

# Preventing late-life suicide: 6 steps to detect the warning signs

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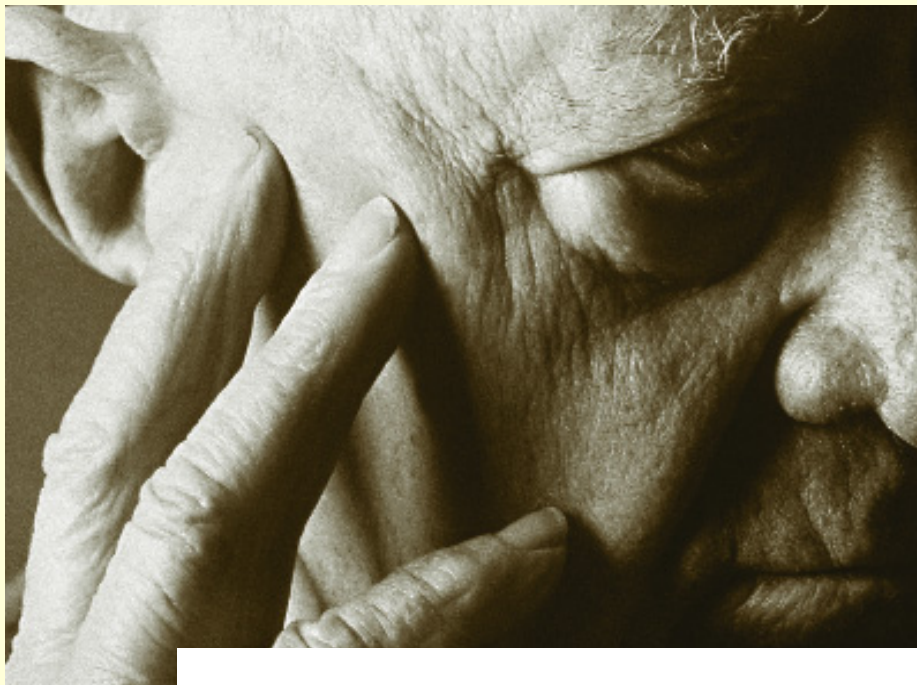
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When a life is at stake, vigilance for deadly plans and weapons and a specific strategy for screening and decision-making are vital.

**CASE REPORT** I have a gun

**M**r. V, age 77, appears depressed and anxious during his appointment at a mental hygiene clinic. He reports insomnia, concentration trouble, and anhedonia. He tells the psychiatrist he keeps a loaded gun at home and is not sure he can control his suicidal impulses.

The patient is Caucasian and has a history of heart failure, pulmonary disease, and type 2 diabetes. His wife died 18 months ago. He lives alone, but his sister lives nearby. He recently received a right hip replacement, which required 3 months of rehabilitation in a nursing home to recover from surgical complications. He still has trouble walking.

As in Mr. V's case, treating older patients referred for psychiatric care often involves evaluating sui-



Box

## Studies: Suicide risk increases in later life

Approximately 20% of all suicides in the United States are committed by persons age 65 or older,<sup>1</sup> who account for 13% of the total population. The suicide rate among persons older than 75 is three times higher than it is for the young.<sup>2</sup> Older Caucasian men have the highest per-capita rate of completed suicide, compared with any other group of Americans.<sup>3</sup>

**Psychiatric disorders.** The rates of Axis I disorders among older persons who commit suicide fall within the average range for all age groups (70 to 90%). However, the types of disorders seen in the older population differ from those of younger suicides (*Table 1*).<sup>4,8</sup>

Affective illness has been termed “the predominant psychopathology associated with suicide in later life.”<sup>4</sup> Among older persons who commit suicide, three-fourths (76%) have diagnosable mood disorders<sup>4</sup> and nearly two-thirds (63%) have depression.<sup>6</sup> Contributing risk factors include alcoholism and substance abuse,<sup>4,6,7</sup> Axis II disorders, and dementia.<sup>6</sup>

**Losses and medical illness.** In later life, bereavement, loss of independence, or financial reversals may lead to depression. Older persons who take their own lives also tend to have greater physical health burdens and more functional disabilities than those who do not commit suicide.<sup>6,8</sup>

cide risk. His age, race, gender, depressed mood, recent bereavement, and medical ailments place him in the population at highest risk of suicide (*Box, Table 1*).<sup>1-8</sup>

This article describes an age-based psychiatric workup of the suicidal older patient, including factors to consider when screening for depressive symptoms, prescribing drug therapy, and determining the need for hospitalization.

