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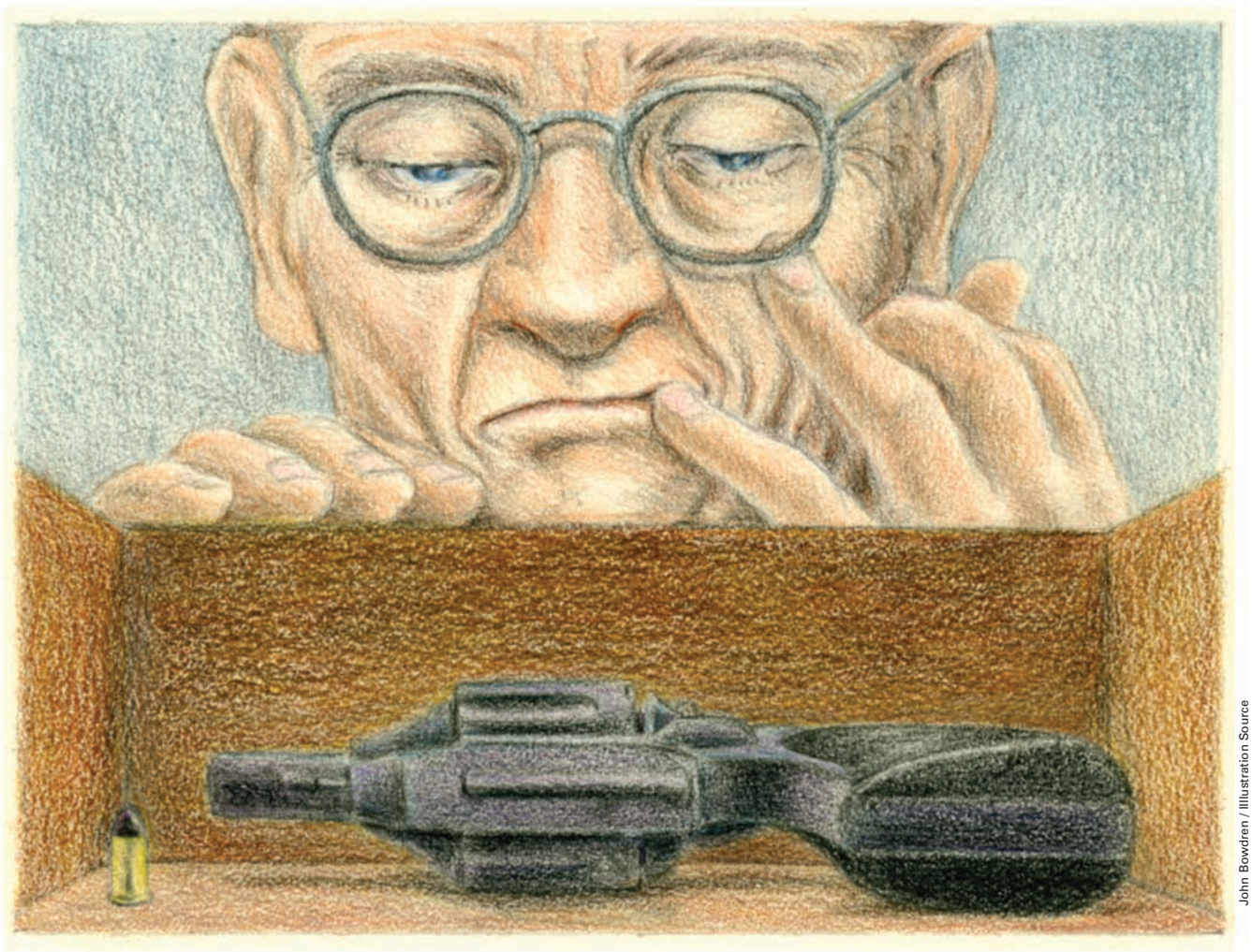

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OLDER ADULT SUICIDES

What You Should Know and What You Can Do

Andrea L. Jones, PhD, LSW, and Diane K. Pastor, PhD, MBA, RN, NP-C

Suicide among most age groups has been on the rise in the United States for the past 20 years. Suicide is currently the 10th leading cause of death in the United States, but suicide completion and suicide attempts may be underreported. Suicide is a very personal act often predicated on a sense of hopelessness and despair, but often prompted by very addressable factors such as pain and social isolation. This article will use a case narrative to illustrate life circumstances that may influence suicidal thinking. In addition, risk factors are addressed. Lastly, the article addresses some useful assessment tools to gauge suicide risk among older adult clients and provides resources for home care clinicians.

