Overview

• Depression
  • Epidemiology
  • Assessment
  • Treatment

• Suicide
  • Epidemiology
  • Risk factors
  • Models
  • Assessment
  • Intervention
The Facts:
Research has found that the vast majority of older adults:
• maintain positive emotions and express high life satisfaction
• have lower rates of psychological disorders than younger persons
• are cognitively intact
• have fewer disabilities than those in the same age group 10 years ago
• have meaningful interpersonal and sexual relationships
• adapt successfully to multiple stressors
• continue to experience personal growth
An important exception: Depression
Prevalence of mood and anxiety disorders by age and gender in the National Comorbidity Survey-Replication

Byers AL et al. Arch Gen Psychiatry 2010;67:489-96
Prevalence of Depression

- Clinically significant depressive symptoms in community residing older adults: 8-16% (Blazer, 2003)
- Increasing rates of depression in medical outpatients (5-10%), medical inpatients (10%), & nursing home residents (12-20%) (Blazer, 2003)
Consequences of depression

• Morbidity, including elevated risk for cardiovascular events and diabetes
• Mortality, due to natural causes and suicide
• Cognitive decline
• Increased health care costs
Major depression: at least 2 weeks with at least 5 of the following, including #1 or #2

1. Depressed mood
2. Loss of interest or pleasure in activities (may describe as “feeling blah” or other words)
3. Fatigue or loss of energy
4. Feelings of worthlessness or guilt
5. Impaired concentration or self-reported memory problems
6. Insomnia or hypersomnia
7. A sense of restlessness or being slowed down
8. Significant weight loss or weight gain
9. Recurring thoughts of death, suicide, thinking life isn’t worth living

Depressed older adults less likely than other depressed people to report depressed mood or worthlessness/guilt

Medical conditions that mimic or cause depression

- Hypothyroidism
- Vitamin D deficiency
- Low blood sugar
- Dehydration
- Among others
- Patients can have both a medical condition and depression
- Excess disability is associated with depression, so don’t assume it’s sufficient to treat the medical condition
Medications that mimic or cause depression

- Beta-blockers
- Corticosteroids
- Benzodiazepines and hypnotics
- Parkinson’s medications
- Estrogen and other hormones
- Stimulants
- Anticonvulsants
- Proton pump inhibitors and H2 blockers
- Statins
- Anticholinergics (including Benadryl, Tylenol PM, and other OTC medications)
- Some herbals
Screening instruments for depression

- PHQ-2
- PHQ-9
PHQ-2

• Designed for primary care
• Can be administered quickly and easily
  • Only 2 items
• Very sensitive
PHQ-2

- Over the past 2 weeks, how often have you been bothered by either of the following problems:
  - Little interest or pleasure in doing things
  - Feeling down, depressed, or hopeless
- Response options:
  - 0 = Not at all (*no problem, not no interest*)
  - 1 = Several days
  - 2 = More than half the days
  - 3 = Nearly every day
Scoring the PHQ-2

• Scores can range from 0 to 6
  • 0-2 suggests no depression
  • 3-6 suggests possible depression
• Can also be asked as “Yes” or “No” for cognitively impaired older adults
  • Either response of Yes suggests possible depression
PHQ-9

- Longer version of PHQ-2
- Also designed for primary care
- Can be administered quickly and easily
  - 9 items
- Response options:
  - 0 = Not at all
  - 1 = Several days
  - 2 = More than half the days
  - 3 = Nearly every day
- Scoring:
  - 0-9 no depression
  - 10-27 possible depression
Over the last 2 weeks, how often have you been bothered by any of the following problems:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself – or that you are a failure or have let yourself and your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Treatment of Late Life Depression

- Most depressed older adults do not receive treatment
- Why?
- Barriers – attitudinal, geographic, financial, lack of detection, scarcity of specialty providers.
- Preferences studies – (Hanson & Scogin, 2008; Rokke & Scogin, 1995) – Given adequate descriptions of psychological treatments elders express preference for them over medication.
Many psychotherapies are effective for depression, including behavioral activation, problem-solving therapy, cognitive-behavioral therapy, and interpersonal psychotherapy. All are short-term (4-12 sessions) and based on learning skills. Behavior activation and PST can be taught to caregivers for older adults with depression and cognitive impairment/dementia. SSRIs and SNRIs are first line medication treatments for depression. Which one depends on past history of treatment, side effects. “Start low, go slow, but go” until response is achieved. Also possibly buspirone, trazodone, mirtazapine, atypical neuroleptics, and mood stabilizers such as topiramate, either alone or augmenting SSRI or SNRI. Avoid benzodiazepines; they are not effective for depression and increase risk of falls and (with long-term use) cognitive decline.
Effect sizes of CBT for depression in older and younger adults