### AGE-BASED CLINICAL WORKUP

For older patients who report suicidal ideation, an age-appropriate workup—using clinical interviews and screening instruments—is essential. The clinical interview can build rapport and gath-

er information about the patient’s suicidal plan or intent. Based on our experience, we recommend the following 6-step screening interview, summarized in *Table 2*.

**1. Ask about a specific plan.** Does the patient have the means readily available to carry out this plan? What is the timeline (imminent versus vaguely futuristic)? Does the patient report having control over this plan?

**2. Gather a suicide history.** Has the patient attempted suicide before? By what means? Is there a family history of suicide? If yes, by what means did this family member commit suicide, and how was the patient affected?

**3. Assess social status.** How isolated is the patient? Have there been recent changes in his or her social circle, such as loss of a spouse? Can the patient identify at least one person who would be negatively affected by the suicide?

**4. Assess medical health.** Does the patient suffer from chronic pain? Does the patient have a recently diagnosed medical condition? Has a longstanding medical condition become more debilitating? Does the patient report feeling hopeless

about impending medical difficulties? Has he or she been keeping regularly scheduled medical appointments with outpatient clinicians?

**5. Assess mental health.** Does the patient meet DSM-IV criteria for depression or schizophrenia, which are associated with high suicide risk? Does he or she report being hopeless or helpless? Is the suicidal ideation ego dystonic?

**6. Ascertain clinical signs of suicidal intent.** Has the patient:

- begun to neglect his or her personal care?
- begun a process of starvation?
- recently written or changed a will?
- been redistributing assets, such as giving material possessions to family members?

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Table 1

**Suicide risk with mental and physical illness, by patient age**

Risk factors	Young (21 to 34 yrs)	Middle-aged (35 to 54 yrs)	Young-old (55 to 74 yrs)	Elderly (77+ yrs)
Psychiatric disorders	●	●	●	●
Mood disorders		▶	●	●
Alcohol abuse	▶	●	▶	
Primary psychoses	●	▶		
Personality disorders	▶			
Physical ailments			●	●

● Significant risk factor ▶ Potential risk factor

Source: Compiled from information in references 4-8.

- been relinquishing responsibilities, such as giving away pets or retiring from positions of authority?

**CASE REPORT continued Some telling signs**

Mr. V's laboratory screening reveals slightly elevated serum glucose and mild anemia. An ECG reveals a type I heart block, but all other lab results are unremarkable. His sister reports he recently gave away his dog, which he and his wife had owned for many years. He has also mentioned a desire to revise his will when speaking to other family members. Hospital records indicate he has missed numerous medical appointments over the past 4 months.

**SCREENING INSTRUMENTS**

Psychological assessments can often buttress the clinical interview findings. Several measurements are well-suited for detecting suicidal risk and concomitant depression (Table 3).

**Beck SSI-C.** The Beck Scale for Suicide Ideation – Current (SSI-C) assesses a patient's preparation and motivation to commit suicide.<sup>9</sup> This short (19-item) self-report measure asks patients to rate their wish to die, desire to

attempt suicide, duration (and frequency) of suicidal thoughts, sense of control over suicide, and deterrents they face. The SSI-C helps to measure or monitor suicidality and is reliable and valid for psychiatric outpatients.<sup>9</sup>

**BDI-II.** The Beck Depression Inventory—recently revised in a second edition (BDI-II)<sup>10</sup>—can be useful because depression is one of the strongest risk factors for elder suicide. The 21-item BDI-II—a psychometrically sound, self-report instrument—asks about general symptoms of depression and gauges their severity. It can be applied to diverse patient populations and ages<sup>11</sup> and is appropriate for older patients who are also being treated medically.