Suicide is the 10th leading cause of death in the United States (American Foundation for Suicide Prevention, 2019). The Centers for Disease Control and Prevention (2018) reported that in 2017, 47,173 Americans died by suicide, and approximately 1.4 million Americans may have attempted suicide. Why would someone take their own life? Often, survivors—those left behind to carry on—are puzzled. Statements such as "He had everything" or "She worked so hard all of her life just so she could retire. Why now?" are often heard. One can never walk in another's shoes. Anyone who has lost a loved one to suicide knows this all too well. But caregivers can, and should be, aware of signs that someone is contemplating suicide, learn to ask them directly, and know about resources to better manage care.

Current Data on Suicide

Suicides have increased in the United States among all age ranges over the past 20 years (American Psychological Association, 2019), due to a variety of likely factors including: financial pressures, cultural changes related to decreased involvement in civic and religious activities, and changes to typical family structures (i.e., many families no longer live in close proximity to each other, and fewer marriages and more divorces than in previous generations). Demographic data point to a suicide problem for older adults. Although older adults account for 12% of the population, they account for 18% of suicide deaths (American Association for Marriage and Family Therapy, 2019). Moreover, the American Foundation for Suicide Prevention (2019) reported that suicides among those 85 years and older represented the second largest number of suicides by age range, topped only by those in the 45- to 64-year age range. Persons ages 65 to 84 were the third largest group. People are also more aware of suicide in the United States today. Publicity generated by suicides of famous people may have created a social contagion effect and reduced the stigma of suicide (Department of Health and Human Services, 2019). Social media may also provide increased awareness due to the broader personal sharing of information with others.

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Life Circumstances and Types of Suicidal Ideation

Researchers and practitioners have identified a number of different types of suicidal ideation that inform our understanding of this critical topic.

Suicide Related to Sense of Loss/Burden

Many professional healthcare providers have worked with older adults who have become reclusive by choice. Sometimes people are socially isolated because they no longer drive and infrequently leave the house. For many older adults, lack of opportunities to socialize makes their worlds seem smaller and smaller. This is true for people who have become dependent upon loved ones and friends for socialization and assistance (Van Orden & Conwell, 2011). Social isolation and loneliness are believed to be experienced by one-third to one-half of older adults and can negatively affect physical and mental health status (Landeiro et al., 2017).

Feeling like a burden to a loved one can be oppressive. Growing dependence can also cause family frustration and exhaustion, creating situations where caregivers can be short-tempered. In worst-case situations, overburdened caregivers can become verbally or physically abusive or neglectful, leaving patients to feel embarrassed and ashamed to ask for help. These emotional circumstances—feeling isolated and dependent—are areas to explore with patients. However, even when family circumstances

are optimal, older adults who feel dependent may succumb to a sense of helplessness, hopelessness, and depression. People in these circumstances often respond positively to supportive psychotherapy in individual and group formats.

Suicide Related to Loss of a Loved One(s)

Another important category of suicide behavior is the emotional tumult that can occur with the loss of a loved one. For older adults, accepting and adjusting to loss is all too common. Parents, aunts, and uncles are long gone. Siblings die, friends in their age group die, spouses die. The losses accumulate and have powerful consequences. The loss of siblings can leave people feeling less moored to the memories of their youth. Friends passing may remind people of their own nearing mortality, and of decline and decrepitude.

Loss of a spouse can create the biggest strain. Other than losing a child, from which some people may never recover, the death of a spouse with whom you have lived, raised a family, and known for decades, may seem emotionally insurmountable. Moreover, the loss of identity and social status can be devastating. Add to this major loss, having to learn and undertake new tasks, such as cooking and cleaning, or paying the bills—tasks for which they are often not prepared. Major loss such as the death of a spouse, or the cumulative loss of several siblings and friends, should not be ignored. In our culture, we generally believe people should grieve briefly and then "get on with it." But, grief rarely progresses in a clean, clear-cut fashion.

