Institute on Aging

SUICIDE PREVENTION

Patrick Arbore, Ed.D., Founder & Director Center for Elderly Suicide Prevention & Grief Related Services

Institute on Aging San Francisco, CA

A Silent Epidemic

Suicide risks increase in middle-aged and older men

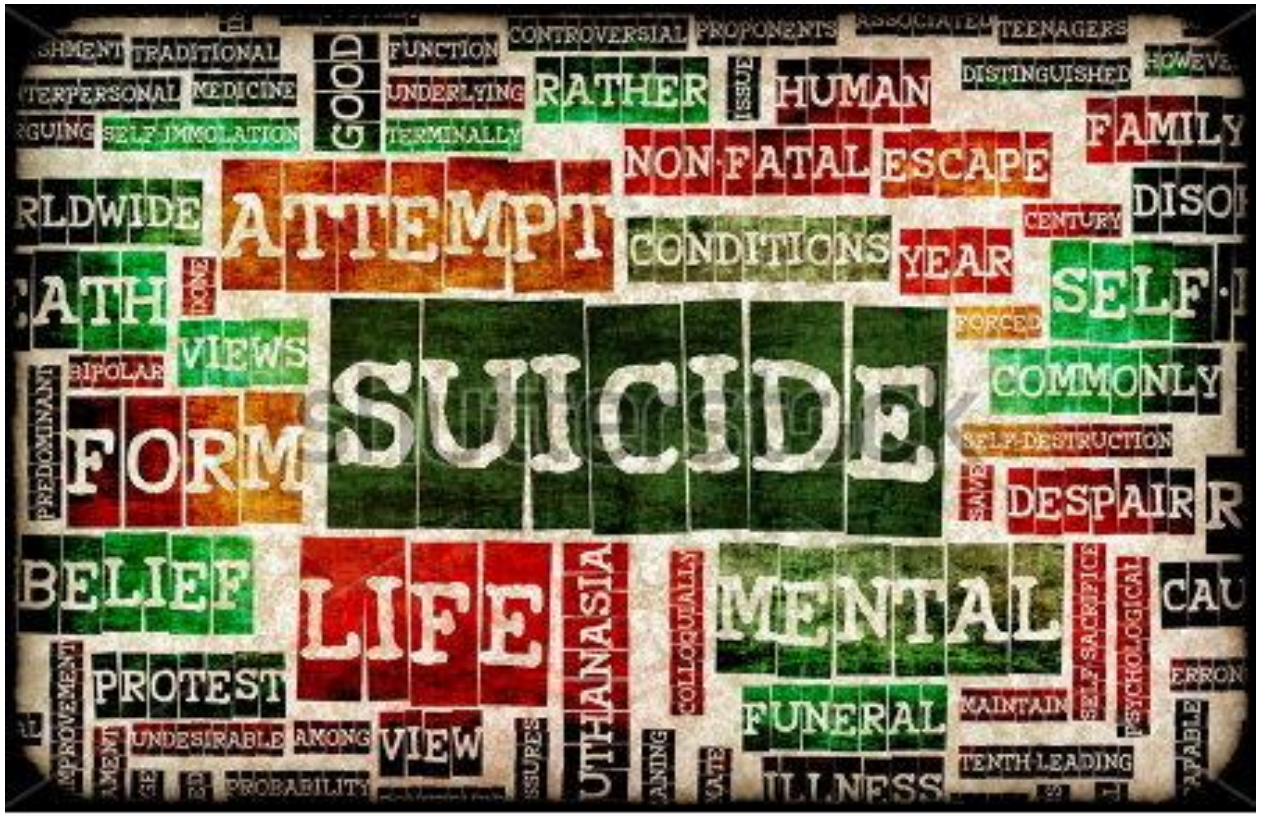
Friendship Line

24-Hour Accredited Crisis Intervention Telephone Hotline/Warmline:

- Call-In Service – Confidential telephone discussions for people 60+ (their caregivers or younger disabled) who may be lonely, isolated, bereaved, depressed, anxious and/or thinking about death or suicide
- A caller does not need to be in a suicidal crisis to use the call-in service
- Patrick Arbore – parbore@ioaging.org or 415.750.4133