**Beck Hopelessness Scale.** Hopelessness has been recognized as a possible harbinger of suicide.<sup>12</sup> One study showed that depression became a clin-

**91% of patients who scored 10 or more on the Beck Hopelessness Scale eventually committed suicide**

ically meaningful suicide predictor only when accompanied by hopelessness.<sup>13</sup>

A score of 10 or more on the Beck Hopelessness Scale identified 91% of patients in



Table 2

### 6-step clinical interview with an older suicidal patient

1. **Determine** plan and specify means
2. **Gather** suicide history (personal and family history)
3. **Determine** level of social support
4. **Evaluate** medical health
5. **Evaluate** mental health
6. **Determine** presence of suicide warning signs:
  - Neglect of personal care
  - Intentional self-starvation
  - Recent writing or changing of a will
  - Giving away material possessions
  - Relinquishing responsibilities, such as pets or positions of authority

Source: Adapted from the Cincinnati Veterans Affairs Medical Center general psychological suicide assessment

one study who eventually committed suicide. The hopelessness patients expressed on this scale more strongly differentiated between those who did or did not commit suicide than did their scores on the BDI or SSI-C.<sup>14</sup>

**HRSD-R.** The revised Hamilton Rating Scale for Depression (HRSD-R) documents patients' levels of mood disturbance and suicidality. One item in this 21-item, clinician-administered instrument specifically asks about the patient's level of suicidality in the past week. The scale has well-documented reliability and validity and is appropriate for psychiatric populations.<sup>15</sup>

#### CASE REPORT continued Alarming findings

Along with the clinical interview, Mr. V. is screened with the Beck Hopelessness Scale and Beck Depression Inventory-II. These instruments are chosen because they are easy to administer, and patients can readily comprehend the questions—even when under duress. Mr. V's results reveal moderate depression and severe hopelessness.

#### INPATIENT VS. OUTPATIENT CARE

Older patients are often referred to a psychiatrist because of vague suicidal ideation, but they may also present in an acute crisis—with immediate plans for suicide and readily accessible means. The first concern for their safety is to ensure they are not left alone.

**Patient interview.** First, listen empathetically and ask detailed questions, especially ones that remind patients of their daily connections and responsibilities. For instance, ask, "Do you have children who would be affected by your decision?" Address patients' immediate needs, such as hunger, thirst, or pain.<sup>16</sup> Work on building a therapeutic alliance before asking questions that may appear trivial to agitated patients (such as tasks assessing cognitive abilities).

Avoid arguing with patients, and refrain from offering advice or sermonizing. Allow them to describe their emotions, and communicate that you understand their concerns. Discuss how they can expect to receive treatment to ease their discomfort. Inform them that mental health specialists can treat them and monitor their progress.

**Hospitalization.** Begin discussing treatment options and broach the notion of hospital admission if necessary. One way to foster an alliance is to frame inpatient care as a way of helping them recover from their crisis in a safe environment.

To ensure patient safety, it is best to err on the side of admission. Admitting the suicidal patient not only guarantees strict supervision but also allows time for necessary psychological assessment. Hospitalization may also allow family members to remove any weapons or hazardous conditions from the patient's home.

Including the family in problem-solving is especially important when managing older suicidal patients. For patients who are isolated from family or friends, recovery may depend on improving their support network.

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Table 3

### Comparing screening instruments for suicide risk

Measure	Description	Time (minutes)
Beck Depression Inventory (BDI)	21-item, self-administered; identifies depressive symptoms in past week	10
Beck Hopelessness Scale (BHS)	20-item, self-administered; measures hopelessness, fatalism, and pessimism in past week	5
Beck Scale for Suicide Ideation-Current (SSI-C)	19-item, self-administered; gauges suicidal intention	10
Hamilton Rating Scale for Depression-revised (HRSD-R)	21-item, clinician-administered; rates depressive symptoms in past week	25

**Outpatient care.** Not all acutely suicidal older patients require hospital admission. They may be safely managed as outpatients if they:

- have strong social support
- are not isolated
- have no access to firearms or other dangerous weapons.

