Suicide in the Elderly

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Case presentation

- 88 yo man, Holocaust survivor, recently widowed, lives at home with paid help
- Presents regularly to the clinic with the paid help
  - Impaired hearing
  - Chronic resistant depression
  - Dementia - mild
  - Holocaust survivor
  - Polyneuropathy - pain
- Reports being depressed, hopeless, wants to die, does not think of suicide
- Has a weekly short meeting with the children
- Very rigid personality
Case presentation

• 78 yo man, mildly demented
• Was very prominent in the financial world, recently retired
• Wife has difficulties in coping with his declining cognitive abilities
• In one of their arguments, threatened to kill himself
Case presentation

• 73 yo woman
• Advanced PD with difficulties swallowing, wheelchair
• Has been diagnosed several years prior to present assessment with MDD
• Multiple antidepressant treatments with no response
• Asks for psychiatric approval for Dignitask
• Not demented, not psychotic
Case presentation

• 74 yo man
• Severe back problems, Ca of prostate
• Wheelchair
• Delusional thoughts – wife infidelity
• Resulting suicidal ideation
Questions

• How often should we see the patient?
• Should we communicate with the family?
• What about psychotherapy?
• How aggressive should antidepressant treatment with medications be?
• In what setting should the patient be treated?
What is considered to be suicide?

- Intentional causing one’s own death
- Passive refusal to receive treatment or go through medical workup?
Why suicidality in the elderly deserves a separate discussion?

• (Fill in the syllabus)
• Suicidality in the elderly is in the context of
  - Psychological and psychiatric issues specific for aging
    • Depression in old age
    • Dementia
  - Neurological and medical complexity
  - Multiple losses
    • Familial
    • Societal
    • Perception of the role of one’s self
    • Income
    • Loved ones
    • Health
  - End of life issues
Why suicidality in the elderly deserves a separate discussion?

In contrast to younger suicides, parasuicides and attempters, seniors:

- Choose more lethal means of suicide
- Give fewer warnings or indications of suicidal intent
- May more frequently engage in careful planning of the suicide as opposed to more spontaneous behaviour and actions
- Seniors often live alone—↑ likelihood of an uninterrupted act of suicide
- Medical co-morbidity and low physiological reserve ↓ chance of recovery from a parasuicide event.

Voaklander et al. J Epidemiol Community Health. 2008
Suicidality in the elderly

- In the elderly - highest prevalence of successful suicide
- Hopelessness and suicidal ideation - considered as essential part of aging since early history
  - Ancient Greece: elderly could receive assistance in suicide if they convinced they no longer have a role in society
  - Freud: The gods are merciful in making life unpleasant towards the end; this makes death as a better option
Continuum

- Feeling of hopelessness and despair
- Thoughts that life is worthless
- Passive thoughts of death
- Suicidal thoughts
- Suicidal plans
- Suicide attempt
Epidemiology

- Thoughts of despair or suicidal thoughts: 1-17% of elderly
  - High risk for suicide
  - Associated with
    - Psychiatric symptomatology
      - 80% depression

- Suicide attempts: young >>> old

- Successful suicide
  - Male:
    - 19.2/100,000 ages 15-24
    - 55.7/100,000 ages > 75
  - Female
    - 5.6/100,000 ages 15-24
    - 18.8/100,000 ages > 75
Risk and protective factors for suicide in the elderly

**Risk:**
- Increased pessimism
- Increased helplessness
- Initial week of admission to inpatient unit
- Discharge week from inpatient unit
- Prior affective disorder
- Current affective disorder
- Medical comorbidity
- Functional disability

**Protective:**
- Perceived social support
- Close interpersonal relationships
- Feeling useful
- Realistic outlook
- Positive future outlook
- Achieving goals
- Successful adjustment to aging
Psychological/psychiatric factors associated with elderly suicide

- Depression
- Basic personality - coping with
  - Effects of aging on brain
  - Losses
    - Role in family and society
    - Health
    - Income
    - Family members and friends
Physical factors associated with suicidality in the elderly

• Physical illness and disability
  - Loss of vision
  - Neurological diseases
    • Dementia
  - Malignant diseases

• Most often in the presence of depression
Social factors associated with suicidality

- Social isolation
- Losses
- Populations at risk:
  - Widows
  - Bachelors
  - Divorced
The role of personality
Stages of development- Erik Erikson

