

SUICIDE AND THE ELDERLY: A POPULATION AT RISK

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SUICIDE AND THE ELDERLY: A POPULATION AT RISK

TUESDAY, JULY 30, 1996

**U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.**

The committee met, pursuant to notice, at 9:31 a.m. in room D-628, Dirksen Office Building, Hon. William S. Cohen (chairman of the committee) presiding.

Present: Senators Cohen, Reid, Burns, Wyden, and Warner.

Staff present: Mary Berry Gerwin, Priscilla Hanley, Beth Watson, Vicky Blatter, Sally Ehrenfried, Lindsey Ledwin, Rick Martinez, Peter Brown, Jerry Reed, Michelle Kitchen, Rem Dickinson, Lori Otto, Jim Brown, and Joni Hong.

OPENING STATEMENT OF SENATOR WILLIAM S. COHEN, CHAIRMAN

The CHAIRMAN. Good morning.

The Special Committee will come to order.

Suicide is the eighth leading cause of death in the United States today, accounting for more than 30,000 deaths each year. To date, most of the public attention has been focused on teen suicide. But suicide is not primarily a phenomenon of adolescence. The startling fact is that it is older Americans who are the ones most at risk.

For many of our parents and grandparents, the retirement years have apparently not been quite so golden. Americans over the age of 65 are more likely to commit suicide than any other age group.

While older Americans make up only about 13 percent of our population, they account for one-fifth of all suicides. White men over the age of 80 are at greatest risk and are six times more likely to commit suicide than the rest of the population.

While many teenagers attempt suicide as a plea for attention or a cry for help, older people are deadly serious. They don't attempt suicide, they do it. They use more lethal weapons and take care that their suicide will not be discovered or interrupted. The ratio of suicide attempts to completions is 200 to 1 in young people, but in the elderly, the ratio is 4 to 1.

Ironically, as advances in medicine and medical technology are extending our life spans, more and more older people are choosing to end their lives. The Centers for Disease Control recently sounded the alarm that elderly suicide is emerging as a major public health problem.

After nearly four decades of decline, the suicide rate for people over the age of 65 began to increase in 1980 and has been growing ever since. If we're to avoid an epidemic of late life suicide as the baby boom ages, we have to do a much better job of identifying and helping those older persons most at risk.

According to the National Institute of Mental Health, the decision to take one's life is generally based upon a complex constellation of risk factors. Among the elderly, these factors, often working together, include loss, physical illness, and depression.

While old age can be a time of contentment, pleasure, and productivity, it also brings many losses—of family members, friends, and physical abilities. For many, illness takes its toll and medications to relieve symptoms of the body may have unintended consequences on the mind itself.

All of these factors contribute to making older persons prime candidates for depression. Most experts agree that suicide in the elderly is overwhelmingly related to depression.

In his memoir, *"Darkness Visible,"* William Styron wrote of his own late life depression, "The gray drizzle of horror induced by depression takes on the quality of physical pain and because no breeze stirs this caldron, because there is no escape from this smothering confinement, it is entirely natural that the victim begins to think ceaselessly of oblivion."

The good news is, of course, that there are ways of treating this particular disease.

I'm going to include my full statement in the record because I know that Senator Reid would like to address this issue. He can speak of the problem on a firsthand basis. It was due to his personal request that we're here today holding this hearing.

He will attest to the fact that it is not just the victim of the suicide but family members who also are victims of it. What we need to do is focus on ways to help identify the signs of depression, and that is a responsibility not just of family members but of the medical community as well.

We must also remove the stigma of depression. We've had hearings this year where Mike Wallace and others have come forward to talk about their depression. We have tried to help remove the stigma of mental illness as something that shouldn't be discussed either privately or publicly in order to help provide relief to the many millions of people who potentially will become victims of depression and possibly suicide.

[The prepared statement of Senator Cohen follows:]

PREPARED STATEMENT OF SENATOR WILLIAM S. COHEN

Suicide is the eighth leading cause of death in the United States today, accounting for more than thirty thousand deaths each year.

To date, most of the public's attention has focused on teen suicide. But suicide is *not* primarily a phenomenon of adolescence. The startling fact is that it is older Americans who are most at risk.

For many of our parents and grandparents the retirement years apparently have not been quite so "golden," and Americans over 65 are more likely to commit suicide than any other age group. While older Americans make up only about 13 percent of our population, they account for one-fifth of all suicides. White men over 80 are at greatest risk, and are six times more likely to commit suicide than the rest of the population.

While many teenagers attempt suicide as a plea for attention or cry for help, older people are deadly serious. They don't attempt suicide—they do it. They use more

lethal weapons and take care that their suicide will not be discovered or interrupted. The ratio of suicide attempts to completions is 200 to 1 in young people. For the elderly, the ratio is 4 to 1.

Ironically, as advances in medicine and medical technology are extending our life spans, more and more older Americans are choosing to end their own lives. The Centers for Disease Control recently sounded the alarm that elderly suicide is emerging as a major public health problem. After nearly four decades of decline, the suicide rate for people over 65 began increasing in 1980 and has been growing ever since. If we are to avoid an epidemic of late life suicide as the "baby boom" ages, we must do a better job of identifying and helping those older persons most at risk.

Suicide in the elderly is something of a paradox—why take such drastic action to end one's life, when the end of one's life is already so near?

According to the National Institute of Mental Health, the decision to take one's life is generally based upon a "complex constellation" of risk factors. Among the elderly, these factors—often working together—include loss, physical illness, and depression.

While old age can be a time of contentment, pleasure and productivity, it also brings many losses—of family members, friends, and physical abilities. For many, illness also takes its toll, and medications to relieve symptoms of the body may have unintended consequences on the mind. All of these factors contribute to making older persons prime candidates for depression. Most experts agree that suicide in the elderly is overwhelmingly related to depression.

Depression is not a normal consequence of aging. But it is a serious illness that affects approximately 15 out of every 100 adults over 65 in the United States.

In his memoir, *Darkness Visible*, William Styron wrote of his own late-life depression:

"The gray drizzle of horror induced by depression takes on the quality of physical pain. Because no breeze stirs this caldron, because there is no escape from this smothering confinement, it is entirely natural that the victim begins to think ceaselessly of oblivion."

The good news is that there is an "escape" from the "smothering confinement" Styron describes. Depression in the elderly is highly treatable, and most seniors at risk of suicide because of depression can be helped not just to stay alive, but to enjoy rich and fulfilling lives. As many as 80 percent of older persons diagnosed with clinical depression can be treated successfully with medications, psychotherapy, or a combination of both.

Sadly, while recent advances make depression eminently treatable, only a minority of elderly depressed individuals are receiving adequate mental health care.

Some older persons refuse to seek help because of a perceived stigma of mental illness. Others may simply accept their feelings of profound sadness without realizing they are clinically depressed. Many of those who do seek help are too often underdiagnosed or misdiagnosed, leading the National Institute of Mental Health to estimate that as many 75 percent of depressed older Americans are not receiving the treatment they need, which places them at increased risk of suicide.

Clearly, opportunities to prevent suicide in the elderly are being missed. A number of recent studies have shown that most older patients who have committed suicide have visited their primary care physician within a short time of their death. Maybe their doctor did not ask them the right questions. Maybe the patient was putting on a "good face" and was reluctant to talk about his or her feelings or maybe the doctor was too quick to attribute the patient's depressive symptoms to the fact that he or she was ill or perhaps "just getting old."

In our youth-oriented, and some would say "ageist" society, elderly suicide is somehow more publicly acceptable than suicide in the young. In fact, many argue that elderly persons have a "moral right" and even a "moral duty" to commit suicide in the face of advancing age, illness, and disability.

However, this completely ignores the fact that suicide always has more than one victim. For an elderly person who chooses death in order to avoid becoming a further burden on family and loved ones, suicide is inevitably a "sacrifice" that backfires.

Suicide leaves a tragic legacy for surviving family and friends whose lives are irretrievably damaged by the planned death of a loved one. Twenty years after her father's suicide, Washington Post reporter Roxanne Roberts wrote:

"These are the legacies of suicide: guilt, anger, doubt, blame, fear, rejection, abandonment, and profound grieving."

Today's hearing will examine more closely the lingering effects that suicide can have on surviving family members. In addition, we will discuss the increasing incidence of suicide among the elderly, as well as the warning signs and factors that

might put an elderly person at risk. Finally, we will explore how increased vigilance to signs of depression and efforts to intervene can prevent these suicides from occurring.

On our first panel, we will hear from family members of older persons who have taken their own lives who will share personal experiences and talk about the impact that suicide can have on survivors. We will also hear from an older couple who were once at risk of suicide, but who received help from a particularly innovative program in Spokane, WA.

On our second panel, we will hear from researchers and clinicians who will talk about the prevalence of suicide in the elderly and about the factors that put elderly persons at risk.

Finally, our third panel will talk about strategies and interventions that can prevent elderly suicides from occurring.

The CHAIRMAN. With that, I would like to yield to Senator Reid. I should point out we're trying to keep our remarks relatively brief by Senate standards because we have a series of three votes starting at 10 a.m. and we'd like to try to at least get the first panel to testify before we have to go over and vote.

Senator Reid.

Senator REID. Mr. Chairman, I'd ask unanimous consent that my full statement be made a part of the record.

[The prepared statement of Senator Reid follows:]

PREPARED STATEMENT OF SENATOR HARRY REID

Mr. Chairman, members of the Special Committee on Aging, invited panelists, ladies and gentlemen. I am very honored to join all of you here this morning to address the very serious issue of suicide and the elderly. I would like to start by expressing my sincere appreciation to Senator Cohen for his agreeing to hold this hearing at my request. As a survivor myself, having a family member who committed suicide, this is an issue that is very close to me personally. The loss of my own father to suicide many years ago has had a tremendous impact on me. As we will learn today, suicide knows no boundary. This tragedy can occur in any home, to any family, anywhere in this vast country so many of us call home. My hope today is that by talking openly and honestly about this issue, we can become more aware and learn from others about what we as a Nation need to do to prevent suicide from being such an unfortunate option to so many of our Nation's senior citizens. If by holding this hearing we can prevent but one elderly person from taking their own life, our efforts will have not been in vain.

The elderly are often overlooked as a vulnerable population when suicide is discussed. Compared to other age groups, those 65 years and older have the highest suicide rate in the United States. Seniors have a suicide rate that is more than 50 percent higher than the suicide rate for the general population. Each year more than 6500 older adults take their own lives. This translates to 18 older Americans ending their life each and every day. Put another way, every 83 minutes someone over the age of 65 takes their own life in this country. While the elderly make up 13 percent of our overall population, they commit 21 percent of the total suicides committed in this country every year. In my home State of Nevada we have the highest suicide rate in the Nation with 23.4 per 100,000. While seniors make up 12 percent of the Nevada population, they account for 36 percent of total Nevada suicides. There is no doubt in my mind that with these statistics, and the evidence that the incidence of suicide amongst the elderly is rising, the time has come for us to take a hard look at this issue and put our collective wisdom and energy together to do something about it.

The reason an elderly person might take his or her own life is a complex matter to understand. It is rarely a single factor that leads to this tragic decision. What we do know is that depression is a significant factor in an overwhelming amount of cases. Others factors which often come to bear include loss of a loved one, loneliness, alcoholism or drug abuse, financial problems, and deteriorating health.

It is tremendously important that we address the issue of elder suicide in this Nation and this committee is the appropriate forum to begin our dialog. In my view, how we address this issue is a clear reflection on the way we address mental illness as a society. We need to muster the courage to speak honestly about this topic and lift the veil of secrecy that for too long kept us in the dark on understanding the

dynamics of elder suicide. No life should be lost to suicide if there is something, that through our efforts, we could have done to prevent it from occurring.

I believe that by addressing this issue in a straightforward and candid manner, we will bring hope to many generations of seniors to come, as well as their families, and relief to countless survivors who have lost a loved one to suicide. Mr. Chairman, this is a challenge with practical solutions some of which we will hear about today from our distinguished panel of witnesses. We need to ensure that professionals who interact with the elderly are sensitive to mental health issues; we need to ensure the availability of community resources that are capable of dealing with patients who are vulnerable to suicide; and we need more awareness and education that familiarizes families, professionals, and the community at large on the warning signs of suicide.

There is no reason for an elderly person with mental illness to suffer silently. Depression is a successfully treated illness. There is no reason for an elderly person to live in isolation or to live with a substance abuse problem. We have community resources that through initiatives like the one we'll hear about a little later are in a wonderful position to serve as "gatekeepers" linking at-risk elderly with needed services.

Mr. Chairman, let me state again how grateful I am that you agreed to hold this hearing today. I, for one, am very appreciative, and as I have said so often before, we will miss your leadership of this committee upon your departure.

Senator REID. I compliment and applaud you for holding this hearing. You're right, it was during the time that we held the hearing on depression in seniors that Mike Wallace testified.

I have not always agreed with Mike Wallace, I think a lot of times his narratives on television and his programs have been somewhat mean-spirited, but he, of course, is a prominent, renowned journalist and I was very much impressed with his forthrightness in acknowledging publicly—this very proud man who prides himself on being tough on television, on camera, came before this committee and with a great deal of humility, acknowledged his depression, his thoughts of suicide.

It was as a result of that hearing that I acknowledged for the first time publicly that my dad killed himself. I didn't need to acknowledge it publicly, people in Nevada, I'm sure, knew that anyway, but for me to acknowledge this publicly before my colleagues in the Senate, staff and people back here, was something that probably I needed to do.

It was very important that I do that and as a result of that, I've since written an article for a major senior publication about my own experiences.

Basically, as Senator Cohen said, suicide knows no boundaries; it affects us all. All you have to do is keep your ear to the ground and listen and it is happening all around us.

In Nevada, we have a particular problem. We lead the Nation in suicides. About 12 percent of Nevada's population is senior, but almost 40 percent of the suicides are seniors. So it is a nationwide problem, but we, in Nevada, have an especially difficult problem.

What we need to do is muster the courage to speak honestly about this topic and lift the veil of secrecy that for too long has kept us in the dark in understanding the dynamics of this thing we call elder suicide.

There is no reason for an elderly person with mental illness to suffer silently. Depression is a successfully treated illness. There is no reason for an elderly person to live with isolation or live with a substance abuse problem. We have resources where they can reach out for help and we'll learn about some of those today.

I want to close, Mr. Chairman, by reading from "Suicide in Later Life," by Nancy Osgood, a book she sent to me and I'm sure others of this committee. Her opening paragraph quotes Simone deBeauvoir who wrote, "Above all, even if the old person is struck by no particular misfortune, he has usually either lost his reasons for living or he has discovered their absence. When the world alters or displays itself in such a way that remaining in it becomes unbearable, a young man can hope for change, an old man cannot. All that is left for him is to wish for death." The purpose of this hearing is to make sure that there is no more wishing for death.

The CHAIRMAN. Thank you very much, Senator Reid.
Senator Burns.

STATEMENT OF SENATOR CONRAD BURNS

Senator BURNS. Thank you, Mr. Chairman, for holding these hearings. Going through aging parents is a challenge that I don't think I was quite prepared for.

Thank you for holding these hearings and I look forward to hearing from our witnesses this morning.