Friendship Line

- Call-Out Service – Friendship Line Staff or Trained Volunteers will make phone calls to older adults for emotional support or medication reminders – Referrals can be arranged by calling IOA Connect **415.750.4111**
- Grief Services – **Saturday** Morning Drop-In Traumatic Loss Group – 10:30 a.m. – Noon – 8-week Traumatic Loss Grief Group and 8-week Advanced Traumatic Loss Grief Group – Contact IOA Connect for more Information: 415.750.4111



Difference Between Suicide & Other Forms of Death

- Suicide is voluntary – other deaths are not (for the most part)
- Suicide death is very hard to reconcile
- Facts – The person who dies as a result of suicide leaves all loved ones behind; deprives the survivors of any chance to change his/her mind; severs irreparably all ties with family, friends, co-workers, and/or professional helpers

Suicide Death in the U.S. 2013 Official Final Data – American Association of Suicidology

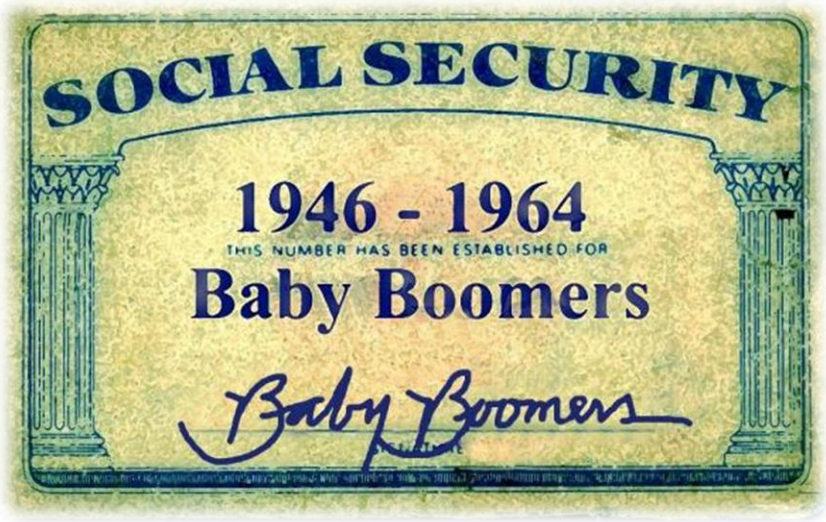
- Suicide rate for the nation – 13.0 per 100,000 population
- Suicide rate for young persons – 11.1 per 100,000 population (15-24)
- Suicide rate for older adults – 16.1 per 100,000 (65+)
- Suicide 10th leading cause of death; homicide is 16th leading cause of death

The Rise in the Suicide Rate

- The rate of suicide had been falling from 1979 to 2000. During the next 11 years, the suicide rate has risen – there was a noticeable increase, post 2007, during the Great Recession
- ---DeFina & Hannon (2015)

Considering the cohort…

- Higher suicide rates compared with earlier or subsequent cohorts
- 2011 First baby boom cohort reached 65
- Rate of suicide in elderly anticipated to rise again



Van Orden and Conwell 2011

Suicide and the Elderly

According to AAS (2013)

- People 85+,45-54; and 55-64 have the highest rates of suicide
- In 2013, the suicide rate for these groups was 85+ 18.6; 45-54 19.7; 55-64 18.1

Suicide Rates in Middle-Aged Adults

According to a study by the CDC May 2, 2013:

- Ages 35-64 – 1999 – 13.7/100,000
- Ages 35-64 – 2010 – 17.6/100,000
- The greatest increases were observed among American Indian/Alaska Natives (65.2% from 11.2 to 18.5/100,000) and Whites (40.4% from 15.9 to 22.3/100,000)