Karlin B et al., J Gero: Psychol Sci
Suicide
Suicide is a Public Health Problem

- Nearly 1 million suicides/year globally
- Suicide in US – 2010
  - 38,364 suicidal deaths
  - 10th ranking cause of death
  - Suicide rate: 12.4/100,000 population (105/day)
    - Homicide rate: 5.3/100,000 population
- Suicides in Individuals Aged 65+
  - 5,994 suicidal deaths
  - Suicide rate: 14.9/100,000 (16/day)

McIntosh, 2012
Suicide and Older Adults

• Rate of suicide in white men 85 years+ is four times higher than nation’s average
• Rates of suicide among older men is seven times higher than women
Suicide by Age in Men and Women

2010 US data from CDC/WISQARS
Means of Suicide
Old Men More Often Use Guns

Females 15-24
- Poisoning: 17%
- Suffocation: 9%
- Firearm: 24%
- 50%

Females 65+
- Poisoning: 16%
- Suffocation: 12%
- Firearm: 36%
- 36%

Males 15-24
- Poisoning: 8%
- Suffocation: 6%
- Firearm: 49%
- 37%

Males 65+
- Poisoning: 5%
- Suffocation: 7%
- Firearm: 78%
- 10%

2010 US data from CDC/WISQARS
Previous Suicide Attempt

- History of suicide attempt dramatically increases likelihood of suicide:
  - OR 10.8 (2.4–48.6) (Conwell et al., 2001)
  - OR 36.3 (14.8–89.3) (Beautrais et al., 2002)

- But...only 6% of older adults who died by suicide had a previous suicide attempt (Kaplan, 2008).

- For older adults, absence of a previous attempt does not mean an individual is not at risk.
Neuropsychological Factors

- Executive impairment
- Increased subcortical gray matter hyperintensities on MRI
- Decreased brain volume, especially in the dorsal medial prefrontal cortex
- Decision making
- Problem-solving

Ahearn et al. 2001
Conwell et al. 2002
Dembrovski et al. 2010
Gibbs et al. 2009
Hwang et al.
King et al. 2000
Miller, 1978
Social and Other Factors

- Relationship problems
- Family discord
- Low social support
- Financial problems
- Employment change
- Access to lethal means
  - Presence of a handgun

Beautrais, 2002
Conwell, 2002
Rubenowitz et al., 2001
Duberstein et al., 2004
Enduring Predispositions

- Neuroticism
- Low Openness to Experience
  - Associated with death by suicide
  - High openness associated with reported suicidal ideation
Psychopathology

• Between 71%-85% of older adults who died by suicide had a diagnosable Axis I disorder
  • Any mood disorder
  • Major depressive episode
  • Substance use disorder
  • Anxiety
  • Schizophrenic spectrum
  • Dementia/delirium (no risk, may be protective)

Conwell & Thompson, 2008
Depression and Suicide

- Depression is stronger risk factor in older adults than in younger adults
- Mood disorders present in 54%-87% of older adult suicides

Beautrais 2002:
- Current mood d/o: OR 184.6 (57.8 – 589.3)
- Lifetime hx: OR 12.5 (5.9 – 26.1)
- Population attributable risk of 73.6%

Conwell et al., 2001:
- Any mood d/o: OR 21.6 (8.5 – 54.8)
Even Minor Depression Increases Risk

<table>
<thead>
<tr>
<th>Mood Disorder</th>
<th>Odds Ratio (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depression, single episode</td>
<td>8.9 (2.3–34.0)</td>
</tr>
<tr>
<td>Major depression, recurrent</td>
<td>59.3 (7.9–445.9)</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>13.9 (1.7–112.5)</td>
</tr>
<tr>
<td>Minor depression</td>
<td>15.2 (3.9–58.4)</td>
</tr>
</tbody>
</table>

➢ For older adults, the presence of any depressive symptoms should trigger a suicide risk assessment.