[The prepared statement of Senator Burns follows along with prepared statements of Senators Pryor, Craig, Kohl, Feingold, and Warner:]

PREPARED STATEMENT OF SENATOR CONRAD BURNS

Mr. Chairman, I want to thank you for holding this hearing today. Not only is suicide among the elderly a timely topic, unfortunately, for too many Americans it is becoming more than a topic, it is becoming a reality.

As the demographics clearly point out, our Nation as a whole is aging. As the number of Americans who live longer continues to rise, I am afraid we are going to find ourselves dealing with the tragedy of suicide among the elderly more and more. Though we have all heard, or perhaps personally know, about suicide among the elderly, it still takes hearings like this to bring to the forefront the extent of the problem.

The facts of the impact of elderly suicide are incredible and sad. While a great deal of attention is focused on teenage suicide, and well it should be, little notice has been given to the fact that suicide rates among the elderly are also rising. In fact, statistics show that the highest rate of suicide among age groups is actually the elderly, those over the age of 65. While representing only 12.4 percent of the population, older folks take their own lives at a rate of 21 percent, a rate higher than found among members of any other age group in our Nation. Suicide is the third leading cause of deaths from injury among older American residents, following deaths from falls and from motor vehicle crashes. Given these disturbing statistics—not to mention the fact that the "baby boomer" generation is rapidly closing in on what is considered "old age"—we need to take steps to avoid what could become a virtual epidemic in our country of late life suicides.

As we examine today the prevalence of suicide among the elderly, and look at ways to prevent them from occurring, I wholeheartedly believe that we must work as a Nation to remove the stigma that surrounds aging. We need to overturn those old-fashioned attitudes and stereotypes about older people that distort reality and keep older folks from seeing their own strengths.

I recently read a statement by Father Robert Chenoweth, a gerontologist and chaplain at St. Louis University Medical Center, in which he said, "We tend to say all older people are the same and put them into one category, but the exact opposite is true." I wholeheartedly agree with Father Chenoweth's assessment. We do need to acknowledge the special gift and role older folks provide to our families, friends, and community. If we did so, I think that would go a long way toward combating instances of elderly suicide.

We should also acknowledge the role elderly services programs and health professionals provide in helping at-risk seniors. The work these folks do helps elderly persons adjust to the multiple changes that come with aging—such as the loss of family members, career, friends and mobility. These are the factors generally attributed to depression among the elderly, which, most experts agree, is the predominant reason

that leads seniors to commit suicide. Though depression among the elderly is not easily recognized, the good news is that it is highly treatable. Congress should commend and support those organizations, like Spokane Mental Health Center's Elder Services program, and individuals who increase the awareness of the elderly to these problems and help reverse and prevent the suicidal tendencies of at-risk seniors.

In closing, Mr. Chairman, we all know that suicide among the elderly has a health cost. But, most important, as the first set of panelists will point out, it has a human cost. I believe appropriate treatment and intervention is always the surest way to save both dollars and lives. Nevertheless, I will be anxious to hear today how we, in Congress, can be of assistance in promoting both suicide prevention and in educating our elderly.

I thank you, Mr. Chairman, for your continual leadership in this area. I also want to thank the panelists for taking the time out of their busy schedule to be with us today. I look forward to working with all of you to find a solution to this terrible problem. Suicide among the elderly is a dilemma that we all could confront at some point, if we have not already.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, I want to thank you for holding this hearing on elderly suicide—a matter of grave concern in recent years. I commend the committee for holding this hearing so that Members of Congress and the American public can learn about this important topic.

Unfortunately, as we will hear today, elderly suicide has already made its presence felt in the lives of thousands of Americans. I realize that this hearing has special significance to my colleague and long time friend, Senator Reid. He has had a primary role in bringing this issue to the forefront of the committee's agenda.

This hearing is being held at a time when our Nation and the Congress are making monumental decisions on how to accommodate the growing number of older adults. The elderly population is facing exponential growth as the baby boomers approach retirement age. It is inevitable that, if we ignore this problem, elderly suicide will continue to plague our Nation's seniors at disproportional rates. Ironically, as more older Americans enjoy better physical health, their risk for suicide increases.

Suicide is a serious public health problem. Each year over 30,000 people take their own lives. While I understand that suicide is a leading cause of death among young Americans, we will learn today that the frequency of suicide is greatest among seniors 85 years and older.

Today, I am looking forward to learning more about all aspects that comprise elderly suicide from our panel of expert witnesses. I am hopeful that they will help us understand the complexity of this problem.

Perhaps even more important is learning how physicians and other providers can better identify the symptoms of depression that lead to suicide in older patients. According to the National Institute of Health, 90 percent of elderly suicide victims had been to the doctor during the last 3 months of their life. It seems to me that there might be warning signs during an older patient's visit to his or her doctor which, if noticed, could be treated and might prevent suicide.

Finally, we are grateful to have with us today a panel of witnesses who have first-hand experience with elderly suicide. They will help us to understand the factors that potentially drive elderly adults to commit suicide. Furthermore, family members of suicide victims bear the burden of the "ripple effect" of mental illness. They are forced to confront the pain and heartache that led to such a tragedy.

Mr. Chairman, let me again commend you for holding this hearing. I look forward to hearing the testimony of our witnesses and engaging in discussion about identification and prevention of elderly suicide.

PREPARED STATEMENT OF SENATOR LARRY CRAIG

Mr. Chairman, time and again, this committee has confronted troublesome issues regarding our Nation's senior citizens.

The subject of this hearing challenges what most people assume about the tragic problem of suicide in American families—that suicide is a problem exclusive to teenagers. This assumption ignores the fact that the rates of suicide among the elderly are higher than for any other age group. Even more distressing is the fact that this number is rising. America's senior population makes up 13 percent of the population, but accounts for one-fifth of all suicides. In the State of Idaho, there are

121,265 citizens over the age of 65. It is crucial that we focus much needed attention to this issue.

I am grateful for the opportunity to hear from our witnesses on this important matter. I thank them in advance for their help in bringing this issue to the attention of the Senate, and I look forward to hearing about their findings and their recommendations for policy changes in the future.

PREPARED STATEMENT BY SENATOR HERB KOHL

Older Americans face many difficult life challenges that can seem overwhelming— isolation, health complications, mounting bills, and con-artist scams are just a few. Depression can be a manifestation of one or all of these factors. Like many of these challenges, however, depression is not part of the natural aging process and it can be treated.

The increase in elderly suicide over the past decade is an American tragedy. Although the elderly represent only 12 percent of the population, the suicide rate is 21 percent. When a beloved family member commits suicide, the loss to family, friends and society can not be measured. We must address this problem now for all those that may be helped today and to put in place prevention strategies for the retiring generations of tomorrow.

To address this growing problem, there are obstacles that must be overcome.

Depression is difficult to face and self-help is generally not sought. A lifetime of negative reinforcement about mental illness combined with a strong sense of pride may cause avoidance. But we now know that mental illness can be diagnosed and treated, and depression is highly treatable—we just need to help identify the symptoms and take action. Families, communities, and medical professionals all have opportunities to attack this problem by recognizing signs of depression and helping provide a reason for hope.

Information about depression and treatment resources presents another obstacle that can be remedied. Medical training can teach doctors to diagnose factors leading to depression and plan treatment options. Supportive programs that have proven successful are available for local agencies to model.

There is much the Federal Government can also do to help alleviate conditions that affect the elderly, such as expanding options to long-term care and medical treatment, building upon meals programs, and enhancing opportunities for elder volunteer service. But like many challenges facing our society, the government can't provide the only solution. It takes commitment from families and the community to help identify depression and encourage solutions.

The testimony we are about to hear from family members whose loved-ones took their lives will bring sobering reality to this serious challenge. Their willingness to come forward is a testament to the value of their loved-ones. I am pleased that the panel of experts in the field of depression will also help the committee learn about the causes of elderly suicide and explore intervention strategies.

Older Americans are one of our Nation's greatest resources and should be treasured as such; they embody our strong heritage and can provide enormous benefit to our young people and communities. The elderly deserve respect and help during troubled times. No one should be left to feel that ending their life is the answer to their problems. There are few issues more demanding of care, understanding, and positive action.

PREPARED STATEMENT OF SENATOR RUSS FEINGOLD

Mr. Chairman, I commend you and the ranking member for holding this hearing. It explores a serious matter that deserves the attention and visibility that a public hearing can help provide.

Though statistics cannot convey the full human cost of the problem of elderly suicide, they do begin to reveal the extent of the problem. A nation-wide study done for AARP found that the elderly are the age group most at risk for suicide, with a suicide rate 50 percent higher than that of the general population.

Among other things, that study concluded that education and public awareness are central ingredients in the prevention of suicide among the elderly. This hearing, therefore, can itself play a role in suicide prevention, and for that reason alone we owe the Chairman and ranking member our thanks.

The background materials provided for this hearing indicate that some of the factors that some suggest may contribute to elderly suicide are isolation from friends, family, and community, and the loss of physical function and role in society. I have no doubt that this is the case.

Two years ago, as part of a Special Committee on Aging field hearing on long-term care reform, Chuck McLaughlin, a long-term care administrator from Black River Falls, WI, testified he had seen many seniors forced to enter nursing homes who would have liked to remain in their own homes or communities. He said though some "eventually adjusted to leaving their home and entering the nursing home, others never did." Although McLaughlin noted he had no hard empirical evidence to document the fact, he said:

"* * *(I) saw people who simply willed their own death because they saw no reason to continue living. These were people who were literally torn from familiar places and familiar people. People who had lost the continuity of their lives and the history that so richly made them into who they were now. People who had nurtured and sustained their communities which in turn provided them with positive status in that community. These people were truly uprooted and adrift in an alien environment lacking familiar sights, sounds, and smells. Many of them simply chose not to live any longer. While the medical care they received was excellent, they were more than just their physical bodies. Modern medicine has not treatment for a broken spirit."

Chuck McLaughlin's eloquent testimony was a telling argument for reforming our long-term care system. But it also provides insight into the problem of elderly suicide, and as a caution to policymakers. The inadequacies of the network of aging services have a cost beyond the immediate role individual services play.

I look forward to hearing the testimony offered today, and again thank the Chairman and the ranking member for their efforts in convening this hearing.

PREPARED STATEMENT OF SENATOR JOHN WARNER

Mr. Chairman, I am pleased to join you this morning as the committee examines a serious and little known problem confronting older Americans and their families. While Americans over the age of 65 only equal about 13 percent of the population, one-fifth of all suicides tragically take place in this age group.

I will remember a decade ago when I served on this committee in joint hearings with the remarkable Congressman and former Senator, Claude Pepper. At that time, Congressman Pepper was the lead Member of Congress in the fight to abolish the mandatory retirement age. We succeeded in that fight, and now, under U.S. law, older Americans have the assurance that they may remain in the workplace, if they so choose, as long as they are able to carry out the duties of their employment.

We are supposed to be a society that nurtures and protects the elderly—not one which casts them adrift in their golden years to lives without hope and purpose and which may prompt the taking of their own lives. If older Americans are sound in body, society should be prepared to assist them in keeping sound in mind and spirit as well.

Today we will hear from the friends and loved ones of individuals who have committed suicide at the time of life when they should be enjoying the fruits of their long careers. We will then examine the causes and prevalence of the problem to gain a better understanding. Finally, we will attempt to look at some solutions.

I am one who has been supporting improved mental health coverage for all Americans as a part of Senator Kassebaum's proposed Health Insurance Reform Act. As a part of this hearing and its follow up, I hope to learn the extent to which the Nation's Medicare beneficiaries may access appropriate mental health services. If, indeed, mental health coverage is NOT there as needed for the Medicare population, we can use the findings of this hearing to begin to remedy the situation.

I would like to welcome to this hearing one of my constituents, Ms. Daryl Workman of Richmond, VA. This is a difficult morning for Ms. Workman, for she is asked to relate to the committee the difficult story of her own father's suicide this spring. I convey to her and all the "personal" witnesses my deepest sympathies.

Thank you, Mr. Chairman, and also to Senator Harry Reid of Nevada, whose family, I understand, has also been deeply touched by the problem of elderly suicide.

The CHAIRMAN. Thank you, Senator Burns.
Senator Wyden.

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Mr. Chairman, and I'll be very brief.

Let me congratulate you, Mr. Chairman, and Senator Reid in particular, for your leadership. I was co-director of the Gray Pan-

thers, a senior citizens group, for many years at home before I was an elected official and I've been concerned about this problem. There is no question that suicide among seniors has become a hidden tragedy of American life.

I would just make two points, Mr. Chairman, that I would hope we would examine.

As Senator Reid and you have noted, this problem is particularly linked to depression. My sense is that we are on the verge of a pharmaceutical revolution which is going to produce new medications and new therapy that will help deal with these problems of depression among seniors. I hope today and in the days ahead, we'll learn more about some of those pharmaceutical developments.

The second point that I would mention, Mr. Chairman, is the need for geriatric training among those who work with older people. We're going to hear today, for example, how almost 40 percent of victims of suicide see their primary care provider during the last week of their life, and 70 percent during the last month of their life.

Working with geriatricians and those who are close to older people creates an opportunity to intervene at a critical time.

Those are two areas I look forward to working with you on.

The CHAIRMAN. Thank you very much, Senator Wyden.

Our first panel consists of Ms. Daryl Workman of Richmond, VA; and Ms. Paige Garber of Kensington, MD, who are going to give us some insight about the impact that suicide can have on surviving family members. We also have with us, Hy and Esther Nelson who have traveled to be with us today from Spokane, WA, to talk about what can be done to prevent suicide in at-risk elderly people.

We're going to start with Ms. Workman.

STATEMENT OF DARYL WORKMAN, RICHMOND, VA

Ms. WORKMAN. Thank you for this opportunity to speak before you today.

In January 1989, my father's father committed suicide at the age of 94. In March 1996, my father committed suicide at the age of 67.

It is with reluctance and unresolved grief that I share my story with you. It is a story I have only shared with immediate family and close friends. I choose to share it with you today in loving memory of these two men, and the expectation that this personal disclosure will be used to further our understanding of elderly suicide.

My grandfather did not fit the profile of the successful, elderly suicider. He lived with his 88-year-old wife, youngest son, daughter-in-law, and granddaughter. For a man of 94 years of age, he was relatively healthy. He never showed signs that he was suffering from depression and it shocked the entire extended family when he shot himself in the heart with a Smith & Wesson .357 Magnum revolver.

It was my father who informed me of grandpa's suicide. Dad presented the information matter-of-factly, and showed little grief. He explained that grandpa was at the end of his life and had earned the choice to live or die. Baffled and appalled, I chose to ignore the subject as much as possible.

That was a great mistake. Little did I comprehend at that time that my grandfather had just modeled values and behavior that my father would one day reenact.

My father was ex-military and a Pan American 747 airline pilot. In 1974 while on a checkride that would result in his promotion to captain, he developed heart arrhythmia that never resolved. He was stripped of his medical certificate to pilot an aircraft and was permanently grounded. In his mind, he had been emasculated and deemed a failure. He became depressed.

For 22 years, he fought his condition alone, afraid to accept professional help. The stigma associated with mental illness, as well as the shame he felt about himself, prevented him from acknowledging and accepting his disability.