Suicide Rates for Men & Women

- The suicide rates for men aged 35-64 increased 27.3% from 21.5 to 27.3/100,000
- Rates for women increased 31.5% from 6.2 to 8.1/100,000.
- For men – Greatest increases were among those aged 50-54 and 55-59
- For women – Greatest increases were among women aged 60-65 years from 4.4 to 7.0/100,000

Asian American Women

According to the CDC:

- Asian American women 65+ had a higher suicide rate – 6.5 per 100,000 – than any other racial or ethnic group between 2004 and 2007
- According to a 2007 study, researchers found that less than 9% of Asian Americans nationwide seek mental health services – this is much lower than the 18% of the gen'l population who do

Method of Suicide Death

According to CDC May 2, 2013:

- The greatest increase was observed for use of suffocation (81.3% from 2.3 to 4.1/100,000)
- Poisoning (24.4% from 3.0 to 3.8/100,000)
- Firearms (14.4% from 7.2 to 8.3/100,000)

How Do We Know Who May Be Contemplating Suicide?

- Identify the **presence or absence of risk and protective factors**
- Psychological autopsies of older adults who died by suicide suggest the following **risk factors**– psychiatric illness (especially depression); social isolation; functional impairment, physical illness; pain; personality (including low openness to experience; negative life events – and others