Waern et al., 2002
Other Disorders Less Prominent in Late Life

• Less likely to involve alcohol abuse, other disorders in late life
• Beautrais 2002:
  • Substance Use Disorder OR 4.4 (1.7–11.0)
• Waern 2002:
  • Substance Use Disorder OR 43.1 (5.9–329.7)

Reviewed by Conwell 2002
Physical Illness

• Most evidence suggests that physical illness increases risk for suicide among older adults.
• However, risk varies by disease.
Specific Illnesses and Suicide Risk

- The following diseases are associated with increased risk for late life suicide:
  - Cancer (breast and prostate)
  - Neurological disorders (seizure disorders)
  - Pulmonary Disorders (chronic lung disease)
  - Genitourinary Conditions (incontinence and renal failure)
  - Sensory impairment (vision, hearing)

Reviewed by Fiske, O’Riley & Widoe, 2008
Timing of Disease May Be Important

- People who receive diagnoses associated with physical illness appear to be at increased risk for suicide:
  - During the period surrounding diagnosis
    - Psychological reaction
  - Later stages of illness
    - Associated with functional decline

Reviewed by Fiske, O’Riley & Widoe, 2008
Suicide and Sensory Impairment

- Individuals who experience hearing and vision losses may be at increased risk for suicide
  - Risk might be associated with increased depression

Reviewed by Fiske, O’Riley & Widoe, 2008
Insomnia in Older Adults

• Half of older adults complain of sleep difficulties\(^1\)
• Relation between Insomnia and Depression
  Poor sleep quality at baseline significantly predicted completed suicide\(^2\) even when controlling for depression\(^3\)
  • Sleep Quality vs. Insomnia

\(^1\)Vitiello, Larsen, Moe, 2004; \(^2\)Turvey, et al., 2007; \(^3\)Bernert, Turvey, Conwell, and Joiner, 2007
Nightmares have been shown in mixed age samples to be related to:

- Suicidal ideation \(^1,^2\)
  - Nightmares related to suicidal ideation independent of depression, insomnia, anxiety and PTSD symptoms

- Non-fatal suicide attempts \(^3\)
  - Frequency of nightmares related with high suicidality after controlling for depression, anxiety, and PTSD.

- Deaths by suicide \(^4\)
  - Frequency of nightmares predicted death by suicide 14 years later.

\(^1\) (Cukrowicz et al., 2006); \(^2\) (Nadorff, et al., 2010) \(^3\) (Sjostrom et al., 2007); \(^4\) (Tanskanen, et al., 2001)
Interpersonal-Psychological Theory

May endorse suicidal ideation

Those Who Desire to Die

- Perceived Burdensomeness
- Thwarted Belonging

Those who are capable of suicide

At greatest risk of suicide

Those Who Desire to Die

- Perceived Burdensomeness
- Thwarted Belonging

May endorse suicidal ideation

- Habituation to painful and provocative experiences (e.g., repeated suicide attempts, alcohol abuse, combat duty)

Those who are capable of suicide

At greatest risk of suicide

Interpersonal-Psychological Theory

May endorse suicidal ideation

Those Who Desire to Die

- Perceived Burdensomeness
- Thwarted Belonging

Those who are capable of suicide

At greatest risk of suicide

Perceived burdensomeness related to suicidal ideation in older adults above and beyond depression, hopelessness, etc.

Van Orden et al., 2008; Joiner, 2005, *Why People Die by Suicide*; Cukrowicz et al. 2011
Peri-suicidal state
Depression, hopelessness
↑ Symptoms, ↓ Resiliency
Role Changes, Medical Illnesses, Acute & Chronic Stressors
Personality Factors, Social Ecology, Cultural Values & Perceptions

"Distal" RISK FACTORS "Proximal"

Developmental Process of Late Life Suicide

Caine & Conwell, 2001; Adapted from Conwell, 2006
Stair-Step Model of Suicide in Elders

Role Changes, Medical Illnesses, Acute & Chronic Stressors

Personality Factors, Social Ecology, Cultural Values & Perceptions

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Developmental Process of Late Life Suicide

