Suicide in Later Life

Failed Treatment or Rational Choice?

Whitney L. Carlson, MD[a,*], Thuan D. Ong, MD, MPH[b]

KEYWORDS

• Geriatric • Suicide • Depression • Physician-assisted dying • Primary care

KEY POINTS

- Suicide rates in older adults remain high and may continue to increase with the aging of the baby boomer cohort unless more effective suicide prevention interventions are developed.
- Real-world implementation of successful models of depression treatment and suicide prevention offers opportunities to reduce the number of suicides in older adults.
- Hastened death, by suicide or legally sanctioned assistance in dying, can arouse complex emotions in survivors and clinicians that may have lasting impact.
- Investigating feelings of hopelessness, perceived burdensomeness, and thwarted belongingness may help identify older adults who may be thinking about hastening their deaths but do not voice suicidal ideation. All can be symptoms of a depressive illness or a result of deeply held, enduring personal beliefs and values in patients facing insurmountable illness.
- Physicians should explore older adult patients' concerns about dying. Motivations behind a patient's request for physician-assisted dying (PAD) should be explored regardless of a physician's personal attitudes and views.

INTRODUCTION

Suicide is the deliberate act of causing death by self-directed injurious behavior with intent to die as a result.[1] Suicide may be planned or impulsive but by definition involves only personal acts by individuals who intend to end their life, whereas assisted dying (also known as assisted suicide) involves others and usually includes planning to hasten death. PAD specifically refers to receiving the help of a physician who has the means to end life and is subject to strict regulatory protections. All 3 forms of hastening one's own death are used by older adults.

Funding: T.D. Ong, MD, MPH, is supported by Health Resources and Services Administration, Geriatric Academic Career Development Award, Grant: K01HP20463.
Conflict of Interest: None.
[a] Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine, 325 Ninth Avenue, Seattle, WA 98104-2499, USA; [b] Department of Medicine, Division of Gerontology and Geriatric Medicine, University of Washington School of Medicine, 325 Ninth Avenue, Seattle, WA 98104-2499, USA
* Corresponding author.
E-mail address: cwhitney@u.washington.edu

Clin Geriatr Med 30 (2014) 553–576
http://dx.doi.org/10.1016/j.cger.2014.04.009 geriatric.theclinics.com
0749-0690/14/$ – see front matter

Older adults generally have higher suicide rates than younger people (Fig. 1) and are the group who most often request PAD in the states where it has been legalized for the terminally ill. Age by itself is not as important as contextual factors that may motivate older adults to seek a hastened death. In the following sections, what is known about situational factors and motivations of these older adults and the emotional and psychological effects their decisions can have on survivors are discussed. The clinical implications of suicide and legalized PAD and the impact both have on clinicians also are discussed.

SUICIDE

Suicide can be one of the most emotionally devastating events a family can experience, and it is a deeply troubling event for treating clinicians. Most clinicians who care for older adults face a patient with suicidal ideation at some point in their careers and some encounter a patient who has had a suicide attempt or died by suicide or meet the survivors left behind by suicide. Being aware of the need to face such situations and the complex issues and emotions that surround suicide is important for clinicians who care for older adults and their families.

The following case of Mr. X illustrates one author's personal experience with a patient suicide

Mr X is a 72-year-old retired, married man with hypertension, diabetes, and hyperlipidemia who presents to his long-time primary care provider (PCP) with neuropathic pain and sleep disturbance. He lives with his wife of 47 years and has a son who lives nearby. Mr X drinks an average of 2 drinks per night and has for many years, but has been drinking more lately due to poor sleep and tension in his marriage but does not reveal this to his PCP. He does not report other symptoms of depression and because his presenting concerns seemed related to pain, no depression screen was done at that time. He is prescribed amitriptyline (25 mg) at bedtime for neuropathic pain with the thought that this would also be sedating enough to help him sleep. Three days later, Mr X comes home to find that his wife has unexpectedly, and without explanation, moved out of their home. He learns from his son that he had helped her move out. That night he took a handful of pills, including some amitriptyline, along with his nightly cocktails and that evening is found by his son, who happened to come by to get things for his mother. He was admitted to a monitored bed for 24 hours and showed no signs of arrhythmia. He was seen by a consulting psychiatrist and agreed, with the encouragement of his son, to a voluntary psychiatric admission to address his sleep, poor appetite, and depressed mood. He had no prior history of depression and no history of suicide attempts. He was started on mirtazapine (15 mg) at bedtime and tolerated the medication. He met criteria for major depression because he also acknowledged symptoms of depressed mood, low energy, and weight loss that had been present before the acute stressor. Mirtazapine was titrated to 30 mg every night to target depression. He participated in groups and individual sessions. He met with the inpatient psychiatry team and his son for a family discharge planning meeting and was agreeable to follow-up with his long-time physician in 1 week. Accessing outpatient mental health counseling and psychiatric care was limited by having only Medicare for insurance, a lack of providers accepting this insurance in his geographic area, transportation difficulties, and finances. His son expressed concerns about how his father would do after discharge but agreed to have his father come stay at his home for support after discharge. He was found dead by his son within 48 hours of his discharge. Mr X overdosed on multiple medications while his son was home and asleep.

Older adults have had a higher rate of suicide for decades compared with other demographic groups, particularly in industrialized countries. A recent increased rate of suicide in the 35- to 64-year-old demographic in the United States for the most recent decade suggests that the next cohort of older adults may have an even higher rate of