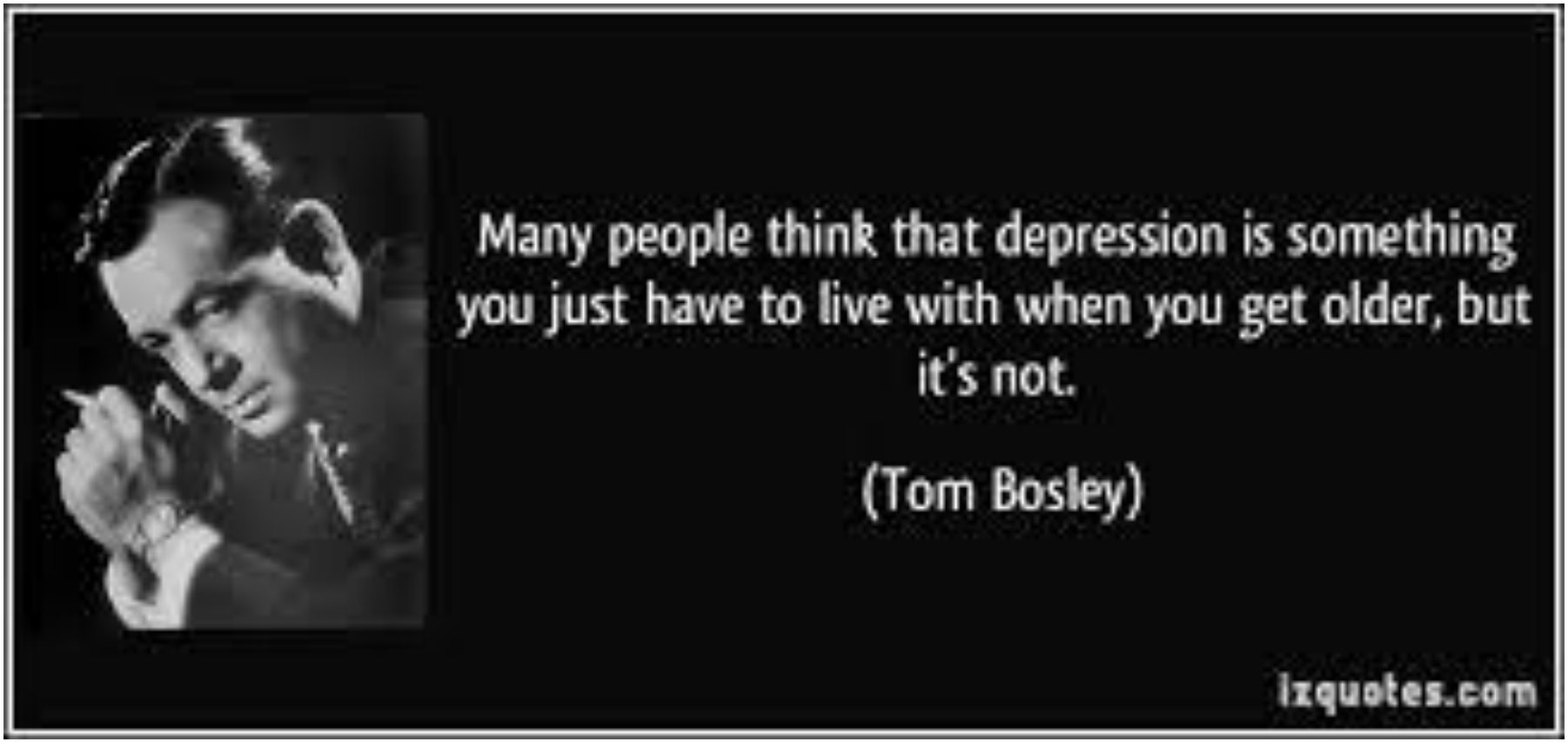
Specific Risk Factors

According to Van Orden and Conwell (2011) risk of becoming suicidal – and dying of suicide – accumulates over time

- Risk is not a static state
- Risk does not progress according to a linear course
- Specific risk factors interact with the broader areas of personality, neurobiology, culture and life events

Denial of Suffering

- One can disengage suffering and pain through the use of: alcohol – shopping – gambling – drugs – food – television – internet
- Suffering and pain are turned into technical matters requiring technical intervention
- The normal medical response to pain is to demand more drugs, doctors & hospitals
- Suffering manifests as depression, loneliness, substance abuse, suicidal ideation, anxiety, worry, hoarding and other mental health issues


Many people think that depression is something you just have to live with when you get older, but it's not.
(Tom Bosley)
izquotes.com

Depression

According to the APA

- Currently, depression is the fourth most common cause of disability worldwide
- It is estimated that by the year 2020, depression will be the 2nd most common cause of disability in the developed world, and the number one cause in the developing world

Quote by Dr. Janet Taylor

Depression is at an epidemic rate in this country. Pain and sadness don’t keep you from functioning. Depression does.

Depression & Isolation

- When emotions go unexpressed, we can become depressed, irritable, and emotionally unavailable
- Some days depression and loneliness can trigger withdrawals – isolating versus reaching out
- Taking time for ourselves (solitude) is very different from isolation

Depression & Isolation

- We may build walls around ourselves w/o knowing it
- We fear being judged by others (why isn't he/she over it?) can keep us from opening up
- Withdrawing heightens the sense of isolation

Depression & Isolation

- Depression & isolation are part of the experience of grief
- In the midst of isolation and depression we may start to wonder “Why me?”
- By reaching out to others, we get the extra support that can help us through a trying time

Cacioppo's Findings Continued

- Both loneliness and depressive symptoms are relatively stable features over a 3-year period
- These data suggest that loneliness and depressive symptoms have strong reciprocal influences in middle-aged and older adults
- It is important to recognize the specific and reciprocal influences of loneliness & depressive symptoms if we are to mitigate their impact on older adults' well-being

What Prevents Conversations about Loneliness, Depression & Grief?

1. Lack of a Vocabulary
2. Ageism
3. Resistance

Loneliness and Depression

- Research has suggested that loneliness can lead to depression which can cause physical and psychological problems including death by suicide

Depression

According to Ebersol & Hess:

- Depression is the most common mental health problem of late life
- Approximately 15% of people >65 are affected by depression
- Remains underdiagnosed and undertreated among older adults

Depression

- Race and culture may affect the meaning of depression
- Race and culture may affect the likelihood of treatment seeking behavior
- There is a need to be sensitive to the ways different racial or cultural groups describe depression – e.g. excessive thinking or being weighed down by a burden

Depression

- To understand depression, we must understand the role of late life stressors, changes, culture, and the beliefs of older people
- Depressive symptoms may be perceived as a normal part of aging – which it is not!
- The stigma associated with depression may be more prevalent among older people
- Older, depressed people report more somatic complaints

Early Trauma and Risk

According to the President of the American Academy of Addiction Psychiatry:

- People who experience early trauma actually undergo changes in the stress systems in the brain
- This disrupted stress response makes them less able to cope with stressors and more vulnerable to addiction

Lifetime Prevalence for Depression

- Depression is the most prevalent mental health disorder for people of all ages in the US
- The lifetime risk for depression is 6 to 25%
- According to the NIMH, 9.5% or 18.8 million American adults suffer from a depressive disorder in any given year
- According to the World Health Organization, less than 25% of individuals with depression receive adequate treatment

Late Life Depression (LLD)

- Major depression affects nearly 2 to 3 million individuals in North America 65+
- When milder levels of depression are included, as many as 6 million older adults in the US might be affected
- Frequently manifests as physical symptoms and is often under-recognized, misdiagnosed, and under-treated

Depression and Men

- Evidence is growing that men are equally vulnerable to depression as are women
- Men's depression, however, remains unidentified, undiagnosed, and untreated
- Men appear to be less willing to seek professional help – more reluctant to seek help even from friends

Depression Symptoms

Table 1: Symptoms of Depression

- Depressed or sad mood
- Loss of interest or pleasure
- Loss of appetite and/or weight, or overeating and/or weight gain
- Fatigue or loss of energy
- Difficulty sleeping or oversleeping
- Difficulty concentrating, making decisions, or remembering
- Irritability, restlessness, or lethargy
- Feelings of worthlessness or guilt
- Frequent thoughts of death, suicidal ideation, or a suicide attempt

Adapted from Reference 5

Depression & Loneliness

- Loneliness is one of our most serious problems in our society
- The lack of relationships creates loneliness
- Occurs when a person has fewer interpersonal relationships than desired
- Research has shown that loneliness leads to depression

Loneliness & Complications

- Loneliness makes a person vulnerable to many different situations – can include more depression, alcohol use, and higher blood pressure
- Loneliness is associated with higher risks for heart disease, lessened longevity, and increased risk for recurrent illness

Prevention of Loneliness

- Emotional support, love and intimacy, are essential to prevent loneliness
- Satisfying two relationship needs will help people overcome feelings of loneliness: (1) The need for emotional attachments; and (2) the need for social ties

DEPRESSION & SUBSTANCE ABUSE

- Depression may be the cause of substance abuse
- Depression may be the result of substance abuse
- Depression may alter or exaggerate substance abuse
- Depression and substance abuse may be two symptoms of a single problem

Alcohol and Suicide

- According to Conwell et al (1996) – At least one third of persons who commit suicide have an alcohol-use disorder
- Individuals with alcohol dependence are at approx. 10x's greater risk for completed suicide compared with the general population
- Individuals with alcohol dependence are 6.5x's greater risk for attempted suicide compared with individuals without alcohol dependence
- Suicide prevention efforts must include a focus on alcoholism

Substance Use and Depression

- Adults with depression are at high risk for escalation of substance problems
- Appropriate intervention has the potential to improve depression outcomes and prevent onset of dependence
- Identification of problematic alcohol and drug use among depressed adults is essential

Substance Use and Depression

According to Satre, D., et al (2011):

- Even moderate drinking may reduce antidepressant response and increase risk of side effects
- Adults with depression use cannabis at rates 2-8 times higher than the general population
- Cannabis users may benefit less from depression treatment than nonusers

Special Issues

- Complexity, severity and urgency of the alcohol problem
- Special populations – Disabled, women, ethnic/cultural minorities, LGBT community, rural populations, homeless
- Housing
- Transportation
- Restoration of family ties

Depression and Suicide

- Depression is the most common diagnosis in older adults who have attempted suicide
- Depression frequently accompanies a chronic illness, particularly when the disease impairs function
- Physical health status is the most consistently reported risk factor for the onset and persistence of depression in late life

