Assessing Suicide Risk

In addition to being alert to the various risk factors and warning signs, it is also imperative to address the extent of possible suicide ideation in a direct way. Asking the elderly patient the following questions should be part of any assessment for suicide:

- In the past two weeks have you had any thoughts of hurting or killing yourself?
- Have you ever attempted to harm yourself in the past?
- Have you had thoughts about how you might actually hurt yourself?
- Is there anything that would prevent or keep you from harming yourself?

Each answer would then be discussed, getting more details about any positive answers the client may have expressed to these questions. Suicidal ideation can range from passive thoughts of how everyone might be better off if the patient wasn't around to active ideation for which a person might have a plan, a means, a set time, and a strong intention. Obviously, the more active the ideation the more active the therapist's intervention must be.

Prevention

If immediate hospitalization isn't imperative, there are the usual contractual agreements of daily check-ins, informing a close friend or family member, providing education regarding depression, etc. Of particular importance in prevention strategies in the older adult is limiting access to firearms and reducing the inappropriate use of sedative medications. When older adults attempt suicide, they are much more likely to succeed than those in the general, younger population. Therefore, interventions must be aggressive and multiple prevention methods should be used.

Referral for a psychiatric evaluation and possible medication should also be close to the top of the list--especially if the depressive symptoms don't seem to be circumstantial but are indicative of a psychiatric disorder. This is especially important since many elderly suicides that are ruled "accidental" are found to have had undiagnosed mental disorders posthumously.

A signed release for communication with the primary care physician would also be a wise intervention. Many seniors still tend to have their physicians on a pedestal so the patient's doctor would be an excellent team member in supporting suicide prevention, especially since statistically, the older generation is known to make frequent visits to their primary physician.

More frequent, perhaps shorter, appointments that would create a safe environment and communicate more caring than the usual once a week contact can be an effective intervention. Getting seniors involved in community support groups can also be invaluable. Most communities have senior centers or perhaps even the local hospital or hospice will have support and/or bereavement groups which can be an effective intervention. A critical element in working with an elderly client is that the psychotherapist should never be the only resource for the client. It is imperative that they have several resources which the therapist can help them find.

The clinician can also encourage hobbies that are appropriate. Perhaps the patient used to be passionate about music, painting, knitting, playing cards, golf...the list is endless. Maybe they had to give up these interests because of the burden of care giving or other circumstances. Explore possible activities that could once again engage their interest in life. Obviously, some things have been given up because of pain or disability, etc., but there will always be some new interests that can be discovered. The internet is an endless resource for games, information,

photographic wonders and even support groups. Finding a local class where seniors can learn to use computers, the internet and social media can be very beneficial. This can open up a whole new world to them--and one that can be enjoyed by almost everyone, regardless of their disability.

If the client has been depressed for an extended period of time, they have more than likely withdrawn from many of their usual social activities. Encouraging them to return to church and social activities, bridge clubs and old friends can be highly beneficial. Social isolation is not a good environment for healing. Although it's not necessary for the patient to give everyone all the details of her illnesses, depression, etc., having one or two confidantes is also important. This can also alleviate the tendency for the therapist to become the one and only resource.

Right to Die

It is the responsibility of a psychotherapist to implement every possible intervention that can possibly be sourced in order to prevent a client from killing him or herself, but what about a patient's "right to die"? This is obviously a *very* controversial subject, but one that would seemingly need to be addressed in the discussion of suicide in the elderly. It is a subject that is becoming increasingly in the limelight, again, as our elderly population is growing at a more rapid rate than ever before.

Death in our culture has always been swept under the rug, so to speak. It's a taboo subject in most families. What one denies has no effect--until it does. In many what might be thought of as more "primitive" cultures, death is as much a central part of the community as birth. In other cultures, people aren't afraid of spending time with the deceased, preparing the

body for last rites, for burial or cremation. In our culture, that's all left to the morticians and funeral homes. So the idea of people being able to make choices around the timing of their death can seem morbid and perhaps primitive.

And then there are the religious factors. In the Catholic faith, suicide is considered a grave sin. On the other hand, Hinduism accepts the right to die for those who are tormented by terminal diseases or those who have no desire, ambition or no responsibilities remaining and allows death through the non-violent practice of fasting to the point of starvation. Jainism has a similar practice.

And another aspect for consideration would be an individual's own code of ethics. Not everyone would feel that voluntary termination of one's life would be morally congruent. And certainly, if this final act is to be physician-assisted, then the doctor would have to feel this course to be consistent with his or her own ethical standards.

The following statement is from an article in the March 24, 2014 issue of *U.S. News & World Report* which is extremely critical to any discussion of assisted suicide or the right to die:

> *...The belief that people who request life-ending medication are suicidal is one of the most misunderstood aspects of these laws, says Coombs Lee. People don't want to die. They don't want to take this medication, but they are dying. There's nothing they can do about that. And they want to have the medication in case that dying process is unbearable.*

Some of the Statistics

- Oregon was the first state to legalize assisted suicide in 1994.