The Case of Anna

A case narrative can illustrate a situation of suicidal ideation related to loss of a significant other. Anna was an 82-year-old woman caring for her spouse with colon cancer. The home care team received the referral to assess their needs for support. At the first visit, the home care nurse found that Stephen, Anna's husband, was suffering with end-stage illness and was uncomfortably living on the living room sofa. He was relatively immobile and in severe pain, and Anna was both frustrated and frightened that she could not adequately help him. Stephen was admitted to hospice care and the team was mobilized to provide medical equipment, pain medication, family teaching, home healthcare aide services, and emotional support. An interprofessional care plan was developed in concert with the couple's wish to have Stephen remain at home. The nurse visited and learned more about their history together, including the loss of a stillborn child years ago and Anna's struggles with alcoholism. Having no children, they were very close and relied heavily on each other's company. The social worker began meeting with them to provide support in anticipation of Stephen's death. Stephen passed away within 1 month, and when the nurse made the first bereavement visit to the home, she found Anna intoxicated, lying on the foyer floor and sobbing. She told the nurse she could literally "feel my heart breaking in my chest" and that she could not go on alone. She was completely isolated—without family or friends for support—and said she wanted to die. The nurse remained in the home until the social worker could visit and they made a plan to have a hospice volunteer remain overnight with Anna. In the morning, the bereavement team revisited the home, and Anna was open to going to a geriatric/psychiatric emergency center for further assessment by an interprofessional healthcare team.

Case Summary

This case narrative illustrates the impact of the loss of a significant loved one. We also note some circumstances, such as a history of substance abuse, and the presence of the following risk factors for suicide (Van Orden & Conwell, 2011):

- Intolerable pain, illness, or dire diagnoses. (In this case, her husband's illness.)
- Unwanted social isolation and/or growing dependence on others. (Anna expressed that she relied a great deal on her husband for companionship.)
- Significant loss(es) such as death of spouse, siblings, and friends.

Other very important warning signs include:

- A history of depression with or without previous suicide attempts
- Expressions of hopelessness or feeling trapped
- Uncharacteristic anger, cynicism, bitterness, impulsivity
- Access to lethal means, especially fire arms or a large cache of medications

Anna's case illustrates several of these risk factors: overwhelming caregiving of a long-time spouse, the loss of a child, a history of alcohol abuse, the lack of family or other supports, and the eventual death of her spouse. Although it

is expected that a surviving spouse would be devastated by such a loss, in the absence of a support network, Anna's situation may have been overlooked. Anna was fortunate to have had the involvement of competent hospice care. Despite treatment for grief and alcohol use, Anna most likely would have remained at high risk for suicide post discharge without appropriate follow-up.

Rational Suicide

There is an oft-told story of George Eastman, the founder of Eastman Kodak, an international camera and film company. At age 77, he met with friends to discuss his estate. Following this meeting, Eastman famously wrote a note saying "My work is done. Why wait?" Mr. Eastman then fatally shot himself. After the fact, people who knew him came to understand the underlying reasons included very serious and painful health issues.

Healthcare professionals have come to accept that one type of suicide is called "rational suicide." Facing severe pain, limited mobility, or a dire diagnosis, such as dementia or advanced cancer, many people choose to take their own lives. Often, people trying to cope with such significant issues will say that the pain may be treatable, but it is the loss of autonomy, or loss of control over their own lives that is the heaviest burden (Cook, 2015). Of course, each situation is individual. People in this position should undergo a thorough assessment by a team of healthcare providers, including a palliative care provider, who will help to manage pain with fewer side effects of medications, and a psychiatrist, psychologist, or clinical social worker to explore the issues of depression and anxiety. If appropriate, spiritual counseling may also be helpful. To the extent that pain and depression, if evident, can be managed, people may respond positively.

Several states now support legislation that allows physicians to evaluate patients with a terminal illness who may wish to end their lives. A national nonprofit organization, Compassion and Choices (compassionandchoices.org), works with policy officials at all levels of government to identify the most appropriate legislation in each state including education in palliative and hospice care for healthcare professionals. Oregon was the first state in 1997 to ratify "right to die" or "assisted suicide" legislation called the Death with Dignity Act. Medical aid in dying legislation is now available in Washington, Montana, Vermont, California, Colorado, Washington, DC, Hawaii, and New Jersey. The most important tenet in any state legislation is to first address unmet needs and untreated but treatable pain and emotional distress.