Stressful Life Events

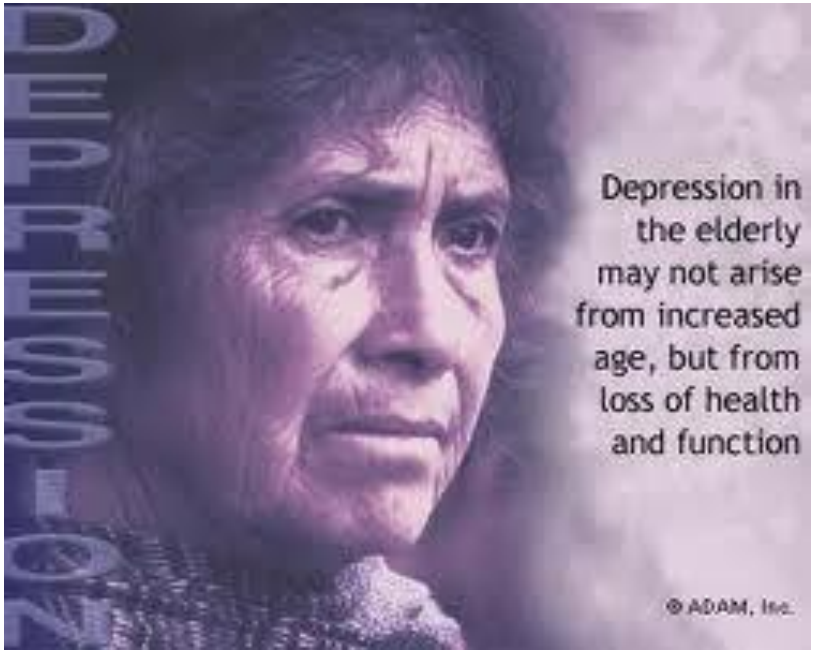
- A variety of stressful live events might serve as situational triggers for suicidal ideation or attempts
- These may include: prolonged illness, financial stress, and relationship problems
- Poor social support and the loss of a loved one may precipitate suicidal ideation

Denial of Aging

According to Gillick (2006): “When we believe we will stay young forever, and when we purchase special vitamins, herbs, and other youth-enhancing chemicals to promote longevity, we are engaging in massive denial.”

Suicide and Older Men

- Risk factors for suicide in elderly men include: depression, early dementia, alcoholism, severe and chronic medical conditions, recent loss, and availability of a firearm



Middle Age and Older Gay and Bi-Sexual Men

From the LGBT Suicide Prevention Conference 3.22.14:

- Because we know very little about mortality in the LGBT populations, it is impossible to have accurate rates for suicide death
- However, in virtually every study, there is an increase in suicide attempts among the gay and lesbian population with gay and bi-sexual males attempting at least 4x's more often than lesbians
- Gay and Bi-sexual males have higher rates of mental health problems than women

Conroy Quote

- “I could feel the tears within me, undiscovered and untouched in their inland sea. Those tears had been with me always. I thought that, at birth, American men are allowed just as many tears as American women. But because we are forbidden to shed them, we die long before women do, with our hearts exploding or our blood pressure rising or our livers eaten away by alcohol because that lake of grief inside us has no outlet. We, men, die because our faces were not watered enough.”

Possible Explanations for Suicide and Men

- Economic stress
- Multiple chronic diseases increased from 13% in 1996 to 22% in 2005
- Complex interaction of social change and aging
- Men's general reluctance to seek help for suicide related concerns and the stigma associated with mental health problems in general

Possible Explanations Continued

According to Bilsker and White (2011):

- More hopeless
- More clearly resolved to die
- More likely to be intoxicated
- More willing to carry out actions that might leave them injured
- More unconcerned with consequences
- More likely to have greater capacity to enact lethal self-injury

Reasons for Suicidal Behavior

According to Joiner (2009):

The **acquired capability** to enact lethal self-injury is necessary to a full understanding of suicidal behavior.

