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Suicide and the Elderly

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The questions raised by the possibility of the legalizing of euthanasia and Physician-Assisted Suicide do not always look at the existing rate of suicide among the elderly. In Canada, statistics show an increase in the number of elderly people who take their lives. A literature search shows that many conclude that most of these suicides take place among those who are depressed. An obvious conclusion would be that more should be done to conquer depression. Another conclusion would be to enquire how we should recognize symptoms of depression, and what measures can be taken to counter it?

There are implications here not only for the important matter of suicide prevention, but also the matter of the role depression plays in those who ask for euthanasia or PAS. An already well-grounded suspicion exists that many people who do demand these practices are, in fact, depressed, and that treatment of that illness would remove their perceived desire for ending their life. This is not to say that only those who are depressed ask for euthanasia or PAS, but that they are the ones who might take advantage of the availability of these practices should they be legalized, and yet clearly not be of truly sound mind in doing so. This is why so many fear that such practices are dangerous.

ELDER SUICIDE

In their article "Suicide and Old Age: A Tragedy of Neglect," authors Duckworth and McBride write that: "The prevention of suicide in old age has received little attention, despite suicide rates being highest in older men. About 90% of older people who attempt or complete suicide have a mental disorder, usually depression, which often has been inadequately treated. Other treatable contributing factors include pain, grief, loneliness, alcoholism and carer stress. Few suicides in older people occur in the context of terminal illness or can be regarded as 'rational'. Educational programs are required to improve the recognition and treatment of depression in primary care."[1]

The American Psychological Association issued a resource document on the connections between depression and suicide in older adults, reminding us that both of these are major public health issues.[2] Depression continues to be one of the most common mental disorders experienced by older people, although treatable by a variety of means. An added concern is that those about to enter later adulthood, the 'Baby Boom' cohort, are suffering from depressive disorders at significantly higher rates than previous groups. The reasons for these changes are not yet clearly understood. Depression also tends to recur, meaning that depressed, older adults use health services at high rates and do not take care of themselves as well as their non-depressed peers. Statistically, depression is also associated with suicide: older adults have the highest rates of suicide of *any* age group, and, mostly, are older men.

A Canadian study in 2005 revealed that approximately 12/100,000 individuals aged 65 years or over die by suicide in Canada annually.[3] The study noted that suicide is most prevalent among older white men. It notes some specific

risk factors: "… suicidal ideation or behavior, mental illness, personality vulnerability, medical illness, losses and poor social supports, functional impairment, and low resiliency."[4] It notes that more research is needed on risk and resiliency, and on the effectiveness of clinical assessment and interventions for at-risk older adults.

Duckworth and McBride examined coroners' records, autopsy and police reports for suicide victims aged 65 or over in Ontario over three years, showing that: "Over 80% of the elderly who committed suicide received no psychiatric referral. Of the sample, 87% were untreated while only 13% received antidepressants."[5] It stated that women were three times as likely to be treated as males, and those seeing psychiatrists were four times more likely to be treated with antidepressants than those seeing family doctors. These findings suggest that early geriatric-psychiatric assessment and vigorous treatment could prevent many suicides in old age.

The APA guide similarly suggests: "Several efficacious treatments are available for geriatric depression but seem to be underused. Pharmacotherapy and several versions of psychotherapy, including interpersonal, brief psychodynamic, problem-solving, and cognitive-behavioral, significantly reduce depressive symptoms. Interestingly, when given thorough descriptions of these treatments, older adults, group support, and life review have also received support."[6]

A further paper on depression in older adults found that some risk factors could be offset through protective factors including "… higher education and socioeconomic status, engagement in valued activities, and religious or spiritual involvement."[7] The authors noted that treatments such as behavioral therapy, cognitive-behavioral therapy, cognitive bibliotherapy, problem-solving therapy, brief psychodynamic therapy, and life review/reminiscence therapy are effective but are too infrequently used with older adults. [8] Studies show that most older adults who commit suicide see their physicians within a few months of their death and more than a third within the week of their suicide. Agreeing with other studies that "… elderly patients with severe depression, poor social support, and history of serious suicide attempts have high suicide potential," the authors emphasize the importance of reliable assessment of suicide risk in these adults.[9]

These same factors are important indicators of people who may seek out PAS and euthanasia. The authors found that "… depressed seniors and even seniors with subtle, passive suicidal ideation were markedly more interested in PAS and euthanasia than nondepressed seniors in hypothetical situations."[10]

WHAT CAN BE DONE?