Staunchly denying mental illness, he successfully convinced our entire family that he was really OK. Symptoms of hopelessness, irritability, fatigue, loss of interest in hobbies and social isolation were explained through other, more acceptable medical conditions. Heart disease and later development of chronic obstructive pulmonary disease were defenses against the label of "mentally ill."

During this 22-year period, our family also came to deny his condition. Sensing that an acknowledgment of mental illness was equivalent to causing him direct injury, we colluded with him in denial and unwittingly further exacerbated his condition.

Over time, the depression slow-burned to deeper levels and his daily functioning steadily declined. The man who had piloted planes around the world, in charge of complicated equipment, and responsible for the safety of many lives now could not manage his finances, social interactions, or simple activities of daily living such as preparing a meal. He was despondent, hopeless, and gripped by an unrelenting disease.

By late 1995, at the age of 67, his depression became even more virulent and his behavior life-threatening. Mood swings resulted in dangerously poor judgment and an absence of insight into his condition. Seeking relief from his pain, he made suicidal gestures to his wife, who had him committed to a geriatric psychiatry ward at a major university medical center.

For 30 days, doctors attempted to regulate his mood. Thinking they had been successful, they released him. Within less than 24 hours time, he lay dead at his home from a self-inflicted gunshot wound to his head. Ironically, the gun he used was the same .357 Magnum that his father suicided with 6 years earlier.

How have these suicides affected me? Greatly. I miss these men, especially my father. He was the most important and constant man in my life. By his example, I learned much of my own value system. He helped me build the foundation upon which I now function as an adult. His suicide has rocked my world and made me question my perceptions of him. To question him in this way is painful and not an easy task with which to contend. It also is not the way I want to remember him.

Each of these suicides has also denied me the opportunity to give a proper goodbye to these men. Thinking I had more time, I did not say the things they needed to hear and I needed to say. I am full of regrets which are painful. I replay the events leading up to my dad's suicide and wonder, "what if I had done such and such,

could I have changed the outcome?" These questions dog me, even in my dreams, and are likely to continue to do so.

As his daughter and a professional counselor with a Master's degree, I feel I have failed him. There is so much more I should have done for him, both personally and professionally. Yet, the depth of his torment and despair, nonetheless, eluded me.

I wish I could tell him how little I really understood, but would have tried my best to comprehend. Ultimately, I feel extreme guilt and an enormous desire to turn back time to make things right for him.

These suicides have had other effects on me as well. For many years now, I have suspected a family history of depression. These suicides confirm my suspicions and worry me that depression is an inheritable illness. Research studies show that it is and I therefore fear that suicidal depression may also be an inheritable illness.

I do not have children yet, but I am concerned that they too may suffer from the ravages of affective disorder. The decision to have children of my own has become increasingly difficult for me in light of my family history.

Most importantly though, these personal experiences of two generations of suicide pale next to this last reality: Mental illness has denied my father and grandfather the greatest gift of all, their lives. My father did not believe in an after life and did not choose to exit this world for a better place. He believed that death is final and an annihilation of one's self. Because of this, he greatly cherished the gift of living. That he could take his own life in exchange for relief is testimony to the depth of pain and suffering he must have been experiencing.

Thank you, Senators, for focusing attention on this issue.
[The prepared statement of Ms. Workman follows:]

Remarks to the
United States Senate Special Committee on Aging
July 30, 1996

by Daryl J. Workman

Thank you for this opportunity to speak before you today.

In January of 1989, my father's father committed suicide at the age of 94.

In March of 1996, my father committed suicide at the age of 67.

It is with reluctance and unresolved grief that I share my story with you. It is a story I have only shared with immediate family and close friends. I choose to share it with you today in loving memory of these two men, and the expectation that this personal disclosure will be used to further our understanding of elderly suicide.

My grandfather did not fit the profile of the successful elderly suicider. He lived with his 88 year old wife, youngest son, daughter-in-law, and granddaughter. For a man of 94 years of age, he was relatively healthy. He never showed signs that he was suffering from depression, and it shocked the entire extended family when he shot himself in the heart with a Colt 357 magnum revolver.

It was my father who informed me of grandpa's suicide. Dad presented the information matter-of-factly, and showed little grief. He explained that grandpa was at the end of his life and had earned the choice to live or die. Baffled and appalled, I chose to ignore the subject as much as possible.

That was a great mistake. Little did I comprehend at that time that my grandfather had just modeled values and behavior that my father would one day re-enact.

My father was ex-military and a Pan American 747 airline pilot. In 1974, while on a check ride that would result in his promotion to captain, he developed heart arrhythmias that never resolved. He was stripped of his medical certificate to pilot an aircraft, and was permanently grounded. In his mind he had been emasculated and deemed a failure. He became depressed.

For 22 years he fought his condition alone, afraid to accept professional help. The stigma associated with mental illness, as well as the shame he felt about himself, prevented him from acknowledging and accepting his disability. Staunchly denying mental illness, he successfully convinced our entire family that he was really O.K. Symptoms of hopelessness, irritability, fatigue, loss of interest in hobbies, and social isolation were

explained through other, more acceptable, medical conditions. Heart disease and later development of chronic obstructive pulmonary disease were defenses against the label of "mentally ill."

During this 22 year period our family also came to deny his condition. Sensing that an acknowledgment of mental illness was equivalent to causing him direct injury, we colluded with him in denial, and unwittingly further exacerbated his condition. Over time, the depression slow-burned to deeper levels, and his daily functioning steadily declined. The man who had piloted planes around the world, in charge of complicated equipment and responsible for the safety of many lives, now could not manage his finances, social interactions or simple activities of daily living such as preparing a meal. He was despondent, hopeless and gripped by an unrelenting disease.

By late 1995, at the age of 67, his depression became even more virulent, and his behavior life-threatening. Mood swings resulted in dangerously poor judgment and an absence of insight into his condition. Seeking relief from his pain, he made suicidal gestures to his wife, who had him committed to a geriatric psychiatry ward at a major university medical center. For 30 days, doctors attempted to regulate his mood. Thinking they had been successful, they released him. Within less than 24 hours time, he lay dead at his home from a self-inflicted gunshot wound to his head. Ironically, the gun he used was the same Colt 357 magnum that his father suicided with six years earlier.

How have these suicides effected me? Greatly. I miss these men, especially my father. He was the most important and constant man in my life. By his example, I learned much of my own value system. He helped me build the foundation upon which I now function as an adult. His suicide has rocked my world and made me question my perceptions of him. To question him in this way is painful, and not an easy task with which to contend. It also is not the way I want to remember him.

Each of these suicides has also denied me the opportunity to give a proper good-bye to these men. Thinking I had more time, I did not say the things they needed to hear and I needed to say. I am full of regrets, which are painful. I replay the events leading up to my dad's suicide, and wonder "what if I had done such and such? Could I have changed the outcome?" These questions dog me, even in my dreams, and are likely to continue to do so. As his daughter and a professional counselor with a master's degree, I feel I have failed him. There is so much more I should have done for him, both personally and professionally. Yet, the depth of his torment and despair nonetheless eluded me. I wish I could tell him how little I really understood, but would have tried my best to comprehend. Ultimately, I feel extreme guilt and an enormous desire to turn back time to make things right for him.

These suicides have had other effects on me as well. For many years now, I have suspected a family history of depression. These suicides confirm my suspicions, and worry me that depression is an inheritable illness. Research studies show that it is, and I therefore fear that suicidal depression may also be an inheritable illness. I do not have

children yet, but I am concerned that they too may suffer from the ravages of affective disorder. The decision to have children of my own has become increasingly difficult for me, in light of my family history.

Most importantly, though, these personal experiences of two generations of suicide pale next to this last reality: Mental illness has denied my father and grandfather the greatest gift of all -- their lives. My father did not believe in an after-life, and did not choose to exit this world for a better place. He believed that death is final and an annihilation of oneself. Because of this, he greatly cherished the gift of living. That he could take his own life in exchange for relief is testimony to the depth of pain and suffering he must have been experiencing.

Thank you, Senators, for focusing attention on this little understood subject.

The CHAIRMAN. Thank you for your testimony.
Ms. Garber.

STATEMENT OF PAIGE GARBER, KENSINGTON, MD

Ms. GARBER. Distinguished Senators, ladies and gentlemen, my father's suicide should not have surprised us, but in fact, it dealt a stunning blow to all who knew him.

He had often spoken of suicide being preferable to nursing homes. It was a recurring point of conversation with him. He was a big fan of Dr. Kervorkian and had been a contributor to the Hemlock Society.

After my mother's death last December, this topic began showing up more and more when we talked. I told him how hurt and angry I'd be if he committed suicide and he said he'd give life 6 months to persuade him to stay with it.

The week Dad died, we went to a psychiatrist. He prescribed Prozac, warning that it took several weeks to become noticeably effective. On Wednesday, March 20, I made lunch for us in his apartment, cleaned up and kissed him goodbye, promising him that things would get better. He then got his prescription filled and went to play cards with his friends.

His best friend said it was as though Dad was in a fog, even though he managed to win at the game. I don't know what his last night was like. From what I've been able to piece together, on Thursday, March 21, he arose, ate breakfast, took his first dose of Prozac, read the newspaper, made out a deposit to his checking account, wrote a short loving note asking forgiveness, took the kitchen knife and a portable phone to his bathroom and called 911 and immediately hung up. This I am sure he did to spare me the horror of finding his body.

At approximately 8:10 a.m., he got into his bathtub and mortally stabbed himself in the stomach, lacerating his liver. He retained consciousness until the police came and then the paramedics arrived and he died in the ambulance at 9:53 a.m. He knew I arrived every day between 10 a.m. and 11 a.m. That morning, I came at 10:20 a.m.

Although he was dead on arrival, over \$7,000 in medical bills were incurred trying to resuscitate him. Had they succeeded, I shudder to think in what condition he would have been brought back.

Ironically, these events confirmed his worst fears, that under no condition would many in the medical profession be willing to let someone go.

In the last 3 years of their lives, my mother was hospitalized seven times and my father five times. They both had chronic conditions that made life difficult. However, their marriage gave them the support that made life worthwhile.

On November 20 last year, my mother suffered a massive stroke that rendered her paralyzed, unable to speak. She could only make eye contact and hold your hand with her left hand. She could not even swallow.

She and my father had made up living wills forbidding tube feeding, so we were left with the horrible alternatives of starvation or dehydration to bring about her end. I think society would be out-

raged if we offered this horrendous choice of death for capital punishment executions.

We sadly agreed with her doctor that dehydration would be the more humane alternative but by the fourth day when she finally died, we were all overcome with misery at the spectacle of watching her wither.

This served to confirm my father's worst suspicions that the medical profession was of little help in shortening the suffering of those in decline. At first after mama's death, daddy seemed to rally a little, though deeply sad he was relieved her ordeal was over. He even started to try to combat his congestive heart disease with daily sessions on a treadmill, but new ailments began to plague him—cracked and bleeding toes and fingers, insomnia and a burning sensation on his tongue that ruined his enjoyment of food.

As winter deepened with record snows, he became more homebound and the magnitude of his loss gradually sank in. Though I saw him practically every day and had a brunch for him and my sister every Sunday, we began to realize he was becoming deeply depressed. Concurrently, he felt worse, stopped exercising, and worse, stopped eating enough to keep up his energy.

On February 20, he went to the Mayo Clinic for a medical workup that he hoped would offer some treatment to help him feel better, but after a week of tests, their diagnosis shed no new light on his condition.

When we reviewed the Mayo Clinic's report with my father's cardiologist who had volunteered to also act as his primary care physician, the doctor almost chided my father for going to such lengths to help himself. He said, "See, Alan, it's just as I told you, you have emphysema, congestive heart disease, and dry skin. We are doing the most medicine can offer to make you comfortable."

When I remarked that my father's depression was making me afraid of suicide, he made an offhand remark that perhaps we should see a psychiatrist—no overt concern, no referral, no encouragement was offered to promote my father's mental well-being.

He sank lower, buying little to eat. His best friend and I brought our cooking over to him but it remained uneaten or barely picked at. We started going to a special bereavement group once a week, primarily for widowed spouses. The others' stories all seemed more tragic than Dad's. No one else there had had the 56 years of marriage and devotion that he'd known, but the past was of no comfort. All he could see was a bleak future of increased pain, loneliness and dependency.

There is some comfort in knowing this was my father's decision. Rationally, I have accepted that suicide was the preferable alternative for him, but I miss him desperately. The double loss of my parents is sometimes overwhelming. I know I was a good daughter to him, as were all my sisters, but the fact that I was his daily companion whom he relied on most has left me with a wound of guilt and self-recrimination that may never fully heal.

My mother's death was a blow, but it was brought on by an act of God. Though we had to watch her die a terrible death, we knew we had chosen the best available option under current law. My father's death was an act of will. He had promised to hold on until June 1, 6 months, to see if he could reclaim his desire to live. On

March 21, after 81 years of life, he found he could not keep his promise.

Thank you for giving me the opportunity to speak.
[The prepared statement of Ms. Garber follows:]

Remarks by Paige Garber

Distinguished Senators, Ladies & Gentlemen:

My father's suicide should not have surprised us, but in fact it dealt a stunning blow to all who knew him.

He had often spoken of suicide, with great pride and clarity, as being preferable to a nursing home. It was a recurring point of conversation with him, and he was a supporter of Dr. Kervorkian and had been a contributor to the Hemlock Society.

After my mother's death last December, this topic began showing up more and more when we talked. In response, I told him how hurt, and yes, how angry, we would be were he to commit suicide. He told me that he would give me 6 months to persuade him to stay with it.

The week my father died, in late March of this year, we had been to a psychiatrist, who prescribed Prozac. The psychiatrist warned us that it often took several weeks for the drug to have a noticeable effect. On March 20, we had lunch together, I kissed him good-bye, and promised him things would improve. He then had his prescription filled for prozac and went to play cards with his friends. His best friend later told me that it was as if my father was in a fog, even though he managed to win at cards.

I don't know what his last night was like. From what I have been able to piece together, on Thursday, March 21, he rose, took his very first dose of Prozac, read the newspaper, made out a checking account deposit, wrote a short loving note to his daughters asking forgiveness for what he was about to do, took a carving knife and a portable phone into his bathroom, and around 8:15 am, called 911, then hung up. I am sure he did this to spare me the horror of finding his body, since he knew I arrived each morning at around 10 am. He climbed into his bathtub and mortally stabbed himself in the abdomen. The police and paramedics who arrived - responding to the 911 hang-up call - told me he was still conscious when they arrived. He died in the ambulance.

Although he was dead-on-arrival, the hospital presented us with over \$7000 in medical bills for attempts to resuscitate him. Had they succeeded, I shudder to contemplate what condition he would have survived in. I mention this, and the dollar figure, because ironically, these events confirmed my father's deep-seeded belief and genuine fear, that our health care system did not know when to let someone go, would not honor his personal decision, could financially ruin you in the blink of an eye.

In the last 3 years of their lives, my mother and father were hospitalized numerous times for chronic conditions that made their lives difficult. However, their marriage gave them the support that made their lives worthwhile.