- Perceived Burdensomeness
- Failed Belongingness

Joiner's Interpersonal Theory of Suicide "Only those with both the capability and the desire are at risk for suicide"

Acquired Capability – Thomas Joiner

1. A multiple attempter
2. A nonmultiple attempter with 3 out of the following 5 symptoms:

- Single suicide attempt
- Aborted suicide attempts
- Self-injecting drug use
- Self-harm
- Frequent exposure to physical violence

Suicide Risk Assessment

- Direct inquiry regarding **suicide intent**
- Final decision must be **subjective and intuitive**

Cultural/Ethnic Diversity Rates of Suicide for People of all Ages US 2013

- Native Americans 11.7
- Rates for all Hispanic 5.3
- Rates for all Asian 6.0
- Rates for all African-American males 9.0
- Rates for all African-American females 2.0

Protective Factors

- **Protective factors** – Include: the ability to adapt and adjust to changing circumstances; maintaining involvement in family and community activities; decrease loneliness; communicating one's concerns about health, financial, and existential thoughts or fears; increasing one's knowledge about depression, substance abuse, grief and loss, nutrition and exercise

Depression & Intervention

- If you suspect the presence of depression, let someone know about your concerns – your supervisor, for example
- Depression is often reversible with prompt and appropriate treatment
- Treatment can include: Medication, Psychotherapy, and Psychosocial interventions – Or a combination of all three

Intervention Stategies

- Continuous monitoring of the person's lethality rating
- Active outreach--befriending and caring
- Knowledge and use of community resources such as the Friendship Line
- Consultation as needed for the helper
- Offer transfusions of hope
- Involve significant others

Interventions continued

- Modification of confidentiality
- Suicidal persons demand a great deal of psychic investment on the part of the helper
- Helper needs to demonstrate self-care

What Helps the Distressed Individual

- Being empathic
- Listen attentively
- Reflect feelings
- Create rapport
- Offer appropriate resources/referral

Social connectedness

- “One of the National Strategy’s primary aims is to promote opportunities and settings to enhance connectedness among persons, families, and communities.
- Connectedness is a common thread that weaves together many of the influences of suicidal behavior and has direct relevance for prevention.
- Accordingly, CDC has adopted as its theme “Promoting individual, family, and community connectedness to prevent suicidal behavior” to define this area of prevention.
- We define connectedness as the degree to which a person or group is socially close, interrelated, or shares resources with other persons or groups.

Excerpt from: Strategic Direction for the Prevention of Suicidal Behavior: Promoting Individual, Family, and Community Connectedness to Prevent Suicidal Behavior

http://www.cdc.gov/violenceprevention/suicide/prevention.html

What We Can Do

- Connect with people -- Telephone contact
- Connections are paramount to caring for people who are lonely – assist them with keeping contact with people who are important to them
- Be as present as possible with people who are lonely
- Empathize with people’s losses and suffering

How Do We Recognize Loneliness?

- Does the person initiate contact?
- Is the person anxious, withdrawn, apathetic, or hostile? Does the person provoke to get attention?
- Does the person cling to others or attempt to detain them?
- Is the person eager for visitors and distressed when they leave?
- Does the person exhibit contempt for his or her condition for self?

Loneliness Interventions

- Ask about loneliness
- Spend time with the person in silence or in conversation
- Assist the person in keeping contact with people important to them
- Explore the nature of loneliness with the person
- Develop community support for the person

Implications

- Depressed adults who took their own lives escaped adequate diagnosis and treatment
- Suicide risk is associated with physical illness and functional limitations
- Reductions in adult suicide hinge on the understanding of the interplay of depression, physical illness, and functional impairment.

The Assisted Suicide Debate

Important Questions

- Is a terminally ill patient's wish to die different from that of other suicidal individuals?
- What are the common characteristics of terminally ill older patients?
- What implications do these questions have for treatment by methods other than assisted suicide to relieve the person's suffering?
- Who are those individuals most involved in assisting older adults to commit suicide?

States Have Legalized PAS

- Three states (OR, VT, and WA) legalized physician-assisted suicide via legislation
- One state (MT) has legalized physician-assisted suicide via court ruling

Federal Laws on Euthanasia and Assisted Suicide

The federal government and all 50 states and DC prohibit euthanasia under general homicide laws.

The federal government does not have assisted suicide laws.