A Canadian Parliamentary Report published in November, 2011 devoted one of its sections to prevention of suicide and noted from one of its contributors:

> "Suicide prevention in Canada remains fragmented, disconnected and lacking a national vision. The UN guidelines listed all the things that could be part of a strategy and it was up to jurisdictions to decide want they wanted to do, but at least they started with the whole picture and worked down to their individual parts. In Canada, we're just starting from our disparate provincial or local parts without any idea of where they fit into the big picture."[11]

This may be true, but other jurisdictions have made recommendations from which Canada can benefit. For example, the US Surgeon-General's Department issued a long list of factors of which to be aware in discovering depression and other risk factors for suicide, including those affecting the elderly.[12]

Their report points out: "Understanding risk factors can help dispel the myths that suicide is a random act or results from stress alone. Some persons are particularly vulnerable to suicide and suicidal self-injury because they have more than one mental disorder present such as depression with alcohol abuse. They may also be very impulsive and/or aggressive, and use highly lethal methods to attempt suicide."[13]

The impact of some risk factors can be reduced by interventions (such as providing effective treatments for depressive illness). Those risk factors that cannot be changed (such as a previous suicide attempt) can alert others to the heightened risk of suicide during periods of the recurrence of a mental or substance abuse disorder, or following a significant stressful life event.

The list of risk factors noted by the Departments is as follows:

- Previous suicide attempts
- Mental disorders—particularly mood disorders such as depression and bipolar disorder
- Co-occurring mental and alcohol and substance abuse disorders
- Family history of suicide
- Hopelessness
- Impulsive and/or aggressive tendencies
- Barriers to accessing mental health treatment
- Relational, social, work, or financial loss
- Physical illness
- Easy access to lethal methods, especially guns
- Unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts
- Influence of significant people—family members, celebrities, peers who have died by suicide—both through direct personal contact or inappropriate media representations
- Cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma
- Local epidemics of suicide that have a contagious influence
- Isolation, a feeling of being cut off from other people

Most of these factors could be listed by any one of us if we stopped to think about what may predispose people to suicide, or, by extension, asking for PAS or euthanasia. With the exception of access to guns (although not ruling that risk factor out completely in Canada) these factors seem unfortunately all too prevalent in many societies. Lack of capacity, lack of control, lack of company, lack of spiritual awareness or sustenance, a sense of purposelessness, crises of confidence, health, memory and so on: these risk factors are all too real.

Yet many of them can be helped and treated, some through medication, some through solidarity with the elderly. This, of course, will make demands on us as those who must provide that solidarity, and this in turn involves our Christian commitment. I find the comments of Dr. Marnin Heisel of the University of Western Ontario compelling:

> "My colleagues and I have found that older adults who recognize meaning in life are less likely to endorse thoughts of suicide. And this protective effect seems strongest for those with greater depression symptom severity. Our psychotherapy study with suicidal older adults has shown that focused psychological intervention can significantly reduce or resolve suicidal thoughts and depression symptoms and can enhance perceived meaning in life, well being and social functioning. It's critical that innovative clinical research continue to develop and test novel therapeutic measures for older adults. Nevertheless the average older Canadian struggling with mental health problems will

be hard pressed to access recommended services provided by trained mental health providers. Clinical treatment guidelines for older adults at risk for suicide recommend interdisciplinary care provisions, including access to psychotherapeutic services and medication where necessary. Unfortunately many older adults at risk for suicide never receive interdisciplinary care and cannot access recommended psychological intervention."[14]

A lot is being done, but will we do more?
It is true that clinical depression needs professional care, and we can insist that the elderly should not be precluded. This demands our involvement in mental health issues and policy making through our elected representatives. At the same time, as individuals and as members of the Body of Christ we can all help give people some meaning in life by looking after their personal and spiritual needs. The Catholic Church, clerical and lay, does immense good through regular visits to the elderly and shut-ins, by personal visits and liturgical services in long term care facilities and in residencies for the elderly, taking the Eucharist to shut-ins after Mass on Sundays, and so on. Parish nurses make contact with many of our elderly sick or shut-in parishioners, and their ministry will no doubt be even more in demand as the number of elderly people grows. Many CWLs visit nursing homes on a regular basis, providing sing-a-longs or monthly birthday parties. Even little things can mean a lot to many of our elderly.

I know I cringe when I hear the phrase "an unwanted baby" — no child of God should ever be so designated. Do I react the same way when I hear about "the warehousing" of the elderly, or discover the extent to which elder abuse exists in this country? Are these further factors which might push some of our elderly into thinking death would be preferable? Dr. Heisel's statement that most of our elderly do not have access to necessary mental health care is a reminder that the health care pie may need to be sliced even more thinly if they are to receive care on the same footing as everyone else. Are we ready for that? ■

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