- **Infancy**: Birth to 18 Months
  - Ego Development Outcome: Trust vs. Mistrust
  - Basic strength: Drive and Hope
- **Early Childhood**: 18 Months to 3 Years
  - Ego Development Outcome: Autonomy vs. Shame
  - Basic Strengths: Self-control, Courage, and Will
- **Play Age**: 3 to 5 Years
  - Ego Development Outcome: Initiative vs. Guilt
  - Basic Strength: Purpose
- **School Age**: 6 to 12 Years
  - Ego Development Outcome: Industry vs. Inferiority
  - Basic Strengths: Method and Competence
- **Adolescence**: 12 to 18 Years
  - Ego Development Outcome: Identity vs. Role Confusion
  - Basic Strengths: Devotion and Fidelity
- **Young adulthood**: 18 to 35
  - Ego Development Outcome: Intimacy and Solidarity vs. Isolation
  - Basic Strengths: Affiliation and Love
- **Middle Adulthood**: 35 to 55 or 65
  - Ego Development Outcome: Generativity vs. Self absorption or Stagnation
  - Basic Strengths: Production and Care
Stages of development- Erik Erikson

Late Adulthood: 55 or 65 to Death
- Ego Development Outcome: Integrity vs. Despair
- Basic Strengths: Wisdom
  - Much of life is preparing for the middle adulthood stage and the last stage is recovering from it
  - As older adults we can often look back on our lives with happiness and are content, feeling fulfilled with a deep sense that life has meaning and we’ve made a contribution to life, a feeling Erikson calls integrity
  - Our strength comes from a wisdom for the whole of life, accepting death as the completion of life
  - Some adults may reach this stage and despair at their experiences and perceived failures. They may fear death as they struggle to find a purpose to their lives, wondering "Was the trip worth it?" Alternatively, they may feel they have all the answers (not unlike going back to adolescence) and end with a strong dogmatism that only their view has been correct
The role of personality

• Research on late-life personality disorders: under-detection
• Inconsistent assessment procedures
• Problematic diagnostic criteria that do not account for age-related social and cognitive changes
• Epidemiology late life personality disorders: varies markedly by setting and age
  - 6.6% (0% for NPD) in an epidemiological sample 55 years or older
  - 13% (0.5% for NPD) in community-dwelling adults > 60
  - 27% in psychiatric inpatients > 65
  - 55.4% (7.1% for NPD) in inpatient veterans > 60 years or older
Impact of personality disorder in old age

Association with:

• Impaired general, social, and psychological functioning, interpersonal relationships, and quality of life

• Older personality-disordered psychiatric inpatients are more likely to be single, separated, or divorced

• More complex clinical presentation when depressed

• Higher prevalence of suicidal behavior
Narcissism at old age and suicidality

• Theory and research support an association between narcissism and late life suicidal ideation and behavior

• Suicide risk- associated with
  - Lack of openness
  - Lack of flexibility
  - Difficulty adapting and accommodating to losses inherent in aging
Study of the association between narcissistic personality disorder/traits and suicidality

• Heisel et al Am J Geriatr Psychiatry 15:9, September 2007
• Patients admitted to psychogeriatric daycare for the treatment of depression
  - 608 patients ≥ 65 (mean: 76.1, range: 65–94; 69% female)
• Excluded:
  - No available information regarding presence of suicidal ideation or behavior
  - No available information regarding Axis II diagnostic data
  - Psychotic disorder
Study of the association between narcissistic personality disorder/traits and suicidality

Results:
• Severity of patient suicidality was significantly associated with NPD, and more broadly with narcissistic personality traits
• The association of NPD with severity of current suicide ideation
  - Demographic variables
  - Self-reported depression severity
  - Cognitive functioning
• Depressed older adults struggling with issues of self may be vulnerable to suicidal thoughts and behavior
Suggested model

- Latent narcissistic features underlie suicidal crises among older adults
- Become activated in the presence of age-related transitions
- Exacerbated in the face of mood and substance use

Clark DC. Suicide Life Threat Behav 1993
Possible mechanisms

• Low sociability reported for depressed older adults with NP
  - Interpersonal style that can engender conflict and alienate potential providers of social support

• Late-life personality disorders increase the severity, chronicity and recurrence of depression
Implications for clinical practice

- Assessment of narcissistic personality (traits and disorder) in depressed older adults
- Assessment of late-life suicide risk ideally involves exploration of accommodations to age-related changes and of personality characteristics and psychological resiliency
- Therapeutic focus on:
  - Depression
  - Transitions
  - Self-pathology
The role of depression
Suicidality and age of onset of depression

• > 50% of elderly patients diagnosed to have MDD 1st episode starts in later life (Fiske et al., 2009)
• Late onset depression (LOD) > 60
• Early onset depression (EOD) < 60
LOD vs EOD

