Senior suicide: The tricky task of treatment

It's a generation, to be sure, that can be difficult to diagnose and treat when it comes to mental health problems. They have often been taught, or are conditioned to keep such problems behind closed doors or disinclined to acknowledge depression or a desire to die. Some even express mental distress as bodily aches and pains, or flu-like symptoms, rather than more traditional psychological symptoms.

Such factors make it a challenge to identify and aid despondent seniors who may be contemplating suicide. It's an age group that exhibits the highest rate of suicide, the incidence of which is projected to rise as the postwar baby boom matures (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4287).

Although society is increasingly more open about mental health problems, the current crop of seniors is more prone to concealing mental health problems, says Marnin Heisel, a scientist with the Lawson Health Research Institute of the London Health Sciences Centre and St. Joseph's Health Care London in Ontario. "It wasn't something growing up that they were taught to do and in fact, it was the sort of thing that one did not air — one's dirty laundry."

That led Heisel to co-develop the Geriatric Suicide Ideation Scale, which aims to help physicians better detect suicide risk in adults 65 years and older (*Am J Geriatr Psychiatry* 2006;14:742-51). To further assist busy health professionals, Heisel and his colleague have also created abbreviated versions of the suicide ideation scale for those who might not have time to administer the longer test, or the expertise to interpret its results.

The scales are measures designed to help health professionals distinguish between suicidal thinking and the sort of normal thoughts of mortality that invariably come to mind as people age, Heisel says, adding that such age-specific considerations typically haven't been taken into account in existing scales.

But unfortunately, most requests for the scale are made too late, he notes. "As these things often go, often people look for a tool after they've needed one, meaning either they've had a close call — somebody has tried to end their life — or somebody has killed themselves."

Other tools designed to help health professionals identify and prevent

Risk factors for suicide by seniors include ideation; the presence of mood disorders, addictions and physical illnesses; personality disorders and "rigid personality styles"; as well as occurrence of negative events (such as the death of family members) or transitions such as change of residence.

suicide among seniors include the *National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide*, which were developed by the Canadian Coalition for Senior's Mental Health, an advocacy group based in Toronto, Ontario (www.ccsmh.ca/en/guidelinesUsers.cfm). They're also available in a *Late Life Suicide Prevention Toolkit: Life Saving Tools for Health Care Providers*, along with an interactive DVD, a pocket-sized guide for suicide risk assessment and management and materials for educators (www.ccsmh.ca/en/projects/suicide.cfm).

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They also include recommendations for reducing suicide risk, such as instilling a sense of purpose and meaning in life, fostering social support networks and promoting better health practices.

Many health professionals find themselves on the hunt for such resources, once they've had a client who committed suicide, says Kimberley Wilson, executive director of the coalition. "Anybody who works in the field — particularly those who have experienced a death within the client population they work with — they're so eager to have resources because it's hard on staff, it's hard on people who work with older adults on a team and they want to know what to do."

But treatment of suicidal seniors is just as tricky as diagnosis, says Sylvie Lapierre, professor of psychology and director of the gerontology laboratory at the Université du Québec á Trois-Rivières.

Most strategies focus on reducing risk factors but often neglect the need to bolster resilience, Lapierre says. A systematic review of empirically evaluated elderly suicide prevention programs indicated that they typically overlooked strategies that "enhance positive aging," such as increasing self-esteem, sense of belonging, religion or spirituality (*Crisis* 2011;32:88-98).

Lapierre says that among the most effective approaches have been ones that aim at the establishment of personal goals. "We ask them 'what would make your life worth living?' And then we help them reach this goal. They become less depressed, less distressed, less suicidal, because how can you be suicidal if you have a goal in your life, if you have meaning in your life?"

Re-establishing lost hope can be a particularly effective deterrent to suicide, concurs Sharon Moore, an associate professor at the Centre for Nursing and Health Studies of the Faculty of Health Disciplines at Athabasca University in Alberta. "It doesn't matter what age we are — we all want to feel that we can make a difference. We all want to feel that our lives have some kind of meaning and purpose."

But to achieve that, it is critical that both the patient and the health professional believe that a "person who is suicidal can get better with the appropriate help and support," Moore adds. "There's sometimes this attitude that we can't teach an old dog new tricks, but I don't think that's relevant here. No one is doomed to die by suicide."
— Michael Monette, *CMAJ*

***CMAJ* 2012. DOI:10.1503/cmaj.109-4288**

Editor's note: Second of a two-part series.

Part I: **Senior suicide: An overlooked problem** (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4287).