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Assessment Issues

- Widening gap between male & female rates
- Lifetime vs. late-onset mental disorder
- Older adults may provide less warning (fewer prior attempts, higher level of intent, atypical presentation of depression, more isolated)
- Use of medical vs. mental health services
- Attitudes toward suicidal older adults
- Hopelessness may be more common in late life
Help-Seeking Behavior Differs with Age

- Less likely to have visited mental health professional.
- More likely to have visited primary care.
- Up to 70% (mean 58%) of individuals 55+ visited PCP in month before suicide

Source: Conwell et al., 1998; Luoma et al., 2002.
Self-Concealment Not Significant Problem

• Tendency to self-conceal was significantly associated with suicidal ideation among college students:

\[ F(2, 624) = 107.86, \ p < .0001, \ \text{adjusted } \Delta R^2 = .15 \]

• But not among older adults:

\[ F(2, 82) = .59, \ ns, \ \text{adjusted } \Delta R^2 = .01 \]

➤ If you ask an older adult about suicidal ideation, you will probably get a candid answer.

Friedlander, Nazem, Fiske, Nadorff & Smith, in press
Assessment Tools

• Suicide Older Adult Protocol (SOAP)
  • Fremouw, W., McCoy, K., Tyner, E., & Musick, R., 2009
  • Acute and Static risk factors

• Reasons for Living Inventory - Older Adults
  • Edelstein et al., 2009

• Geriatric Suicide Ideation Scale
  • Heisel and Flett, 2006
  • Four subscales: Suicide ideation, Death ideation, Loss of personal and social worth, and Perceived meaning in life
Prevention Strategies that Work: In Primary Care

• 43-70% of older adults who died by suicide visited physician in month before death (Luoma, Martin & Pearson, 2002)

• Training physicians increases rate of diagnosed depression, reduces suicides (Rutz, von Knorring, & Wålinder, 1992)

• Systematic screening for depression and suicidal ideation; depression care specialists embedded in primary care; reduces suicidal ideation (Bruce et al., 2004)
Prevention Strategies that Work: Mental Health Treatment

• Treatment for bipolar disorder
  • Lithium reduces suicides (Cipriani et al., 2005)
  • Effect not shown for other bipolar treatments

• Treatment for depression
  • Cognitive therapy reduces repeat suicide attempts in mixed age samples (Brown et al., 2005)
  • Dialectical Behavior Therapy (DBT) reduces repeat suicide attempts in younger samples
Center for Elderly Suicide Prevention
Results after 1 year of services

* P < .05; source: Fiske & Arbore, 2000-2001
Tele-Help/Tele-Check

Expected vs. Observed Suicides (10 Years)

* P < .05; source: De Leo et al., 2002; n = 18,641 service users
Recommended Prevention Strategies: Long-Term Care Facilities

- Need to have a protocol to deal with suicidal behaviors among residents.
  - 15 min checks are not effective (Busch et al, 2003)
- Low Risk:
  - Refer to a mental health specialist
- Medium Risk:
  - One-on-one supervision
  - Environmental management
  - Multidisciplinary care plan meeting
Crisis Intervention

• Imminent risk requires more directive intervention.
• Establish rapport and offer hope.
• Safety plan.
  • Do NOT rely on contract for no harm.
• Do not leave the person alone until safe.
  • Remove access to means (stockpiled pills, etc.).
• Refer for evaluation and treatment.
  • Monitor and ensure safety until appointment.
• Engage others in support network (family, other staff).
All APA Resources Available on line, cost-free at http://www.apa.org/pi/aging/index.aspx
Resources

• National Suicide Prevention Hotline:
  • 1-800-273-TALK (1-800-273-8255)

• Friendship Line for the Elderly:
  • Toll-free, 24-hour support and crisis line
  • 1-800-971-0016
Training Resources

- **ASIST Training – LivingWorks**
  - [http://www.livingworks.net/](http://www.livingworks.net/)
- **QPR Training – The QPR Institute**
  - [http://www.qprinstitute.com/](http://www.qprinstitute.com/)
- **Recognizing and Responding to Suicide Risk – American Association of Suicidology**
Questions?

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