A New Type of Suicide: Suicides of Despair

In our contemporary society, several public health issues have surfaced, such as methamphetamine and opioid addiction, and increases in reports of depression and anxiety that may be linked to changes in family structure and the economy. Public health researchers are currently looking at the explosion of "diseases of despair,"—those illness that may be driven by poor economic circumstances (Shanahan et al., 2019). These diseases, including substance abuse and mental health issues, obesity and associated diabetes, and liver disease associated with alcohol use are affecting the life expectancy of Americans (Case & Deaton, 2017).

Even in the absence of any of the risk factors noted previously in this article, many older adults feel socially isolated, may be coping with financial circumstances that limit their ability to afford their medications and good nutrition, and as a result, may compromise their own health. Sometimes, older adults succumb to suicidal despair and choose to neglect their health. This type of self-neglect is sometimes referred to as passive or slow suicide (DeSpelder & Strickland, 2015). Passive suicide is a desire to die, without a specific plan to carry out death (Lai et al., 2018). Diseases of despair and related suicides, as well passive suicide, may be a response to unmet financial and social needs that influence depression, anxiety, hopelessness, and despair.

The Need for Awareness and Assessment

Statistically, it is known that older adults most often successfully complete suicide (Older Americans Behavioral Health Technical Assistance Center, 2012). This is because older adults may choose more lethal methods, such as firearms. Despite the method, older adults are generally more medically compromised, so any attempt, including overdosing on medication, may be more lethal than for younger adults. Additionally, more older adults live alone, and may not be discovered immediately, make completed suicides more common in this age group.

It is important to remember that many people who attempt or successfully complete suicide talk about suicide before the attempt. This talk must be taken seriously, and not responded to by statements such as "Oh, don't talk about that." It is a myth that people who are contemplating suicide

do not talk about it in advance. If you have a sense that someone may be contemplating suicide, and several of the risk factors already mentioned are evident, ask the person directly and clearly, "Are you thinking about taking your life?" or "Are you thinking about hurting yourself?" The National Institute of Mental Health (2017) has developed a five-question tool with questions about suicidal ideation in a specific way to help us understand the idea of burden for our patients (Table 1).

There are several other well-known, validated assessments of suicidality. The Columbia-Suicide Severity Rating Scale (Posner et al., 2011) asks two questions to assess suicidal ideation and behaviors in the past month. In the absence of an affirmative answer regarding suicidal ideation in the past month, the assessment also asks about history of suicide. The questions are direct, and affirmative answers should be addressed immediately. The Patient Health Questionnaires (PHQ) (Kroenke et al., 2003) are two- and nine-question screenings more specifically for depression; the PHQ-2 asking about sense of depression, hopelessness, and anhedonia, which may presage suicidal ideation, but it does not definitively ask about suicidal ideal. Clinicians should follow with a question to specifically address suicidal ideation if necessary. The PHQ-9 (Kroenke et al., 2001) asks eight questions to gauge level of depression building off the PHQ-2. The final question asks specifically about suicidal ideation. All three assessments have been widely validated. All three assessments are available in the public domain.

Table 1. Suicide Risk Screening Tool Ask Suicide Screening Questions (ASQ)

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself? (If yes, how and when?)
5. Are you having thoughts of killing yourself right now?

Source: National Institute of Mental Health. (2017). *Suicide risk screening tool.* Retrieved from https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening-tool_155867.pdf

Table 2. IS PATH WARM?

I	= Ideation: threatened for communicated thoughts of suicide
S	= Substance abuse: new, increased, or excessive
P	= Purposelessness: perception that there is no reason to live
A	= Anxiety: agitation, insomnia
T	= Trapped: feeling there is no way out
H	= Hopelessness
W	= Withdrawing: from friends, family, activities
A	= Anger: expressions of inappropriate anger, rage, vengeance
R	= Recklessness: taking inappropriate risks (skipping medications, eating inappropriately)
M	= Mood changes: unusual for that person

Source: Berman (2006).