Last November, my mother suffered a massive stroke that rendered her totally paralyzed, unable to speak, and only able to make partial eye-contact. She could not even swallow. She, and my father, had made up living wills forbidding tube-feeding. So, we were left with two horrible alternatives to choose from to bring about an end: starvation or dehydration. I think society would be outraged if we offered this horrendous choice of death for capital punishment executions.

We sadly agreed with her doctor that dehydration would be the more humane alternative, but by the 4th day, when she died, we were all overcome with misery at the spectacle of having had no alternative but to watch her wither. This served to confirm my father's suspicions that the medical professional would be of no help in shortening the suffering of those in decline, most especially, when the time came of his own decline.

At first, my father seemed to rally after my mother's death. Though saddened, he was relieved her ordeal was over. He even started to try to combat his congestive heart disease with daily exercise. But, new ailments began to plague him, including a burning sensation on his tongue that ruined his enjoyment of food.

As this past winter deepened and record snows fell, he became more homebound and the magnitude of his loss sank in deeply. Though I saw him nearly every day we began to recognize that he was becoming deeply depressed. Concurrently, he stopped exercising, and worst of all, stopped eating enough to maintain his energy.

In February, he took himself to the Mayo Clinic for a medical workup that he hoped would offer some treatment or insight. But after a week of tests, their diagnosis shed no new light nor offered any new treatments to help him feel better.

When we reviewed the Mayo Clinic's report with my father's cardiologist, who had also volunteered to be his primary-care physician, the doctor almost chided my father for going to such lengths to try and help himself. The doctor said, "See, Alan, it's just as I told you. You have emphysema, congestive heart disease and dry skin. We are doing the most medicine can offer to make you comfortable." When I remarked that my father's depression was making me afraid of suicide, the doctor made an offhand remark that maybe we should see a psychiatrist. No overt concern, no referral, no encouragement to pursue this further was ever offered.

My father sank lower, buying little to eat. His best friend and I brought our cooking over to him, constantly, but it turned up uneaten or barely picked at.

We started going to special bereavement groups once a week, primarily for widowed spouses. The others' stories were almost all more tragic than Dad's. No one else there had had the 56 years of devotion he had known. But the past was of no comfort to him. All he could see was a bleak future of increased pain and dependency. He had lost his will to live, and was afraid of what the future would do to him, would take from him.

There is some comfort in knowing that this was my father's decision. Rationally, I have accepted suicide as a preferable alternative for him. I know I was a good daughter, as were all my sisters, but his suicide has left me with something I could not have anticipated: The fact that I was his daily companion, whom he relied on the most, has left me with a wound of guilt and self-recrimination that may never fully heal.

My mother's death was a blow, but it was an act of God. Though we had to watch her die a horrible death, we knew we had chosen the best available option under current law.

My father's death was an act of will. He had promised to hold out until June 1st, six months to see if he could rediscover his desire to live. On March 21st, after 81 years of life, he found that he could not keep that promise.

Thank you for giving me this opportunity to speak.

March 24 1996

Dearest Friends,

Let me thank you profoundly for coming to help us celebrate the life of our father, Alan MacNaughton Warfield, and somewhat belatedly, the life of our mother, Helen Litz Warfield. It is fitting we remember them both today, for in death as in life, their souls were intertwined and ultimately unable to sustain life without each other.

And thus it was that Alan found life too difficult without Helen, despite the great wealth of love we all felt for him.

In fact, his great good fortune - his 56 years of happy marriage, his four loving daughters, nine wonderful grandchildren, four caring sons-in-law, his colorful career and long adventurous retirement - did little to prepare him for the enormity of his loss when our mother died.

He was an executive until the end, never wanting to be at the mercy of his failing health and ongoing grief; he found his own way out.

But more than anything else, I want to say to you all today, especially to the friends here of my parents' generation: You give the rest of our lives great depth and dimension by your sheer existence. Those of you who have found that life gets increasingly difficult, please stay and let us younger ones help lighten the load. We need you and want you. You are irreplaceable, valuable beyond expression. You are loved and needed with all the cares that may accompany aging and in some cases, infirmity.

There will never be another generation like yours again. Many of you were born before or during World War I, you endured the depression, you fought and carried our country through World War II. You took enormous risks, you wrought momentous changes, and through it all you danced, sang and laughed whenever you could.

Times change, but your generation will never be surpassed for elegance, strength and valor. We need you more than ever to love and learn from.

Washington is a working town. I think it's especially tough to be retired here, where people ask what you do often before they ask you your name. But the truth is here, in this most historic of American cities, we need our elders more deeply than anywhere, to help us remember who we are and how we want to be. On behalf of our family, I thank you.

Paige Warfield Gerber

The CHAIRMAN. Thank you very much, Ms. Garber.
Mr. Nelson.

**STATEMENT OF HY NELSON AND ESTHER NELSON,
SPOKANE, WA**

Mr. NELSON. Thank you.

The CHAIRMAN. We'll save the poet for last. [Laughter.]

Mr. NELSON. My experience with Elder Services is so fascinating that it is almost unbelievable. I feel so much better that sometimes I actually pinch myself to see that I'm the same person. When they entered my life, I was discouraged, frightened, had no ambitions, and could not make up my mind about almost anything.

Contrast that with my feeling of today when I feel confident, like to smile again, and find life fun, and you get some idea of the transformation. Just how they did this for me, I don't know, but I think that basically from a sense of understanding by those people that they were, and are, interested in the well-being of the patients they meet every day.

I don't mean to indicate in any way that they showed a sense of feeling sorry for me; rather, they gave me a feeling of real caring, that I try to help myself, that they were in my corner, and that I could slide up from the deep depression I was in.

Needless to say, the change in my mental attitude had made a big change in my physical feeling. Instead of sleepless nights, I find myself generally sleeping most nights. Instead of almost constant constipation, I now have almost regular bowel movements. I find physical work, such as gardening, fun instead of a chore that I must do.

Based on my experience, I would certainly say the organization should be supported fully and the personnel be congratulated for their dedication and sympathetic devotion to a very difficult job.

Thank you.

The CHAIRMAN. Thank you very much, Mr. Nelson.

Mrs. Nelson.

Mrs. NELSON. After listening to the two ladies at my left, I know truly how fortunate we are and I'm glad that I have the opportunity to come and tell you here what the Elder Service of Spokane Mental Health means to me, to us.

When our troubles started some years ago, I felt that I was alone in the world without the will or ability to solve my problems. When you have been married for so many years, and we'd been married for 61 years, whatever happens, happens to both of you.

Though we sought professional help, the situation only became worse. We had a lot of medications from a lot of doctors, each of whom was doing his best from his particular point of view. We were truly at the bitter end and both of us were thinking of death as the only possible solution.

We were literally saved by Elder Services. Our wonderful team came out to our home and for the first time, we were evaluated as a unit, as a family. The medications, and there were many of them, were sorted through. We began to feel that someone cared.

When my husband's depression reached crisis proportions, which indeed it did, and he had to be hospitalized, our team was there to smooth the way. I have no other family—I have one daughter

about 300 miles away and I needed someone immediately and they were there.

They helped bring him to the hospital and stayed there until he was admitted. I personally survived because I felt there was a safety net beneath me day and night. When I wanted to give up and go under, they helped me to go on.

Today, we are both quite stabilized, enjoying our lives and in better shape than we could have hoped for. The Bible says that if you save one life, it is as if you saved the world. Our wonderful team saved two of us and perhaps it saved two worlds.

Thank you.

[The prepared statements of Mr. and Mrs. Nelson follow:]

Esther Nelson

July, 1996

I have come here today to tell you what the Elder Services of Spokane Mental Health means to me. When our troubles started (some years ago) I felt that I was alone in the world, without the will or ability to solve my problems. When you have been married for so many years (61), whatever happens, happens to both of you.. Though we sought professional help, the situation became worse, We had a lot of medications from a lot of doctors, each of whom was doing his best from his particular point of view. We were truly at the bitter end and both of us were thinking of death as the only solution.

We were literally saved by Elder Services. Our wonderful team came out to our home and for the first time we were evaluated as a unit, The medications were sorted through. We began to feel that someone cared. When my husband's depression reached crisis proportions, and he had to be hospitalized, our team was there to smooth the way. I, personally, survived because I felt that there was a safety net beneath me, day and night. When I wanted to give up and go under, they helped me to go on.

Today we are both stabilized, enjoying our lives and in better shape than we could have hoped for. The Bible says that if you save one life, it is as if you saved the world. Our team saved two of us and we are very, very, grateful.

The persons least likely to know of the many resources for the elderly that exist in Spokane are those that need it most. When our troubles escalated my middle class values told me to help myself, send my husband to a psychiatrist, see our family doctor, Nothing helped until my wonderful daughter found that Spokane Mental Health had a department of Elder Services. Unlike too many of her class and generation she understood our real needs.

I think that the younger generation of middle class children, some of them very old children, need a lot of education. They must learn not to dismiss depressed behaviour as a symptom of age, but as a human symptom common in all ages. They must understand that suicide is as tragic for the elderly and their families as it is at any age. We were fortunate that our only daughter was smart enough to know that depression wears many masks and we needed professional help.

Families often turn to the family doctor for help, but he is limited by the nature of his profession. It used to be that doctors made house calls and had a pretty good idea of what was going on. Now he only sees what people choose to show him and the rest he must guess. Counsellors and psychiatrists seemed to make things worse. It was only when the Resident Psychiatrist at Elder services began to evaluate and guide us that we made any headway with our problems. When I became aware of how aging and depression came together and intensified the symptoms of both I asked our case worker, Dorothy Mehl, for counseling and reading material which could help me handle the situation. Understanding helped to modify my own behaviour so that now we have had a much happier situation and a much more peaceful life.

How does one reach the people who are either ashamed or too proud to reach out for help? Perhaps physicians need to understand that such a service does not threaten their turf, but can help them. Those of us who have benefited from such services should spread it by word of mouth. People who have known us for many years look astonished when we tell them we are under the care of Elder Services. We are well dressed, socially active, functioning as well or better than many our age, yet we are clients of a public agency. Just the fact that we talk about the agency and sing its praise has opened the door for other people.

Hy Nelson

My experience with Elderly Services is so fascinating that it is almost unbelievable. I feel so much better that sometimes I pinch myself to make sure I'm the same person I was just some 2 to 3 months ago.

When they entered my life, I was discouraged, frightened, had no ambitions and could not make up my about almost anything. Contrast that with my feelings of today when I feel confident, like to smile again, and find life fun and you get some idea of the transformation. Just how they did this for me, I don't know. But I think that basically came from a sense of understanding by these people that they were and are interested in the well being of the patients they meet every day. I don't mean to indicate in any way at all that they showed any sense of 'feeling sorry for me'. Rather they gave me a feeling of real caring that I try to help myself; that they were in my corner and that I could slide up from the deep depression I was in.

Needless to say, the change in my mental attitude has made a big change in my physical feeling. Instead of sleepless nights, I find myself generally sleeping most nights. Instead of almost constant constipation, I now have almost regular bowel movements. I find physical work, such as gardening, fun instead of a chore that must be done.

Based on my experience, I would certainly say that the

organization should be supported fully and the personnel be congratulated for their dedication and sympathetic devotion to a difficult job.

HY NELSON

STATE OF MIND

This is a hard time in my life
I was never good at waiting
Always misinterpreting the semaphores
That flew in contrary winds.

Endless boredom with a world
Where, perforce, I am the center
My pain, My needs, My whims
The depleted soil where no life springs.

FIRST SNOW

How remarkable -
I have lived to see the snow again !
Instead of a blanket on my tomb
It is a wreath of diamonds
Melting on my hair.

Esther W. Nelson

Nov 1994

The CHAIRMAN. Thank you very much, Mrs. Nelson.

I might mention for the benefit of my colleagues that Mrs. Nelson is also a very talented poet and she has submitted several of her poems dealing with depression which will become part of the record as well. I think they do, in fact, convey the depth of the sadness that you felt at one time and the relief that you now are experiencing.

Ms. Garber and Ms. Workman, thank you very much, first of all, for sharing your stories. They were very poignant, moving, and disturbing. I think it's helpful to all of us to hear of those experiences, much as it was helpful, as Senator Reid indicated, to have someone of Mike Wallace's prominence or Art Buchwald, or Bill Styron, or other very notable individuals talk about it publicly in order to help remove the stigma of depression or mental illness.

Your experience, I think, is also very helpful in that it will perhaps give some incentive for families to be more cognizant of what is going on and more determined to find the right kind of assistance.

Mrs. Nelson, you indicated that you had medications and that you were receiving treatment, but that it wasn't working. In your case, Ms. Workman, your dad apparently had a history of some heart problems which contributed to the loss of self-esteem on his part, a sense of worthlessness.

At any time, did medical doctors suggest there might be some psychological-psychiatric assistance that might be of assistance to him?

Ms. WORKMAN. He was seen by many doctors over the last 22 years. Mentions of depression were made, but referrals to doctors were few and far between, but mostly he couldn't take himself to see a psychiatrist. Any kind of psychiatric intervention was always forced upon him because it was too painful for him to acknowledge that he had that kind of problem.

The CHAIRMAN. Were any of the doctors aware that he had access to a firearm?

Ms. WORKMAN. Yes. The last time when he was hospitalized, the last 30 days, I was asked to come in to talk with the doctors to give some of his history and we talked about the fact that he had a huge gun collection. He had inherited guns from his father. Yes, he had access to them and the last thing the doctor said to me, "Well, at discharge, we'll need to make sure that the guns are out of the house."

He was discharged before I realized what was happening and I wonder if I had been more aware of the time of discharge if I might have gone in and removed them. I think he would have been very angry at me. But yes, the doctors were aware; they knew.

The CHAIRMAN. But apparently your father also was quite successful in masking the levels of his depression even from the doctors?

Ms. WORKMAN. He figured out the game to get out of the hospital. He figured out what the rules were, what the things were he needed to say in order to get out.

The CHAIRMAN. The chances are probably very great also that were you to have been successful in removing the guns from the

home, he would have found access to other weapons in order to complete the act.

Ms. WORKMAN. Our family has talked about that and we think probably so. He probably would have found another way.

The CHAIRMAN. Have you sought counseling yourself or other family members since this occurred to try to come to grips with this?

Ms. WORKMAN. I have. I don't feel I can speak for the rest of my family. I'm not sure about them to be honest with you.

The CHAIRMAN. You've spoken about that apprehension that you feel about a possible genetic predisposition to suicide that might occur should you have children. Have you explored the potential help that may be available as a result of the pharmaceutical breakthroughs that Senator Wyden has talked about that may remedy that situation?

Ms. WORKMAN. Yes, I'm pretty aware of what they are doing.

The CHAIRMAN. Mr. Nelson, looking at you today, it's pretty hard to believe that you ever contemplated taking your own life.

Mr. NELSON. I might have been play acting, but I really thought very seriously that there was no hope, everything was just not right, but it's changed. I've come to the conclusion after these last 8 or 9 years, that I've lived so many different fascinating lives and there are more lives to be lived.

The CHAIRMAN. But it was Elder Services that gave both of you a sense that someone cared about your existence?

Mr. NELSON. That's my feeling.