Those laws are generally handled at the state level

Important Questions

- What are the implications for professional caregivers when engaging with someone who is seeking a premature death?
- Do we treat the older client/consumer differently than we would a younger adult with similar issues?
- What do you experience when an older person states a choice to refuse food or water or proposed medical treatment?

Thoughts Continued

- When it comes to “self-determination”, we need to carefully consider our countertransference – Would I want to end my life if I was my client?
- Dr. Shneidman has stated that people at risk for suicide are especially sensitive to the unspoken feelings of the helper – unresolved conflicts in the helper need to be acknowledged and worked through prior to meeting with someone who is considering premature death.

“In a real sense, through our own self-talk, we are either in the construction business or the wrecking business.” – Dorothy Corkville


Questions

References

- Jacoby, S. (2011). Never Say Die: The Myth and Marketing of the New Old Age.
- Moody, H.R. (2010). Aging: Concepts and Controversies, 6th ed.
- Touhy, T., & Jett, K. (2010). Ebersole and Hess' Gerontological Nursing and Healthy Aging, 3rd ed.
- Gillick, M.R. (2006). The Denial of Aging: Perpetual Youth, Eternal Life, and Other Dangerous Fantasies.
- Yalom, I.D. (2008). Staring at the Sun: Overcoming the Terror of Death.

References

- Perissinotto, C., Cenzer, I, and Covinsky, K. (2012). Loneliness in older persons. Arch Intern Med, E1-E6.
- Wilson, A., and Marshall, A. (2010). The support needs and experiences of suicidally bereaved family and friends. Death Studies 34, 625-640.
- McCleane, G. (2010). Pain management in older people. Reviews in Clinical Gerontology. 20, 183-192.
- Crunkilton, D., and Rubins, V. (2009). Psychological distress in end-of-life care: A review of issues in assessment and treatment. Journal of Social Work in End-of-Life & Palliative Care. 5, 75-93.

References

- Robertson, L. (2011). Self-mapping in treating suicide ideation: A case study. Death Studies, 35(3), 267-280.
- Wong, P., and Tomer, A. (2011). Beyond terror and denial: The positive psychology of death acceptance. Death Studies, 35, 95-106.
- Vanlaere, L, Bouckaert, F., and Gastmans, C. (2007). Care for suicidal older people: Current clinical-ethical considerations. Jnl of Med Ethics, 33, 376-381.
- A cross-national study of the relationship between elderly suicide rates and urbaninzation. Suicide and Life-Threatening Behavior, 38(6) 714-719.

Reference

- Wallhagen, M. (2009). The stigma of hearing loss. The Gerontologist, 50(1), 66-75.
- Rogers, R., (2011). Conceptualizing death in a worldview consistent, meaningful way and its effects on worldview defense. Death Studies, 35, 107-123.
- Arbore, P. (2012). The next big thing: Substance abuse among aging baby boomers. Aging Today: The bimonthly newspaper of the American Society on Aging, 3, 1-3.
- Maust, D, Mavandadi, S., Eakin, A, et al. (2011). Telephone-based behavioral health assessment for older adults starting a new psychiatric medication. Amer Jnl of Geriatric Psychiatry, 19(10), 851-858.

References

Bilsker, D., & White, J. (2011). The silent epidemic of male suicide. BC Medical Journal 50(10).

De Hennezel, M. (2010). The art of growing old: Aging with grace.

Joiner, T.E, Van Orden, K.A., Witte, T.K., and Rudd, M.D. (2009). The interpersonal theory of suicide: Guidance for working with suicidal clients.

Osho (2012). Learning to silence the mind: Wellness through meditation.

Tatelbaum, J. (2012). You don't have to suffer: A handbook for moving beyond life's crises.

References

Real, T. (1997). I don't want to talk about it: Overcoming the secret legacy of male depression.

Shneidman, E. S. (1996). The suicidal mind.

DeFina, R., and Hannon, L. (2015). The changing relationship between unemployment and suicide. Suicide and Life-Threatening Behavior, 45(2), 217-229).