- Lower family load of depression
- Fewer premorbid personality disturbances
- More vascular risk factors
- More WM changes
- More concomitant cognitive changes
- More resistance to initial antidepressant monotherapy
- Phenomenology
  - Less likely to endorse cognitive-affective symptoms
    - Dysphoria
    - Worthlessness/guilt
    - Suicidal ideation
Depression in primary care setting

- MDD prevalence in older primary care patients of 5-10%
  - Considerable comorbidity
  - Impact on functional status
  - Risk for suicide

- Minor depression (only 2-4 symptoms) prevalence 5%
  - Similar effect on functional status
Depression in primary care setting

• Patients with sub-syndromal depression had poorer outcomes than non-depressed subjects in:
  - One-year lagged overall depressive symptom severity
  - Suicidal ideation
  - Psychic anxiety
  - Cognition
  - Medical burden

• Results may differ according to definition of SSD
  - Hamilton score >10
  - Any 2 depressive symptoms of the SCID
  - Other

Grabovich et al Am J Geriatr Psychiatry. 2010
The role of hopelessness
Reasons for living, hopelessness and suicide ideation in depressed ≥ 50

• Hopelessness: a system of negative beliefs and expectancies concerning oneself and one’s future

• Reasons for living (RFL): beliefs or expectancies that include survival and coping beliefs, responsibility to family, child-related concerns, fear of suicide, fear of social disapproval, and moral objections
  - Associated with reduced suicidal risk

• In a sample of depressed >50
  - Fear of suicide- associated with ↓ suicidality

Reasons for living, hopelessness and suicide ideation in depressed ≥ 50

- Depressed older adults’ concern that their suicide would hurt family members ↑ association between hopelessness and the presence and severity of suicide ideation
- Depressed and hopeless older adults with a sense of responsibility to family may feel overwhelmed by real or perceived inadequacies, increasing thoughts about suicide to end their own suffering
- In the presence of hopelessness, cognitions that are thought to reduce risk, such as responsibility to family, may be rendered inert or even harmful

The wish to die and 5 year mortality in primary care elderly patients

- What is the impact of suicidal ideation on natural-cause mortality in primary care?
- Does this impact contribute over and above depression?
- Individuals with major depression are among the most likely to express suicidal ideation
- Ideation at more passive levels frequently presents among older adults in the absence of depression
- In usual primary care practice, the wish to die was associated with increased risk of 5-year mortality among elderly patients regardless of depression status
- Even among those individuals without depression, patients who wished to die had lower survival rates
- In primary care practices in which a depression intervention was implemented, this increased risk of mortality among depressed patients was not observed
- The wish to die was related to mortality over and above effects of hopelessness, history of previous depression, medical burden, and functional disability

Raue et al, Am J Geriatr Psychiatry 18:4, April 2010
The wish to die and 5 year mortality in primary care elderly patients

• Possible mechanisms:
  - Feelings that life is not worth living or that one would be better off dead influence psychological factors and behaviors that contribute to the risk of fatal medical illnesses
    - Lowered self-efficacy
    - Lowered sense of control over self-care activities, and environmental safety
  - Health behaviors
    - Limited help seeking
    - Self-neglect
    - Poor treatment adherence
  - The wish to die in the absence of depression may lead to new onset depression
The role of medications and co-morbidities
Medical illness, medication use and suicide in seniors

- Case-control study
- Comparison of medication use by British Columbia (BC) residents > 66 who had died by suicide with that of BC residents > 66 who had not died by suicide over a 10-year period (1993-2002)
- Complete prescription medication histories were available for this population

Voaklander et al. J Epidemiol Community Health. 2008
<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Sex</th>
<th>Total (n602)</th>
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<tbody>
<tr>
<td></td>
<td>Men (n 435)</td>
<td>Women (n 167)</td>
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<tr>
<td>Firearms</td>
<td>(38.4) 167</td>
<td>(2.4) 4</td>
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<tr>
<td>Hanging/suffocation</td>
<td>(23.9) 104</td>
<td>(28.7) 48</td>
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<tr>
<td>Self-poisoning</td>
<td>(14.3) 62</td>
<td>(39.5) 66</td>
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<td>Gas</td>
<td>(10.1) 44</td>
<td>(7.8) 13</td>
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<tr>
<td>Jumping from height</td>
<td>(5.5) 24</td>
<td>(12.0) 20</td>
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<tr>
<td>Drowning</td>
<td>(3.0) 13</td>
<td>(5.4) 9</td>
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<tr>
<td>Laceration</td>
<td>(2.8) 12</td>
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<tr>
<td>Other*</td>
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Associations with elderly suicide

- **Co-morbidities and suicide**
  - Depression/psychosis
  - Neurosis
  - Stroke
  - Cancer
  - Incontinence
  - Liver disease (may be associated with depression?)
  - Previous history of self-harm