The CHAIRMAN. But we know from listening to Ms. Workman and Ms. Garber that there were people in their lives who cared, in fact they cared very much about their father's existence and that was insufficient. What was unique about Elder Services that somehow turned it around for you?

Mr. NELSON. I cannot put my finger on it, but they made most days feel joyful rather than sad.

The CHAIRMAN. Ms. Garber, may I ask you, did you think that your father's own theological philosophy could have accounted for his decision to take his life? That he did not feel that there was anything beyond his own existential existence in this life? That he didn't want to feel a burden and somehow found suicide a noble act, as such, terminating what had otherwise become a very painful existence for him?

Ms. GARBER. Exactly. He was an atheist. He even spoke about how he felt he would have gotten some comfort if he believed in an after life, that somehow my mother's spirit was somewhere in joy and light but he didn't have that belief. In fact, he felt that religions were very factious and caused a lot of war and hatred in this world. He was very existentially alone after she left. She was his soul.

The CHAIRMAN. So in your father's case, the use of medications may not have been a solution?

Ms. GARBER. It may not have, but I wish we had tried earlier. The other thing is my father was an executive with the CIA. He never dropped that persona. With my mother, I was able to almost turn the tables and mother her, but my father always cut me short if I presumed to tell him what to do. This was a problem from my

standpoint. I certainly didn't want to get into any kind of conflict with him after she was gone and we were very, very careful of each other's feelings.

I knew that if I said, "I think you should go to a psychiatrist," he would balk but finally, some of his friends found him a referral and we saw the psychiatrist on Tuesday and on Thursday, I think he decided even if I lighten my mood, my body may break down, I may have a stroke, I may end up unable to take my own life and have to be dependent on others and that would have destroyed his whole personality. He couldn't see himself as dependent on other people. That was just not his lifestyle, his calling in life.

At one point, he was the only man for eight women in my family.

The CHAIRMAN. You'd better explain that. [Laughter.]

Ms. GARBNER. Four daughters, a wife, a widowed mother, a widowed mother-in-law and an elderly sister.

The CHAIRMAN. Senator Reid.

Senator REID. Mr. Chairman, the one thing that we weren't able to hear from Esther Nelson is some other material she submitted to the committee and I think it says it all.

In these days of budget cutting at the Federal, State, and local governments, we're cutting all kinds of programs. A lot of times people think these programs are a waste of money. I don't know anything about the Spokane Mental Health Program, other than what you've told me today, but it sounds like a great program, especially the Department of Elder Services.

Here is what Esther Nelson said in part of her written testimony to the committee, Mr. Chairman, "How does one reach the people who are either ashamed or too proud to reach out for help?" This is what Senator Wyden said this morning. "Perhaps physicians need to understand that such a service does not threaten their turf"—paraphrasing a little bit what you said—"but could help them. We find a lot of times physicians won't refer other than to only physicians and a lot of times, nonphysician referrals is the answer to people like you getting well.

"Those who have benefited from such services should spread it by word-of-mouth. People who have known us for many years look astonished when we tell them that we are under the care of Elder Services. We are well-dressed, socially active, functioning as well or better than many our age, yet we are clients of a public agency. Just the fact that we talk about the agency and sing its praises opens the door for other people."

Mr. Chairman, I think that this is an example of how we back here have to be very, very careful in our zeal for cutting budgets that we don't cut out the very heart of many of these programs that do so much to make Hy and Esther Nelson and others in our country productive citizens.

I know our time is running late. I would ask permission from you, Mr. Chairman, to submit to these witnesses some questions in writing so that they can respond and spread their comments on the record.

The CHAIRMAN. Thank you very much, Senator Reid.

Senator Warner, would you like to make a statement?

Senator WARNER. No, thank you, Mr. Chairman.

The CHAIRMAN. Senator Burns.

Senator BURNS. Thank you, Mr. Chairman.

I am, after listening to this testimony, touched in many ways because I lost my father in 1992 naturally and now I have a mother who has had a stroke and she's in a nursing home. So we face these things.

I also heard another voice, and I have a daughter who is a year away from being a doctor. She graduates from medical school next spring.

We were talking about the situation with her grandparents and the testimony this morning of the Nelsons points to the fact that there is one element that all of us look for and that is we care. Based on anything you want to base it on, even Ms. Garber, your testimony, somewhere along the line you know there was not another voice that said, we care.

Keely has always maintained a little Bible circle every year she's been in college and now she's almost through medical school and she's worked in Spokane, WA—by the way, she's going to the University of Washington in Seattle—and she's gotten to work with the group that you spoke about. She said that's one element that we remove from our lives, that we don't realize when it happens.

Keely is going to go into primary care and I hope she continues that, but I just wanted to offer that maybe this young woman that I've raised has caught onto life a lot quicker than I thought she had.

I thank you for your testimony. Thank you for yours, Ms. Workman, because it takes very brave people to talk about that and then to realize that there's an element, there is an element about Americans—maybe it's our greatest quality and sometimes it's our greatest weakness too—that we have to continue to care.

Sometimes even the programs that Senator Reid talked about—we have programs but we have people that have lifted that one quality as to caring. You can't replace that. That same service could be offered in another town and yet it wouldn't be as successful as it is in Spokane, WA.

I want to thank you very much for giving this testimony. It makes us all realize, makes us all aware how important that element is. I thank you, very, very much for coming this morning.

The CHAIRMAN. Senator Wyden.

Senator WYDEN. Thank you, Senator Cohen.

All of you have been very helpful and I think Senator Cohen, Senator Reid, and Senator Burns have all said things that I agree with.

I wanted to ask you about just one other issue and that is the question of medical education, the education of providers.

I know back in the days when I was director of the Gray Panthers at home, I would often be asked to come up and talk at medical schools about the concerns of seniors. At that time, and I think it's still largely true today, people talked in the medical field about the cause and the treatment and then the cure as if everybody were going to go off and play tight end for the Washington Redskins after this was all done.

Clearly, what we've heard today as it relates to the concerns of seniors and depression and the like doesn't exactly fit that mold of cause, treat, and cure.

If you all had the heads of our medical colleges up here today, what would you say to those heads of the medical schools about how to diagnose and deal with the concerns of your folks and what you've seen as we try to shake up medical education and try to get them more aware of these concerns?

Maybe we can start with either one of you two because both of you I think talked about providers.

Ms. WORKMAN. I think that it would be very helpful if physicians were more aware of the psycho-social aspects of mental illness and aging. I really don't feel that in my father's case it was solely just medical depression. The other things in his life were falling apart. Physically, his health was declining, but his world was closing in, it was becoming smaller and smaller. He was worrying about finances, he was on a fixed income. He had fewer and fewer friends until at the end, he had none.

I think if he could have been reintegrated into society and made to feel important and that people out there cared, it would have made a difference. I feel, especially at the very end, the entire focus was just on the medical condition and once he was released to go home, no attention was paid to what happened next.

Ms. GARBER. I feel that any spouse, especially elderly spouses that are widowed, should through the social worker at the hospital or some agency be followed up on, not necessarily immediately when friends are writing and there's a lot of support from family but at least a month later, someone should check back and see how that person is doing because then the reality really starts to hit. That's one thing.

In my father's case, he picked a very matter-of-fact, no sugar-coating physician. He did not want to be coddled. He didn't want to have the truth sugar coated. On the other hand, I really think, as Senator Burns said, the message that "I care," that you are important, that you are a patriarch or a matriarch of our country, that you are living history, that represents a very, very valuable resource to all of us and needs to be reiterated.

I'm starting to read Robert Bly's "*Sibling Society*." I think that we admire and focus all our envy and attention on youth, and I think that's wrong. I think the elderly are undervalued, under-represented. I even resent the nutritional milkshake ads because they make it seem like if you're not getting the most out of life, white water rafting and doing that sort of thing, you're not having a valuable seniority, and that's just wrong.

I really feel we have to follow up on people, let them know how important they are, and a lot of times because of family dynamics, the family cannot fill that role for the parent. The parent always wants to parent their child, but they need someone they can lean on.

The CHAIRMAN. Senator Warner.

Senator WARNER. Thank you, Mr. Chairman.

I commend you and Senator Reid for holding this hearing. It's one of the most unusual hearings I've ever attended in my Senate career.

Of course it evokes personal memories from all of us. First and foremost is that of my mother who lived to be, we know, 96 but we think she cheated on 1 year. [Laughter.]

It was always a friendly debate within the family.

Fortunately, we were blessed in our family with a very active mother up until just the last few months of her beautiful life. How well I know she would call me up at all hours and complain about certain votes that I'd cast and she vehemently disagreed on occasion.

To you, Ms. Workman and Ms. Garber, I have two daughters, give or take a year or two, not too distant from you and I've looked at these statements and read them before coming. What beautifully written documents and your expressions of love for your parents. I think that sends across an inspiration to all who have children and I would only hope that my daughters some day would think as much as you do.

I think, Mr. Chairman and Senator Reid, we've got to look at the strengthening of the various pieces of legislation we have in place today—the Older Americans Act—because as a Congress, we're becoming more aware of the value of our senior citizens, if only to continue to maintain the productive, competitive age that we, as a Nation, must have if we're going to compete in this one world market.

It's been a wonderful hearing. I'm sorry I was not able to hear it from the very beginning. I commend you on your courage that you've shown.

Thank you.

The CHAIRMAN. Thank you very much, Senator Warner.

The final bells that have been ringing tell us that we have to go but I'd like, before concluding this panel, to just read two things written by Ms. Nelson. One was written in 1992 and it's called, "State of Mind." "This is a hard time in my life. I was never good at waiting, always misinterpreting the semaphores that flew in contrary winds. Endless boredom with a world where perforce I was in the center, my pain, my needs, my whims, a deleted soil where no life springs." You were pretty down that day when you wrote that.

Then 2 years later, in November, you wrote "First Snow." "How remarkable. I've lived to see the snow again. Instead of a blanket on my tomb, it is a wreath of diamonds melting on my hair." It shows what, indeed, 2 years, can make in your life and in Mr. Nelson's life. In 2 years you made the leap from the depths of depression to the snowy heights of having diamonds melting on your hair, Mrs. Nelson.

I want to join in what Senator Warner has said about the two of you, Ms. Garber and Ms. Workman. I think that anyone who has watched the testimony that you have given cannot help but be moved and hopefully cannot help but be enlightened, so we thank both of you for coming as well.

The committee will stand in adjournment for probably the next 20 minutes. [Recess.]

The committee will come to order.

On our second panel, we're going to hear from researchers and clinicians who will talk about the prevalence of suicide in the elderly and about the factors that put elderly persons at risk.

First, we will hear from Dr. David C. Clark, a psychologist and director of the Center for Suicide Research and Prevention at Rush Presbyterian Saint Luke's Medical Center, Chicago, IL.

Second, we will hear from Dr. Eric Caine, M.D., a geriatric psychiatrist, Professor of Psychiatry, University of Rochester Medical Center.

Then we will hear from Dr. Jane Pearson, Ph.D., of the Mental Disorders of the Aging Research Branch, National Institute of Mental Health.

Finally, we will hear from Dr. Mark L. Rosenberg, director, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Dr. Clark.

STATEMENT OF DAVID C. CLARK, DIRECTOR, CENTER FOR SUICIDE RESEARCH AND PREVENTION, RUSH PRESBYTERIAN SAINT LUKE'S MEDICAL CENTER, CHICAGO, IL

Mr. CLARK. Thank you.

Right now, suicide is the ninth leading cause of death in the United States, accounting for more than 30,000 deaths each year. The age group most affected is the elderly who account for a disproportionate share of all deaths by suicide. Yet, public awareness and concern about the problem of elderly suicide is probably at an all-time historical low.

Why? Ageism may help explain some of the disinterest. Ageism has been defined as the belief that it is futile to treat the psychological or physical afflictions of the aged. Thus, for example, it's a common belief that the elderly have understandable reasons for undertaking suicide, reasons such as deteriorating health, outliving family members and peers, isolation, or loneliness.

This kind of belief also leads many to question the utility of squandering precious, limited health care resources on people who are drawing so close in age to their natural deaths anyway.

The findings from scientific, community-based studies of elderly suicide, however, have consistently shown that these kinds of beliefs are not supported by the facts. In fact, deteriorating health, social isolation, and poverty rarely, if ever, stand alone as causes of suicidal thinking or behavior among the elderly.

Our own psychological autopsy study of all cases of suicide by persons aged 65 years and over in Cook County, IL, during the first 10 months of one recent year show the following:

A third were married when they died by suicide. More than half lived with family members. The great majority had frequent social contacts and visitors right up until the time of death. The majority had not experienced unusual life upsets in the most recent 6 months. Only 5 percent were experiencing financial problems. Approximately two-thirds were in good physical health for persons their age. And, information provided by family members made it clear that almost every single older adult who died by suicide was struggling with one or more psychiatric disorders which contributed directly to the suicide, though the symptoms of clinical depression, alcoholism, or prescription drug abuse were rarely recognized in time to prevent the death.

Two typical case examples, one a man, the other a woman, will illustrate our findings. I'm going to use pseudonyms in both cases.

Mrs. Jones was a divorced, 84-year-old woman who lived in a high-rise apartment with her daughter and son-in-law. Twenty-five years ago, following a divorce, she bought a share of the apartment with the couple, then retired after a few years to live on her retirement savings. She suffered from osteoporosis, high blood pressure, and some hearing loss.

Mrs. Jones began expressing suicidal thoughts 10 years before she died. She was referred to a psychiatrist at the beginning but refused treatment. Ever since she continued to make intermittent threats of suicide.

A year before she died, she wrote a suicide note and asked her daughter and son-in-law to read it. When they refused, feeling they did not want to encourage her constant suicide talk, Mrs. Jones took a small overdose of sleeping pills, but the family believed this was the result of miscommunication between her and her doctor, not an attempt.

Six months before she died, Mrs. Jones' brother died of a stroke. Two months before she died, she broke her hip and was hospitalized. While in the hospital, the hospital staff recommended she talk to a psychiatrist, but again, she refused treatment.

Her hospital stay dragged out longer than planned because her daughter needed surgery. Mrs. Jones was angry about having to stay in the hospital longer until her daughter had recuperated. She ate less and lost weight. She had difficulty sleeping and grew more and more tired. Her physical movement slowed and she continued to express suicidal thoughts.

On the day Mrs. Jones finally returned home from the hospital, she threatened to jump from the apartment balcony. Her family's experience was that she never acted on these kinds of threats. Eleven days later, she carried a stool to the apartment balcony and jumped off moments before her daughter and son-in-law arrived home at the end of a work day and she died.

It's important to note that following the death, the family discovered sleeping pills hidden all over the apartment. Mrs. Jones began taking sleeping pills 15 years earlier and since that time, she could never sleep without taking sleeping pills.

The second case is Mr. Smith, who was an active, retired 72-year-old engineer and U.S. war veteran who lived alone in a suburban home for the last 8 years ever since his wife of 42 years died of cancer.

His only son lived out of State, but talked to his father on the phone every week and visited often. Though Mr. Smith had no history of psychiatric problems or symptoms, his son did notice that the father became unusually dependent on him the year before he died. For example, Mr. Smith asked his son to come to town and accompany him to all his medical appointments that year.