In many instances, home care clinicians work with care collaborators, such as home healthcare aides and certified nursing assistants, as well as with family members, informal caregivers, and other lay people who may not know of or feel qualified to use formal assessments. The American Association of Suicidology (Berman, 2006) established an easy-to-use mnemonic device called "IS PATH WARM" (Table 2). Less prescriptive or directive than a formal validated assessment of suicidality, mnemonic devices are successful in assisting nonclinicians in codifying and remembering complex constructs such as the behaviors and ideation that may underlie suicidality (Juhnke et al., 2007).

Perhaps the simplest way to understand how to approach someone who you think may have suicidal thoughts is by using a tool called "**Q**uestion, **P**ersuade, and **R**efer" (QPR) designed by the QPR Institute (qprinstitute.com). The QPR Institute offers an online training module that can be used by lay people or professionals to assess for suicidal ideation and persuade the individual to seek further assistance.

Also assess for and acknowledge protective factors (Suicide Prevention Resource Center, n.d.) including:

- Patients may be resilient. Dealing with loss—your own physical issues and the loss of loved ones—does not necessarily mean you will become suicidal. Many people have very strong spiritual beliefs or enduring family support that sustain them through hard times.
- Patients may be socially well connected. Those who live in communities, especially long-term care communities, may have access to support from people who are experiencing similar issues.
- Patients may have an underlying sense of purpose. Perhaps it is a hobby or lifelong passion.

It may be enjoying the feeling of sun on their faces, or the laughter of a grandchild. Everyone makes meaning of their days in different ways. It is important to listen for these cues, too.

- Many older adults have remained connected to a faith-based practice or community. This may be sustaining. Spiritual beliefs may provide guidance. Faith-based communities are often excellent at reaching out to their ailing congregants. It is important to investigate this with clients who could benefit from this sort of assistance. Many times, older adults may feel too proud or feel too much shame to let their fellow congregants know they are in distress and could benefit from a friendly phone call or a visit. You may want to help them with this type of outreach.
- The ability to be flexible with regard to talking about circumstances and reaching out to others. It may be difficult to admit to depression—our culture still stigmatizes most mental health issues. If someone is depressed and is open to seeking a solution, that is a sign of flexibility.

Conclusion

A recent health column report on Centers for Disease Control and Prevention data highlights the suicide crisis (Stone et al., 2018):

> *Across the country, suicide rates have been on the rise, and that rise has struck the nation's seniors particularly hard. Of the more than 47,000 suicides that took place in 2017, those 65 and up accounted for more than 8,500 of them, according to the Centers for Disease Control and Prevention. Men who are 65 and older face the highest risk of suicide, while adults 85 and older, regardless of gender, are the second most likely age group to die from suicide.*

Many home care patients experience risk factors for suicide, including poor social support, medical comorbidity, disability, pain, and feeling that they are burdens for caregivers. Always keep in mind that, as home care providers, you may be the only person your patient feels they can reach out to. Look for the signs, and do not be afraid to ask questions, even that most sensitive question, "Are you thinking about ending it all?"

Lohman et al. (2016) integrated depression care management delivered by home care nurses into routine home care nursing visits for Medicare patients who screened positive for depression. In their sample, suicidal ideation was identified at baseline in nearly 10% of home care patients. Identifying and managing depression was significantly associated with long-term reduction of suicidal ideation among high-risk patients.

If you do suspect that a patient is experiencing suicidal ideation, ask permission to call a family member, clergy, personal physician, or county aging services for more help and information. Familiarize yourself with resources provided by your local department of social services aging division. To locate an Area Agency on Aging in your area, go to: n4a.org. Often, there are programs and services available to people who are not aware of them. See Table 3 for additional resources. Connecting an isolated older adult with a county-friendly phone call program may be the beginning of a glimmer of hope to an older adult.

You may save a life. ☗

Table 3. Suicide Resources

24/7 National Suicide Prevention Lifeline	1.800.273.TALK (8255)
24/7 National Suicide Prevention Lifeline in Spanish	1.888.628.9454
24/7 Crisis Text Line	Text "HOME" to 741-741
National Association of Area Agencies on Aging	n4a.org

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