- Three other states have also legalized end of life choices: Washington, Vermont and Montana. Several other states have legislation pending.
- According to the Oregon Public Health Division, since 1996, 1,173 patients received medication; 752 died from using the medication.
- In 2013 in Oregon, 122 people were prescribed medication; 71 used it and 8 took medication that had been previously prescribed. Of the 71, 94% were white, 54% had at least a college degree and 44% had private health insurance.
- The Netherlands, Belgium, Switzerland and Luxembourg are the very few countries that have legalized voluntary euthanasia.

Legal and Ethical Dilemma of the Psychotherapist

Most states have a "duty to warn" statute that requires or at least "permits" a therapist to "breach confidentiality" when there is reason to believe that a patient is at risk for harming himself or others. Of course, the potential for suicide is at the core of this responsibility. Not only is there an expectation that a therapist will inform family members, the authorities, and even facilitate the commitment of the patient for a 72-hour psychiatric hold--whatever it takes to prevent a client from self-annihilation--but then the therapist is expected to work with the client until this person is, once again, engaged in life and no longer at risk of committing suicide.

But where does the therapist fit into the picture when a patient is choosing to make a conscious decision to end her life because of encroaching dementia, unremitting pain or some other degenerative disorder that is stealing any semblance of quality of life this person may ever hope to have? Unfortunately the answer to this question is probably a long way off. Ben A.

Rich, a professor in the UC Davis Health System specializes in Internal Medicine, General Medicine, Geriatrics and Bioethics, has addressed this dilemma in the following abstract:

Pathologizing Suffering and the Pursuit of a Peaceful Death

> *The specialty of psychiatry has a long-standing, virtually monolithic view that a desire to die, even a desire for a hastened death among the terminally ill, is a manifestation of mental illness. Recently, psychiatry has made significant inroads into hospice and palliative care, and in doing so brings with it the conviction that dying patients who seek to end their suffering by asserting control over the time and manner of their inevitable death should be provided with psychotherapeutic measures rather than having their expressed wishes respected as though their desire for an earlier death were the rational choice of someone with decisional capacity. ...Recent clinical data indicates that patients who secure and utilize a lethal prescription are generally exercising an autonomous choice unencumbered by clinical depression or other forms of incapacitating mental illness.*

It would seem that a therapist in a "right to die" state would have the possibility of working with the physician who would be legally assisting the end of life process, but that likelihood would need to be researched on an individual basis by the clinician. Oregon's duty to warn is classified as "permissive" vs. "mandatory" but so are some other states that don't have legally assisted suicide.

Real Stories

Stories have certainly been told by people watching a terminally ill patient linger, far beyond any semblance of a life. They have seen them plead, if not with their voice, at least with

their eyes, "Please let me go. I don't want to live any longer." Some have also stood by and watched such a patient refuse food and water in an attempt to starve to death. Craig Brown, a hospital-based internist in Minneapolis wrote a piece in the Washington Post, *Our unrealistic views of death, through a doctor's eyes*, in which he states that:

> *With unrealistic expectations of our ability to prolong life, with death as an unfamiliar and unnatural event, and without a realistic, tactile sense of how much a worn-out elderly patient is suffering, it's easy for patients and families to keep insisting on more tests, more medications, more procedures...At a certain stage of life, aggressive medical treatment can become sanctioned torture. When a case such as this comes along, nurses, physicians and therapists sometimes feel conflicted and immoral. We've committed ourselves to relieving suffering, not causing it. A retired nurse once wrote to me: 'I am so glad I don't have to hurt old people anymore.'*

Diane Rehm, who hosts a show on NPR, told the story of her husband of 54 years. His Parkinson's disease had become unbearable. He told his doctor that he was ready to die. "I can no longer use my legs, I can no longer use my arms, I can no longer feed myself." He asked his doctor to help. The doctor's response: "I cannot do that legally, morally or ethically. I don't disagree with your wish that you could die with the help of a physician but I cannot do it in the state of Maryland." John Rehm had to deliberately die by dehydration. It took nine days.

Resources

There are a number of agencies that provide guidance for people who are looking for ways to make these right to die decisions. If a therapist hears from a patient that he wants to terminate his life rather than linger through a slow, agonizing death, can she offer him these

resources? Again, it seems to be an unanswerable question, but even if only for future reference, it's important to include these in the discussion. There are three that are readily available as online resources: *Compassion & Choices*, *Death with Dignity* and *Final Exit Network.* Oregon also has a *Death with Dignity Act* site.

At present, it seems that a therapist in most if not all states must walk a very fine line in order not to jeopardize one's license. However, there will be many changes where this issue is concerned through the ensuing years. No matter where a clinician's beliefs fall on the "right to die" spectrum, two things are imperative: 1. that each individual explore his/her own values regarding this issue and not attempt to function outside of one's own comfort zone. Even in states where physician-assisted suicide is legal, doctors are not required to participate. 2. That each therapist keeps oneself informed of the legal and ethical positions that are available in the state in which he/she practices. This issue will at some time be an unavoidable concern in the psychotherapy setting.

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