Two months before he died, Mr. Smith began to complain frequently about problems with urination. A complete urological evaluation suggested nothing was wrong. At about the same time, the woman he had been dating for 7 years noticed that Mr. Smith's mood was becoming consistently depressed. He was tired all the time even after resting. He moved and talked slower than usual.

He developed a discouraged outlook which was unusual for him, and often said he was an unwanted burden to his woman friend, though she felt nothing of the sort.

Three weeks before he died, the urologist following Mr. Smith told the son and woman friend that Mr. Smith's problems were probably psychological in nature and he recommended consulting a psychologist or a psychiatrist. From that moment on, the son and woman friend spent increasing amounts of time with Mr. Smith, concerned about his depression and his diminished activities.

Two weeks before he died, Mr. Smith saw a neurologist for vague symptoms that couldn't be diagnosed. Ten days before he died, he went to a local emergency room for urinary discomfort. Six days before he died, he saw his primary care doctor.

During that last visit, the son asked whether his father could be hospitalized for depression. The doctor thought an admission was not warranted at that time. He referred Mr. Smith to see a psychiatrist 7 days later.

The following day, the woman friend phoned the psychiatrist asking if Mr. Smith could see him sooner but the psychiatrist declined because the referring doctor did not feel there was any emergency.

The day before he was scheduled to see the psychiatrist, Mr. Smith killed himself by shooting himself in his own backyard after he sent his woman friend away for a hour to run errands.

The lessons that I would have us draw from these two cases in our study are first, that suicidal ideas accompany most episodes of clinical depression and many other psychiatric illnesses. The subset of patients who develop persistent or compelling suicidal thoughts, including some persons of considerable maturity when not acutely ill, may become convinced that their suicide decision is sensible and meaningful. At the same time, they temporarily lose all sense of the impact their death would have on family members.

The illnesses underlying the suicidal crises of the elderly, most notably depressive illness, alcoholism, and prescription drug abuse, usually respond well to prompt diagnosis and treatment, if they can be enacted in time.

An enormous other obstacle to suicide prevention among the elderly is insidious ageism, which encourages too many people to think that the elderly have understandable reasons, justified reasons for undertaking suicide and which encourages too many people to question the utility of squandering precious health care resources on older adults.

Unfortunately, health care professionals are just as susceptible to this brand of ageism as everyone else. The simple truth, however, is that suicide is senseless, tragic, and often preventable whether the victim is 16 or 86.

Thank you.

[The prepared statement of Dr. Clark follows:]

Submitted testimony by
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**Elderly Suicide is Preventable,
but Stereotypical Beliefs Interfere with Prevention Efforts**

Suicide is a major public health problem

Suicide is the *ninth* leading cause of death in the United States, accounting for more than 30,000 deaths each year. It is a major public health problem, not a narrowly defined psychiatric or psychological problem. When leading causes of death are ranked according to "years of premature life lost", suicide rises in rank order to become the fourth leading cause of death. Those under age 25 years make up 16% of the U.S. population and account for 16% of all suicides. Those aged 65 years and over make up 12% of the population but account for 21% of all suicides.¹

Suicide rates in the U.S. are not uniformly higher among the elderly. Men aged 65 years and over are associated with a much higher suicide rate than other men, but the same is not true for women. Middle-aged women have much lower suicide rates than middle-aged men, and the rate of suicide for women *declines* after age 65.

Suicide rates in the U.S. are not uniformly higher for those with less access to health care. White citizens are associated with more education and a higher average income than African-Americans and hispanics, and consequently whites enjoy better access to health care — yet the suicide rates for whites are consistently two times higher than those for African-Americans and hispanics.

According to World Health Organization statistics, the U.S. suicide rate is near the middle of the pack on the international scene. Countries with suicide rates consistently ranked among the highest in the world include Switzerland, Sweden, (the former) West Germany, and Denmark — all of whom have sophisticated national health care delivery systems.

The age trends for *non-fatal* suicide attempt rates reveal a completely different pattern.

About 2.9% of the general adult population has ever made a suicide attempt. Non-fatal attempt rates are highest for those aged 25 to 44 years, lower for those between 18 and 24 years,

and lowest of all for persons aged 65 years and over.² Thus the ratio of non-fatal to fatal suicidal acts is lowest among the elderly. Older adults try suicide less often than those in other age groups — and survive the attempt less often.

2. Characteristics of persons who die by suicide

2 (a). The value of psychological autopsy studies

Until recently, most clinical studies of suicide were based on samples of persons who had made non-fatal attempts (including those who made medically serious or repeated non-fatal attempts) for the simple reason that they remained alive and available for interview. The remaining studies were based on samples of persons who were in some form of mental health treatment for an extended period of time before they died by suicide because detailed observations for the period preceding the suicide were well-documented.

More recently, it has become clear that neither of these types of samples are representative of the kinds of persons who die by suicide.³ Dahlgren and Stengel and Cook were among the first to show that persons who make non-fatal suicide attempts and persons who die by suicide are more different than alike.⁴⁻⁵ Now it is well-established, for example, that compared to non-fatal attempters, persons who die by suicide are more likely to be male, more likely to use a gun or a rope to effect death, more likely to have no history of any mental health treatment, and more likely to evidence a major psychiatric illness at the time of death. Yet less than half of those who die by suicide have made a prior suicide attempt.⁶⁻¹⁰ The implication is that only community-based psychological autopsy studies provide investigators with an inclusive or comprehensive overview of the diversity of persons who die by suicide.

The phrase *psychological autopsy* refers to a procedure for reconstructing an individual's psychological life after the fact, particularly the person's lifestyle and those thoughts, feelings, and behaviors manifest during the weeks preceding death. It represents an attempt to better understand the psychological circumstances contributing to the death. The essential ingredients of the psychological autopsy method include face-to-face interviews with

knowledgeable informants within several months of the death, reviews of all extant records describing the deceased, and comprehensive case formulation by one or more mental health professionals with expertise in postmortem studies.

The first psychological autopsy study was a community-based study of 134 consecutive cases of suicide in St. Louis.¹¹⁻¹² In the almost 35 years since, there have been only a handful of other community-based psychological autopsy studies of large size¹³⁻²², but this tradition of research has made unique and significant contributions to the clinician's understanding of completed suicide.

2 (b). The validity of official suicide counts

In the United States, determination of suicide as a mode of death lies in the hands of medical examiners, coroners, or coroner's juries. These determinations are based on custom and legal procedures that vary widely from county to county. Nevertheless epidemiological studies of the accuracy of reported suicide rates have consistently suggested that the margin of under-reporting is of relatively small consequence.²³ Kleck has shown that even if most accidental deaths by methods similar to those seen in suicides are re-classified as suicides, the net U.S. suicide rate would rise only about ten percent.²⁴

In Los Angeles, a special psychiatrically-trained death investigation team has studied and advised the Medical Examiner concerning all equivocal cases of death — about 60 out of 1,000 annual deaths — for the last 30 years.²⁵⁻²⁶ During this period, 55% to 65% of the equivocal cases were finally certified as suicides. These trends suggest that the Medical Examiner's initial undercount of true suicides was never more than five percent.

The implication is that while official statistics may consistently undercount the true number of suicides, this undercount is likely to fall between five and ten percent of the true total. Therefore the available community-based psychological autopsy studies are likely to be representative of most suicides.

2 (c). The majority of persons who die by suicide are in good physical health

There is considerable agreement among the findings from large community-based psychological autopsy studies conducted in far-flung regions of the United States, the United Kingdom, Sweden, and Australia. The major studies all agree in showing that the fraction of suicide victims struggling with a terminal illness at the time of their death is in the range of two to four percent.

Nevertheless there is increased physician contact in the months preceding death; 50% of suicide victims have seen a physician within a month of their death, and 80% within six months. Few of these physician contacts were with mental health professionals. The typical final contact before death was for vague and unrelated physical complaints not warranting any physical diagnosis, and the possibility of diagnosing a mental disorder was rarely entertained.

The body of literature considering geriatric suicides includes epidemiologically-based demographic studies,²⁷⁻³¹ a series of literature reviews,³²⁻³⁵ record review studies of medical examiner's records,³⁶ and clinical case reports,³⁷⁻³⁹ but no psychological autopsy studies until the last three years.

Conwell's recent psychological autopsy study of 248 persons aged 50 years and over who died by suicide in Monroe County, New York showed that more elderly persons died by suicide in the mistaken belief that they were dying of cancer than died by suicide with a genuine terminal illness.⁴⁰ His findings also showed that 75% of those who took their lives had seen a primary care physician during the month before death, yet their psychiatric disturbances usually went undetected or were inadequately treated.

Our own recent study was conducted with 73 consecutive persons aged 65 years and over who died by suicide in Cook County, Illinois was based on face-to-face interviews with several next-of-kin and access to all medical records. We demonstrated that only 14% were terminally ill and only 23% were chronically or severely medically ill at the time of death, supporting the conclusions that two thirds of the older adults in their late 60s, 70s, and 80s were in relatively good physical health when they died by suicide.⁴² Nevertheless the rates of physician

contact just prior to death were extremely high: 20% had seen a physician within 24 hours of death, 41% within one week of death, and 70% within one month of death. Once again, few of these physician contacts were with mental health professionals. The typical final contact before death was for vague and unrelated physical complaints not warranting any physical diagnosis, and the possibility of diagnosing a mental disorder was rarely entertained.

In both the New York and Illinois studies, other popular stereotypes of older adult suicides were not justified by the data. More than one third of all elderly suicide victims were married when they took their own lives, and more than half lived with a spouse or family member. The vast majority had a variety of social contacts inside and outside the home right up until the time of death. Major life stressors were not more prevalent among the elderly suicide victims in the months before death than would be true for most other elderly persons — only 11% faced an imminent change in living situation, only seven percent had lost a spouse by death in the last year, and only five percent were experiencing any sort of financial hardship.

2 (d). Almost all persons who die by suicide evidence symptoms of a major psychiatric illness

There is also considerable agreement among the findings from the large community-based psychological autopsy studies on the relationship between major mental disorder and death by suicide. Never less than 88% of the subjects qualified for a psychiatric diagnosis at the time of the suicide (never less than 94% in all but one study).⁴³⁻⁴⁸ Major affective disorder and/or substance use disorders were implicated in 57% to 86% of all suicides, with affective disorder the more common diagnosis. These diagnostic rates may be conservative estimates, because most psychological autopsy studies used a hierarchically organized diagnostic scheme permitting a maximum of one psychiatric diagnosis per subject. Schizophrenia and organic brain syndrome were implicated in a small but consistent fraction of cases. Thus suicides rarely occurred in the absence of major psychopathology.

To consider the relationship between major psychiatric disorder and suicide from another vantage point, follow-up mortality studies of patients afflicted with major affective disorder,

alcoholism, and schizophrenia consistently demonstrate that these patients are at elevated risk for death by suicide,⁴⁹⁻⁵⁵ often at rates higher than the lifetime risk for those with a history of suicide attempts.⁵⁶⁻⁵⁷ Thus the lifetime risk for death by suicide in the U.S. population as a whole is 1.4%, that for persons treated for a suicide attempt is approximately 7%, and the rates for persons with a diagnosis of major depression, schizophrenia, or alcoholism are estimated to be 15%, 10%, and 4-6% respectively.

While it would be simplistic (and erroneous) to think that these specific psychiatric disorders "cause" suicide in and of themselves, there is empirical justification for thinking that a suicide rarely, if ever, occurs in the *absence* of a major psychiatric disorder. This, of course, runs contrary to lay theories that suicide is caused by acute life stress and problems,⁵⁸ and highlights the fact that mental health professionals have not done a good job of educating the public about the nature of psychopathology or the relationship between psychopathology and suicide.

Overall psychological autopsy studies published during the last three decades have clarified the role of diagnosable psychiatric illness as an important contributing factor to suicidal outcome. Prior to these landmark studies, particular types of stressors (e.g., interpersonal, health-related, life circumstance) were believed to be the most important reasons for suicide. The psychological autopsy method has not only provided a new body of knowledge about suicide, but has identified contributing factors that are *amenable to detection and treatment*.

3. The nature of depressive illness

3 (a). Depressive illness is a *temporary and treatable* condition

Symptoms common to depressive illness include: pervasive sadness or irritability, loss of interest in activities that until recently were considered fun, trouble sleeping, appetite and/or weight changes, marked fatigue, hopelessness, loss of insight, and preoccupation with death or suicide. Depressed persons are often the last to recognize the severity of their own symptoms,

often deny psychological symptoms when initially questioned, and often resist accepting help from others as a condition of their illness.

Major depression, the current preferred name for depressive illness, is usually responsive to prompt treatment. Untreated, the illness typically lasts six to eight months before spontaneously remitting, but 15% of persons with major depression die by suicide and a larger fraction experience a devastating array of significant life impairments. A recent multi-hospital treatment effectiveness study pitting one antidepressant medication against two specific types of psychotherapy in a 12-week placebo-controlled trial showed that 70% of depressed outpatients responded well to both the active drug and psychotherapy conditions.⁵⁹ Clinical studies of suicide victims suggest that the elderly appear to be more prone than younger victims to take their own lives during the type of acute depressive episode that responds most effectively to modern, available treatments.⁶⁰⁻⁶²

3 (b). Depressive illness frequently goes unrecognized

The public education efforts of mental health professionals in recent decades have unwittingly created an impression that depressive illness is easy to recognize. In many cases, it is not. People do not always show their depression on their faces, in their voices, in their gait, or in their demeanor. Many individuals — university professors, physicians, lawyers, real estate brokers, telephone operators, bricklayers — who smile politely, have a kind word for their spouses and co-workers every morning, accomplish their work with great dispatch, and appear “normal” live in anguish and despair, struggling each day with a decision about whether to kill themselves or not. Some seek treatment, and so become known to us in our treatment centers — but most do not.

Two-thirds of all persons in the U.S. meeting diagnostic criteria for a psychiatric disorder never make contact with a health professional and never seek health care services.⁶³ The elderly use mental health services less than those of other ages. Only 14% of the men over age 74 who commit suicide have ever seen a mental health worker.⁶⁴

In the same vein, psychological autopsy studies of suicide victims have confirmed the important observation that the *majority* of persons at high risk for suicide by virtue of major depression, alcoholism, drug abuse/dependence, or schizophrenia do not pursue evaluation or treatment by a mental health professional — 43% to 48% of persons who died by suicide in community-based studies had never seen a mental health professional in their entire *lifetime*.⁶⁵⁻⁶⁸ Only 25% to 30% of persons who die by suicide are under the care of a mental health professional at the time of their death.

While the acute psychological symptoms present during the weeks or months prior to suicide can be documented from memory by family members and friends after the suicide, the symptoms of psychiatric illness that are so common among suicide victims are generally not recognized by the suicide victim or the victim's family members until after it is too late.

There is considerable evidence that primary care physicians often fail to recognize treatable depression in their patients,⁶⁹⁻⁷¹ particularly the elderly.⁷²⁻⁷³ In late life, it is common for major affective disorder to present as ill-defined somatic complaints, secondarily to physical illness, or as a side-effect of multiple medications. Unless the primary care physician routinely screens all his/her patients for psychiatric symptoms, these somatic complaints are not likely to raise suspicion or trigger a psychiatric evaluation. Thus while primary care physicians are ostensibly the doctors on the front line who would be responsible for implementing any policy that allowed assisted suicide, they are clearly ill-equipped to assess the presence and effect of depressive illness in older patients.