- **Medications (even after exclusion of those that died by O.D.)**
  - Benzodiazepines
  - Narcotic pain killers (pain associated with depression and hopelessness)
  - ↑ risk for suicide with strong pain medications / elderly inappropriate benzodiazepines (t half ↑, exceed dose recommendation)
  - The same for both poisoning and non-poisoning suicides
Benzodiazepines

- CNS depressants
- May exacerbate undiagnosed depression in seniors
- Hypothesis: use of benzodiazepines leads to:
  - Uninhibited and poor impulse control leading to suicidal impulses in some individuals
- Individuals filling multiple prescriptions of benzodiazepines were at greater risk - hypothesis:
  - Heavy and chronic usage of this class of drugs is a marker for depression
  - Mitigating factor leading to suicide through poor impulse control
- Doctors prescribing these drugs
  - May not have diagnosed underlying depression
  - May be using benzodiazepines as a primary treatment of depression rather than an adjunct therapy to true antidepressant medications.
End of life issues
Death in the 21st century

- 80% of deaths in the United States > 65
- The majority of deaths also occur in the setting of chronic illnesses associated with functional decline
- "medicalization" of death
  - Fears that suffering will be worsened or prolonged by medical procedures or treatments
  - Recognition that death is often removed from the contexts (i.e., social, cultural, religious) that in former generations helped give the dying process meaning for the terminally ill person and her or his family
- 90% of Americans would prefer to die at home
- 60%-80% actually die in institutional settings
  - Invasive procedures
  - Artificial support of basic human functions
  - Resuscitation efforts
Death in the 21st century

- Medicalization of death offers unique opportunities to improve the dying process
  - Physical and emotional symptoms
  - Support of function and autonomy
  - Palliative versus curative care
  - Advance care planning
  - Limitation of unwanted or futile aggressive care near death
  - Patient and family satisfaction
  - Global quality of life
  - Pain control
  - Family burden (including bereavement)
  - Survival time prognostication
  - Provider continuity and skill
Depression in the dying patient

• Depression ↔ co-morbid medical illness
  - Medical illnesses are among the most consistently identified correlates of the presence and course of depression in later life
  - Depression is a powerful predictor of functional outcomes and mortality in broad populations

• Diagnosis of depression in the context of medical illness is problematic
  - Attribution of symptoms
    • Anergia
    • Anorexia
    • Weight loss
    • Sleep or psychomotor disturbance

• How to operationalize hopelessness and recurrent thoughts of death in the context of impending death
Depression in the dying patient

- Depressive symptoms 15%-60%
  - Reflects the heterogeneity of depressive conditions, their definitions and patient populations.
- Depressive conditions in dying patients are multifactorial in origin
  - Physiological effects of the disease process on brain functioning
  - Premorbid diathesis toward death
  - Current psychological and psychosocial factors
- Depression is associated with: ↑ functional morbidity ↓ quality of life in dying patients
  - Better treatment of chronic pain or other physical symptoms may result in improvement in concomitant depressive symptoms
  - Successful treatment of depression may reduce pain severity or pain-associated functional morbidity
Depression in the dying patient

• Choice of treatment (based on extrapolations from other populations)
  - Medical condition
  - Depressive symptomatology
  - Side effect profile
  - Consider stimulants
    • Prominent anergia, abulia
    • Very short life expectancy
Suicidality in the dying patient

- How to differentiate between “normal” hopelessness and worthlessness from pathological process?
- In any case:
  - Persistent wishes to die
  - Specific suicidal ideation or plans

- Careful clinical evaluation for modifiable contributing factors
  - In terminal patients
    - Depressive disorder
    - Pain
    - Agitation/distress as part of delirium or dementia
    - Social isolation
Assessment

• Assessment
  - Emphatic
  - Gradual
    • Despair thoughts of death, deathful wishes, suicidal thoughts, suicidal plans
  - With respect
  - Consider the forum (in presence of family?)

• Be attentive
• Stay calm and nonthreatening
• Provide the patient with space and time to vent
• Be collaborative, use a team approach
• Be willing to say the word "suicide"
Management

- Directly assess frequency and content of suicidal ideation and risk factors
- Explore the initial problem
- Have the patient describe reasons for and against suicide
- Assess the patient's access to means
- Provide education regarding depression
- Decide how to manage an increase in suicidal ideation through either a formal contract or some other formality
- Meet with the patient weekly at minimum if suicidal ideation is present
- Write prescriptions for no more than 1 week until ↓ suicidal risk
- Provide family education regarding suicide
- Provide supportive and collaborative interaction with the patient
- At each treatment assess hopelessness, suicidal ideation, and substance abuse