Safety can be enhanced by having family members take responsibility for the senior’s well-being and by asking the patient to contract for safety. A safety contract may include:

- verbal confirmation—and ideally a written statement—that the patient will not commit suicide within a specified period
- a list of people the patient will contact when feeling suicidal
- steps being taken to monitor the patient’s welfare.

Finally, schedule follow-up appointments soon after discharge to certify patients are being closely monitored. To encourage outpatient medication adherence, build strong alliances with family members and ask patients to bring in their pill bottles during follow-up appointments.

#### CASE REPORT continued Observation begins

The staff is clearly concerned about Mr. V’s suicide risk and requests that he voluntarily admit himself to

the VA hospital. This decision is based on his level of isolation, the lethality of his suicide plan, access to a weapon, and the depression and hopelessness revealed by his screening tests. He reluctantly agrees and is admitted to the inpatient psychiatric unit for observation and treatment by a geriatric internist and a geriatric psychiatrist.

#### DRUG THERAPY FOR SUICIDALITY

For patients with mild depressive symptoms, psychotherapy may be sufficient to manage depression associated with suicidality. However, those with moderate-to-severe depression require both drug treatment and psychotherapy.

Drug selection depends upon the underlying psychiatric illness. If the older patient is experiencing a depressive disorder, a selective serotonin reuptake inhibitor (SSRI) or another antidepressant could serve as first-line treatment (*Table 4*). These medications are safe for suicidal patients because they are not fatal in overdose.

**Administration.** Because age-related changes in pharmacokinetics and pharmacodynamics can slow medication clearance, reduced dosages usually achieve a therapeutic effect and minimize the risk of side effects in geriatric patients.

Antidepressants commonly used for older patients are shown in *Table 4*. Excepting citalo-

Table 4

### Antidepressants commonly used to treat geriatric depression

Medication	Recommended dosage (mg/d)
<b>SSRIs</b>	
Citalopram	20 to 40
Escitalopram	10 to 20
Fluoxetine	10 to 40
Paroxetine	10 to 40
Sertraline	25 to 150
<b>Others</b>	
Bupropion	100 to 400
Mirtazapine	15 to 45
Venlafaxine	75 to 225

pram and escitalopram, these dosages are lower than usual. We start healthy older patients on one-half the usual dosage and those who are medically ill or have neurodegenerative disorders on one-third to one-fourth the usual dosage. We also titrate more slowly to reduce the risk of side effects.

As in younger patients, the most common side effects of SSRIs in older patients include GI difficulties, overactivation, and sexual dysfunction. Paroxetine's potential for anticholinergic effects may be a concern for some older patients.

Drug-drug interactions are of great concern when treating older patients, who take an average of six to nine medications per day.<sup>17</sup> Compared with other SSRIs, fluoxetine and paroxetine, are more likely to inhibit cytochrome P-450 enzymes 2D6 and 3A4. They could thus increase blood levels of drugs taken concomitantly that are substrates of 2D6 or 3A4.

Antidepressant side effects can sometimes be used to advantage. For example, mirtazapine's sedating property at lower dosages could help older patients with insomnia.

### CASE REPORT concluded Finding support

Mr. V is started on an SSRI antidepressant. He also receives supportive and milieu therapy and coping skills training. During his hospitalization, Mr. V contracts for safety and allows his sister to remove the handgun from his home.

Upon discharge, Mr. V is referred to a day treatment program that operates 3 to 5 days a week and offers case management, group therapy, and individual psychotherapy. The program helps him meet other older patients and allows him to discuss his life's accomplishments and losses with others his age. His sister is an integral part of the program, and he maintains close contact with her.

Mr. V reports vague and occasional suicidal ideation, with no specific plan or intent. He and his sister note that his medical condition improved soon after his psychiatric condition stabilized.

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Psychiatrists can prevent late-life suicide by identifying risk factors, strategically screening, and providing crisis intervention. Outpatient care may suffice for those with family support. Hospitalization is prudent when patient safety is in doubt.

**BottomLine**

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