Murphy showed that in a group of 60 suicide victims who had recently been under the care of physicians, the patient's depressive mood was recognized before suicide occurred in most cases.⁷⁴ But in 80% depressive symptoms were interpreted as a "natural reaction" to situational life events of an adverse nature, and not as an illness which requires specific treatment. Thus the physicians tended to deal with piecemeal symptoms (e.g., insomnia) and failed to recognize the depressive syndrome as an illness requiring comprehensive management.

Since it is accepted that primary care health providers treat a far greater proportion of persons with psychiatric disorders in the community than mental health professionals,⁷⁵⁻⁷⁷ and that primary care providers fail to recognize a substantial proportion of the psychopathology posed by their patients.⁷⁸⁻⁸¹ Therefore it would seem that continued efforts to educate the general internist and family physician concerning the authenticity of psychiatric disorders, the importance of diagnosis, the importance of assessing suicide risk, the appropriate treatment of depressive syndromes, and the importance of making referrals to mental health specialists are warranted. The distinction between the depressed mood or sadness that develops as a *natural* response to serious illness and the clinical depressive syndrome for which treatment is warranted is a subtle one that should be made by a mental health professional:

3 (c). Acute situational distress and depressive illness

Proponents of rational suicide often make two *incorrect* assumptions about suicide that follow a physical illness. One is that these individuals are free of mental disorder — an assumption contradicted by the existing medical literature. The second incorrect assumption is that the physical illness is the only basis for the suicide decision.⁸²⁻⁸³

Many believe that the elderly have other understandable “reasons” for contemplating and/or implementing suicide (e.g., deteriorating health, severe illness, outliving family members and peers, loneliness, isolation). These beliefs lead some professionals to question the utility of spending time or health care resources on persons so temporally close to death by natural causes. The findings from community-based psychological studies of elderly suicide, however, consistently show that these attitudes and beliefs are not based on fact.⁸⁴ Social isolation, poverty, deteriorating health, and severe illness rarely, if ever, ~~stand alone~~ (i.e., in the absence of a psychiatric illness) as “causes” of suicidal thinking among the elderly. The great bulk of elderly persons in the general population are not depressed and most do not develop suicidal thoughts.⁸⁵⁻⁸⁶

The common tendency for clinicians and laypersons to overlook the diagnosis of clinical depression when "reasons" for experiencing a depressed mood are present often leads to the omission of psychotherapeutic and psychopharmacological treatment measures that might alleviate the severity of a depressive illness, alleviate functional impairment, and reduce suicide risk. While the importance of precipitating stressful events cannot be ignored in the assessment and treatment of a suicidal patient, the importance of these events is too often permitted to overshadow the fact that patients in episodes of "situational" depressive illnesses are no less likely to die by suicide than patients in episodes of "endogenous" or "somatic" depressive illnesses.⁸⁷⁻⁸⁹

The key problem is that stressful life events impinging on the patient in recent months or interpreted as precipitants of the current disorder or crisis have an enormous potential to *distract* the evaluator from recognizing the authenticity of a depressive illness, the severity of a patient's depressive symptoms, and the acuity of suicide risk. The fact is that depression is an illness and can be treated even though the precipitant is obvious or understandable. In this regard Fawcett's aphorism is useful to remember: "The presence of a *reason* for depression does not constitute a reason for ignoring its presence."⁹⁰

3 (d). Preoccupation with physical symptoms and health

Persons experiencing a severe depressive illness characteristically have difficulty recognizing their own psychological symptoms, and difficulty appreciating the psychological nature of their dilemma. They tend to focus instead on physical symptoms and physical health concerns. The problem is compounded by the severely depressed patient's tendency to lose insight about his/her condition as a common feature of the illness — many severely depressed patients are unaware that they are depressed and complain only about their somatic or anxiety symptoms.

Sometimes a depressed person's preoccupation with somatic symptoms becomes so intense that he/she *erroneously* believes he/she is dying (for example, of cancer). He/she may be

convinced he/she is dying even in light of contrary medical evidence and opinion. At this point many depressed patients will avoid further contact with physicians, preferring to be "left alone to die". In two community-based studies of elderly persons who died by suicide, there were more persons who killed themselves because they *mistakenly* believed they had cancer than there were persons who died with cancer or any other terminal illness.⁹¹⁻⁹²

3 (e). Depressive illness and mental competence

Depressive illnesses are associated with a number of cognitive changes, including a significant and measurable decrease in intellectual functioning, diminished concentration, indecision, mild memory loss, and sometimes confusion.⁹³

Most patients experiencing an episode of major depression develop morbid thoughts or suicidal ideas, however fleeting or tentative. Ideas about death and suicide are simply one of the ubiquitous features of a depressive illness. The subset of depressed patients who develop *persistent, compelling, or convincing* suicidal thoughts, on the other hand, are difficult to characterize with any uniformity. Some extremely suicidal persons may be placed in jeopardy by the severity of their illness state or their sense of acute hopelessness. Others may have less native capacity to inhibit violent or self-destructive impulses that are magnified by their illness. Still others may have a long history of preoccupations with matters of death and afterlife that colors their bout with an acute psychiatric illness.

Whatever the explanation or underlying cause, patients who experience suicidal thoughts with a persistent, compelling, or convincing quality can be conceptualized as persons responding to a deceptively alluring death appeal. Many persons *in acute suicidal crisis* (including those with considerable psychological depth and resources when *not* in an episode of acute psychiatric illness) do not have the capacity to resist the internal logic, the emotional tug, and the pain relief offered by the "solution" of suicide. These patients temporarily lose all sense of the impact their death would have on beloved others. Sometimes, listening to a patient describe his/her experience of suicidal thoughts, the irresistible quality of the appeal is

evident. More often, the appeal can be inferred from the patient's strenuous efforts to rationalize, romanticize, or otherwise justify his/her suicidal preoccupations by donning a cloak of intellectualism, philosophical detachment, existentialism, cynicism, or religious fervor.

The point is that once suicidal preoccupations have reached a level of intensity portrayed here as an alluring appeal, there is great danger that the patient has become irrefutably convinced of the sense and value of his/her suicidal ideas — rendering all verbal interventions (i.e., interpretations, discussions, negotiations, pleas) totally ineffective. One cannot reason with persons in *acute suicidal crisis* any more than one can reason with a person who believes God is sending personal messages to him/her via advertising billboards or a person who believes (medical evidence to the contrary) that a tumor is causing his/her imminent death.

4. Characteristics of terminally ill patients

While it is compelling to assume that many persons with chronic, painful, or terminal illnesses will choose to end their suffering prematurely by opting for suicide, in fact this type of choice — usually referred to as “rational” suicide — is seen rarely in hospital and hospice work. Except in those cases where physical illness is accompanied by a major depressive illness, the great majority of patients spontaneously reject the suicide option and choose to die naturally. The majority of terminally ill patients cling to life throughout their illnesses. Among elderly persons, for whom chronic painful illnesses are not uncommon, only 0.5% of male deaths and 0.2% of female deaths are attributable to suicide. Even if we double these rates, the proportion is extremely small.

The role of terminal illness, physical decline, or chronic pain as a reason for suicide has been seriously questioned by empirical research. Brown and colleagues, in a study of hospice patients diagnosed with terminal illnesses, severe pain, disfigurement or disability, found that the great majority of these patients did not desire to die naturally or by suicide.⁹⁴ Of the small percentage who expressed any wish to die, all met diagnostic criteria for a major depressive

illness. Only three of 44 patients had ever considered death by suicide. Other identifiable factors, therefore, must be present to lead a terminally or severely ill patient to consider suicide.

Terminally ill patients who do voice suicidal thoughts are usually transiently depressed, alternating between wanting to die and wanting to live, or seeking relief from intolerable pain. They tend to change their minds about wanting to die many times. The depressed patients generally respond well to standard treatments for depressive illness — psychotherapy and sometimes antidepressant medication. The patients in pain generally respond well to good medical pain management measures. It is generally a mistake to allow the patient to make an irreversible decision to die, just as it would be a mistake to accept the patient's premise of helplessness and hopelessness, without an adequate assessment for the presence of treatable depressive illness. In response to treatment, patients with terminal illness and intractable pain are usually grateful that no one facilitated their suicide while they were temporarily depressed or having acute difficulties with pain.

5. Conclusions

The wish to end life by killing oneself is almost always a serious symptom arising from a temporary psychiatric illness. While the subtlety and complexity of depressive illnesses often make it difficult for loved ones to recognize the gravity of the problem, it is generally a mistake to assume that a wish to die or end one's own life is a rational, carefully thought-through decision justified by a person's life situation or health status. One should always suspect that an unrecognized psychiatric illness has silently, invisibly influenced the judgement of a patient opting for suicide. Depressive and other psychiatric illnesses often rob medically ill patients of hope and objectivity, compromising their ability to exercise well-considered decisions. Compromised judgement and loss of insight are usually transient symptoms — extensions of the prevailing depressive illness, they exercise a subtle influence on depressed patients' thinking about the quality of their life and future, but they are hard to document.

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The CHAIRMAN. Thank you very much, Dr. Clark.
Dr. Caine.

STATEMENT OF DR. ERIC CAINE, M.D., PROFESSOR OF PSYCHIATRY, UNIVERSITY OF ROCHESTER MEDICAL CENTER, ROCHESTER, NY

Dr. CAINE. Good morning, Mr. Chairman. Good morning, Senator Reid.

I'm pleased to have the opportunity to appear before you today to discuss suicide in later life and the efforts of our research group at the University of Rochester to study this tragic problem.

Before I begin my specific comments, I want to laud this unusual group. It's a highly collaborative group. Yeates Conwell, M.D., leads our suicide team, Jeffrey Lyness, M.D., is leading our primary care research team, and Paul Duberstein, Ph.D., leads our team that's looking at personality and diseases of late life in terms of response to medical illness.

I also want to underscore the really important cooperation of the Medical Examiner of Monroe County for whom we have great pride and respect. Without his help and the aid of his staff we wouldn't be able to learn the kinds of things we have to date.

Suicide is a personal tragedy for all involved, including both those who die and, as we heard this morning, those who are left behind. During the latter years of the 20th Century, we all are aware of public discussion regarding the right to die, debating whether an individual has the right to control his or her own time of death in the face of terminal illness or unending pain.

As I will emphasize, however, this morning, this debate has little to do with the reality of suicide in later life. Despite our progress in understanding suicide, and as many will discuss today, there are many questions that are left unanswered.

One of the greatest problems in studying suicide, of course, is that the victims themselves aren't here to tell us what their motivations were, or what their problems were. We have to reconstruct after the fact what they were going through at the time of their untimely death.

Despite this daunting task, there are a number of things we've learned and a number of lessons we understand now that we can cite with some reasonable order of confidence at this time.

Approximately 90 percent of suicide victims have one form or another of a formal psychiatric diagnoses. Of those in later life, two-thirds have a major depressive episode or clinical depression. Most of these clinical depressions are late onset depressions. These are not life-long depressions but depressions that come within months or a few years of the time of death.

Moreover, this type of depression is very treatable. We're not talking about recurrent and recalcitrant depression that can go for 40 or 50 years and be difficult to treat. We're talking about single episodes where intervention that is available today can make a difference in somebody's life. Typically, these episodes are unrecognized or they're inadequately treated.

While alcohol and substance abuse is a major factor in suicide among younger people, they play an ever diminishing role in later life suicide. Thus by the time someone is 75 or 85 years old, they

play a much lesser role than someone who is 50 or someone who is 25.

Depression by the later years becomes the central issue. Few suicide victims kill themselves in the context of terminal illness or severe, unendurable pain. Rather, there appears to be an association with chronic, nagging diseases. They are troublesome, they are limiting, but they are certainly not fatal, not the kind of terminal illness discussed in a right-to-die debate. More often, it's a problem adjusting to these difficulties rather than succumbing to them.

What's really confounding is that depression itself makes the adjustment all that much harder. Depression, as we heard from some of the family members, begins to limit, begins to chip away, begins to take the very vitality out of the person who is afflicted by it. So it changes the way a person looks, it changes the way a person thinks, it changes the way a person copes.

Few older people, unfortunately, will seek mental health care. They are embarrassed, they don't want to talk about it; they deny they have it. We have to reach out to them because they won't reach out to us.

In more recent work, we've attempted to understand what happens when these victims see their physicians. As others have mentioned, approximately 40 percent see their primary care provider in the last week of life and 70 percent in the last month.

In our subject group, we studied 51 people who had seen their physician in the last month of life. These were people aged 50 years and over. Of the 51, 45 had specific psychiatric diagnoses, about 90 percent, and 16 of those 45 were totally unrecognized. There was no mention in their physician's chart of any type of psychological or psychiatric problem.

Of the others, 10 were recognized in some fashion. Typically, the physician noted that they were a little depressed or they were a little distressed. This is the type of problem that Dr. Clark referred to. Many physicians believe it's normal to be a little depressed when people are older. Therefore, they did not offer treatment.

Nineteen were offered some form of treatment, most often medication; four of those refused; 13 were treated with medicine, but with inadequate doses that wouldn't help a person, but sufficient to cause unwanted side effects. Out of that 45 who needed specific psychiatric treatment, only two had what we thought was adequate therapy.

In a related study, we're finding that primary care physicians will typically treat about half of the people who have some form of clinical depression with antidepressant medication. It's very clear that people who describe themselves as sad or blue, who come into the office saying, "Doc, I'm sad, I'm upset," will get the attention, sometimes even when they don't have actually all the signs and symptoms of clinical depression.

Indeed people are sometimes put on medicine when it would be more important to talk about what's going on in their lives, seeking to understand their stress or their personal problems. Ironically, people who have masked signs of depression, including sleeplessness, social withdrawal, lack of energy, loss of interest, and problems with appetite or constipation, are often missed because they

don't talk about their emotional problems and they don't talk about their depression.

It seems that many physicians in today's environment don't have the opportunity, the time, the energy, or the skill to talk about personal, psychological, or psychiatric problems.

In sum, suicide in later life is a tragedy. It occurs in the context of late onset depressive episodes and is, generally speaking, not related to terminal illness or unendurable pain.

Were they all recognized, the vast majority of suicide victims could be treated effectively. At the same time, we realize that we do not understand all the determinants of late life suicide. For example, why are older depressed men at extraordinarily higher risk than older women? In fact, depression in the general population among the elderly is less frequent than depression in the younger population. Why does the suicide rate increase?

We know that there are biological factors that seem to separate these groups from other groups, but we don't yet know what these are specifically. During the next few years, newer methods of brain imaging, particularly those that afford us the opportunity to look at biochemistry and pharmacology in living people, as well as post-mortem studies from the brains of people who died of suicide, are likely to give us new avenues of research leading to newer medications and newer understanding of what caused these problems in the first place.

As well, very important studies of family circumstances, personality, and individuals' capability of responding to illnesses and life stressors will be critical in complementing what we learn from these biological studies. Thank you.

[The prepared statement of Dr. Caine follows:]

Eric D. Caine, M.D.
Professor of Psychiatry and Neurology
Acting Chair

Statement of Eric D. Caine, M.D.
Department of Psychiatry
University of Rochester Medical Center

I am pleased to have the opportunity to appear before you to discuss suicide in later life and the research efforts that we have undertaken at the University of Rochester in Monroe County, New York. Before I begin my specific comments I want to underscore the efforts of Yeates Conwell, M.D., who is the leader of our research group, as well as Paul R. Duberstein, Ph.D., and the Medical Examiner of Monroe County, Nicholas T. Forbes, M.D.

Suicide is a personal tragedy for all involved, including both those who die and those who are left behind. During these latter years of the 20th century, there has been much public discussion regarding the "right to die," debating whether an individual has the right to control his or her own time of death in the face of terminal illness and extreme pain. However, it is essential to underscore that this debate has little to do with the reality of suicide in late life. Despite our progress in understanding suicide, many questions have yet to be answered. It is to address these that we have organized a series of efforts in Rochester, New York.

One of the greatest problems in studying suicide is, of course, our inability to ask the victim why he chose this mode of untimely death. Thus we are faced with the often daunting task of creating an accurate picture by assembling information gathered from different perspectives. Our principle method has been the psychological autopsy, where we have attempted to construct an understanding of an individual's health, mental state, and personal life

circumstances immediately prior to death by reviewing all available medical records, and interviewing key informants such as family members and physicians. Our initial studies involved comparing older versus younger suicide victims. A second approach has entailed research involving older individuals admitted to acute psychiatric hospitals, comparing those with clinical depression who have attempted suicide versus others who did not attempt suicide but also suffered clinical depression. A third approach that we are now undertaking involves a combined psychological autopsy and community study, matching older suicide victims with a random sample of older people living in the surrounding community. This provides a means of understanding whether the victims experienced distinctive patterns of physical illnesses or adverse life events, or differences in social support and family interactions. Our fourth approach involves a related set of studies, led by Jeffrey M. Lyness, M.D., where we are examining patients in primary care office settings to ascertain the prevalence, presentation, treatment, and course of mood disorders in later life. These studies employ many of the same methods as our suicide work, and are providing critically important complementary information to help further understand how individuals at high risk may be encountered prior to attempting or completing suicide.

To date, we have developed a number of important findings.

- Approximately 90 percent of suicide victims have at least one formal psychiatric diagnosis. In later life, two thirds of all victims have clinical depression.
- Their conditions are most often single, later onset episodes.
- The type of depression they suffer is very treatable.
- Typically it is unrecognized or inadequately treated.

- While alcohol or substance abuse is a major factor among younger victims, they play an ever diminishing role in later life suicide. Depression is central.
- Few suicide victims kills themselves in the context of a terminal illness or severe pain.
- Rather there appears to be an association with chronic nagging diseases; while they may be troublesome and limiting, they are not fatal.
- The clinical depression itself markedly lowers victims' functional abilities, greatly compounding their physical limitations.
- Few older suicide victims see any type of mental health professional, nor do they reach out by calling a crisis center or hotline.

In our more recent work, we have attempted to understand more clearly what happens when victims see their physicians. As others have mentioned, approximately 40 percent see their primary care provider during the last week of life and 70 percent during the last month. In our subject group, among 51 people ages 50 years and over who saw their physician in the last month of life, 45 had definable psychiatric diagnoses. Of these, 16 were missed completely. The conditions of 10 were recognized in some fashion, but were not treated in any specific manner. Of the 19 who were offered treatment, four refused. Thirteen were treated inadequately with respect to medications. Only two of the 45 were treated in a fashion that we rated as meeting current clinical guidelines or standards.

In a related study, we are finding that even well trained primary care physicians may miss clinical depression. Our preliminary data suggests that about one half of patients who require treatment may receive it. Typically patients who describe themselves as depressed or sad will be

recognized, but those who do not label themselves "depressed" may be missed, even while they have symptoms indicative of a significant clinical disorder. Conversely, individuals who do not have a serious condition, but who describe themselves as "depressed," also may receive treatment with medications when an alternative approach, such as dealing with personal stress or a family problem, would be more appropriate. Further complicating the situation, we have noted that many patients do not tell their physicians about their symptoms or difficulties. As well, many physicians are hard pressed in today's environment to have sufficient time to talk to patients about their personal, psychological, or psychiatric problems.

In sum, suicide in later life is a tragedy. It occurs most often in the context of late onset depressive episodes, and is not related to terminal illness or unendurable pain. Were they recognized, the vast majority of suicide victims could be treated effectively. At the same time we realize that we do not yet understand all the determinants of late life suicide: For example, why are older depressed men at such extraordinarily high risk at a time of life when severe clinical depression has leveled off or is declining in the general population? We are beginning now to study the biological determinants as well as the personal and psychological risk factors that contribute to late life depression and suicide. During the next few years, newer methods of brain imaging, particularly as they afford opportunities to assess brain neurochemistry, and cooperative studies to collect brain samples from people who have died will offer greater insights into these conditions. As well, parallel investigations of family circumstances, personality, and individuals' capability of responding to illnesses and life stressors will further add to our understanding of these complex conditions.

Thank you Mr. Chairman for the opportunity to address you this morning. I would be happy to answer questions at this time.

The CHAIRMAN. Thank you very much, Dr. Caine.
Dr. Pearson.

STATEMENT OF JANE PEARSON, PH.D., CHIEF, CLINICAL AND DEVELOPMENTAL PSYCHOPATHOLOGY PROGRAM, MENTAL DISORDERS OF THE AGING RESEARCH BRANCH, NATIONAL INSTITUTE OF MENTAL HEALTH, ROCKVILLE, MD

Ms. PEARSON. Mr. Chairman, Senator Reid, I am pleased to have the opportunity to appear before you to discuss elderly suicide and the research programs in suicide of the National Institute of Mental Health.

Elderly suicide is a major public health concern. Research aimed at improving our understanding of ways to prevent suicide is a significant priority at the National Institutes of Health.

In fiscal year 1995, over \$14 million was spent on studies focused primarily on suicide and suicidal behavior. The National Institute of Mental Health expenditures comprised two-thirds of this figure or about \$9 million. NIMH's expenditures for suicide research have increased eightfold in the last decade.

At NIMH, I serve as the Chair of the Suicide Consortium. The purposes of the Consortium are to monitor and encourage research program development in suicide across the life span. Two NIMH fact sheets, one describing current statistics and risk factors for all age groups and a second focussing on elderly suicide are examples of the type of public information documents and Internet web site pages that have been prepared for public dissemination.

I'd now like to highlight some of what we've learned about elderly suicides.

Among elderly suicides, uncomplicated, major depression is the most common disorder found to precede suicide and it is most often a first episode. This is in striking contrast to younger suicides where substance use and other psychiatric disorders are more common.

This finding is critical since among the elderly a first episode of depression is typically the most treatable. Tragically, the recognition of depression and initiation of treatment among elderly suicide victims has been rare. This is not due to social isolation or withdrawal. Research has shown that most elderly suicide victims either live with family members or were in contact with family members and friends.

We also know that access to health care is not a problem among elderly suicides; the majority of these older suicide victims have visited primary care providers as we've just heard. Virtually none have seen a mental health professional and very few have ever received mental health treatment, including treatment for depression from their primary care physician.

The clear implication from these findings is that a great opportunity to prevent suicide lies at the primary care office door step. Unfortunately, we know that primary care physicians spend less time with older patients and that they frequently do not recognize nor adequately treat depression in their older patients.

Physicians should not get all the blame. Older patients are less likely than their younger counterparts to tell their doctor that they feel depressed. They may sense more than the usual stigma over

mental illness and they may find it easier to verbalize physical pain more than emotional pain.

In addition, older persons, as well as their family members, may hold ageist attitudes that consider depression a normal reaction to growing old.

Fortunately, the groundwork establishing the fact that depression in late life is not normal and that it is treatable is in place. The 1991 NIH Consensus Development Conference on Late Life Depression identified effective treatments for geriatric depression. The next practice and policy challenge is similar to all mental health treatments. How to integrate effective treatment in health care settings where primary care physicians are increasingly asked to take on more responsibilities.

Because suicide is multidetermined, suicide research must proceed on many fronts. In addition to understanding service use patterns in the elderly, new technologies in brain imaging, molecular biology, and behavioral pharmacology are allowing us to develop experimental models of these self-destructive behaviors and to pilot test potential treatments.

Alterations in the serotonin system have been proposed to occur with normal aging, raising the question as to whether a neurobiological vulnerability occurs with aging which may interact with other vulnerabilities and stressors.

In closing, I'd like to emphasize that suicide is a complex, multidetermined event. We are still unable to adequately predict among the elderly who will and who won't commit suicide. We do not know enough about what protects people from acting on suicidal thoughts.

We do know, however, that most elderly suicide attempts and completions are expressions of extreme distress and that they rarely occur in the absence of depression.

Suicide is a public health emergency for the individual, the family, and the community. It deserves our full and active attention as researchers, clinicians, educators, and policymakers.

NIMH is committed to continue to pursue an aggressive program of research in this area.

Thank you.

[The prepared statement of Ms. Pearson follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Statement of Jane L. Pearson, Ph.D.

Chief, Clinical and Developmental Psychopathology Program

Mental Disorders of the Aging Research Branch

National Institute of Mental Health

I am pleased to have the opportunity to appear before you to discuss the elderly suicide statistics in the U.S., and the research programs in suicide of the National Institute of Mental Health (NIMH), part of the National Institutes of Health.

Suicide is an important public health problem. In 1993, the most recent available statistics indicate that the total number of suicides in the U.S. was 31,102. Although persons age 65 and older accounted for 13 percent of the population, they accounted for 20 percent, or over 6,000 of the 1993 suicides. The most accurate index for looking at the total number of suicides in the U.S., and those by age group, are age adjusted rates. Using these rates, the Centers for Disease Control and Prevention's National Center for Health Statistics reports that there were 12 suicides for every 100,000 persons in 1993. For people 65 and older, the rate of suicide climbs with age: It ranges from 15 per 100,000 among persons aged 65 to 69, and to 24 per 100,000 for persons aged 80 to 85--double the overall U.S. rate.

In the U.S. and other industrialized nations, older age and male gender are consistent demographic factors related to suicide patterns. With few exceptions, the most recent World Health Organization Statistics from over 30 industrialized nations (1992-94) indicate that men who are 75 years and older have the highest rates of suicide. In the U.S., older white males have the highest rates of any age, gender or racial group (see attached figure): Suicide rates for white males among the "oldest old", age 80 and older, have been consistently in the range of 60 to 70 per 100,000 since 1985. This is 6 times the current overall national rate, 3 times the rate of same-aged African American

males, twice the rate of Indian and Alaskan Natives, and Hispanic, Asian and Pacific Islander elderly males.

This high risk group has not been ignored by public health officials. *Healthy People 2000*, a document establishing a National health promotion and disease prevention agenda in 1990, targeted older white men among the groups most at risk for suicide. Although objectives to reduce suicides by 15 percent in this group by the year 2000 were set, they are, unfortunately, far from being met.

The NIMH, as part of its mission to understand, treat, and prevent mental disorders, regards suicide as an important public health issue. Research aimed at improving our understanding of ways to prevent suicide is a significant priority for the National Institute of Mental Health. In fiscal year 1995, NIMH spent approximately \$ 9 million for support of studies focussed primarily on suicide and suicidal behavior. This represents a nearly eight-fold increase of expenditures over the last decade.

Along with several other NIH components and Federal agencies, NIMH is a co-sponsor of the Centers for Disease Control and Prevention's National Mortality Follow-back Survey. NIMH is supporting the inclusion of an over sampling of elderly suicide cases, and questions regarding depressive symptoms to be asked of informants about all suicides. This will be the first study of a national sample of elderly suicides that documents their possible depression and their health service use.

In addition to serving as the NIMH contact for this survey, I serve as Chair of the NIMH Suicide Consortium. The purposes of the consortium are to monitor and encourage research program development in suicide across the life span, keep abreast of scientific developments in suicide research, convene workshops to help the field determine new directions to go, and to disseminate scientific knowledge to the public, media, and policy makers. Two NIMH Fact Sheets, one describing current statistics and risk factors for all age groups, and a second focussed on elderly suicide, are examples of the type of public information documents and Internet web-site pages that have been prepared for public dissemination. These documents are in the public domain, and are freely reproduced for use by clinicians, social service providers, professional and lay organizations, and the general public. Copies are attached to this statement.

I would now like to highlight some of what we have learned about suicide. Research has clearly demonstrated that almost all people who kill themselves have at least one diagnosable mental or substance abuse disorder. We know this from data gathered through the use of the psychological autopsy method. Analogous to the physical

autopsy, where organ systems are examined for the purpose of establishing diagnoses of major physical illness, the psychological autopsy uses interview data from family, friends, coworkers, classmates and others to develop a psychological profile and to establish diagnoses of mental disorders. Studies using the psychological autopsy method have consistently documented that nearly 90 percent of those who commit suicide have at least one diagnosable psychiatric condition.

From physical autopsy studies, altered levels of the neurotransmitter serotonin have been found in suicide completers. Similarly, depressed persons, those with extreme impulsivity, and persons who have made violent suicide attempts also have altered serotonin. Psychological autopsy results have also indicated that adverse life events can contribute to suicide risk. Other risk factors that have been identified include family history of violent behavior, mental disorder, or suicide, and exposure to the suicidal behavior of others. Therefore, our current scientific picture of suicide risk suggests that acute stress, in combination with mental disorder, family history, exposure to suicide, and biological risk factors, can result in a significant risk profile.

It is important to note that these are statistical associations only. Suicidal behavior is not the typical response to stress. Many people experience a number of these risk factors, and do not kill themselves.

In a 1992 NIMH workshop on suicide across the life course, researchers further focussed on what may be unique among older suicides, relative to middle-aged and younger suicides. A key finding was that the most common psychiatric disorder among elderly suicides is major depression, most often a first episode. This is in striking contrast to younger suicides, where substance use and other psychiatric disorders are more common. Moreover, this first episode of depression is typically characterized by the absence of complicating factors such as psychosis or mania, and it tends to be of moderate severity. This type of depression is, classically, the most amenable to treatment.

Tragically, however, recognition of depression and initiation of treatment among elderly suicide victims has been rare. This is not due to social isolation or withdrawal. Research has shown that most elderly suicide victims either live with family members or are in contact with family members and friends. We also know that access to health care is not a problem among elderly suicides: At least 70 percent of these older suicide victims have visited primary care providers within a month of the suicide. Virtually none have seen mental health professionals, and very few have ever received mental health treatment, including treatment for depression from their primary care physicians.

The clear implication from these findings is that a great opportunity to prevent suicide lies at the primary care office doorstep. Unfortunately, we know that primary care physicians tend to allot less time with older patients on average, and that they frequently do not recognize nor adequately treat depression in their older patients. But physicians should not get all of the blame: Older patients are less likely than their younger counterparts to tell their doctor that they feel depressed. There may be many reasons for this pattern: stigma over mental illness, or a tendency to verbalize physical pain more easily than emotional pain. In addition, older persons, as well as their family members, may hold "ageist" attitudes that consider depression a normal reaction to growing old.

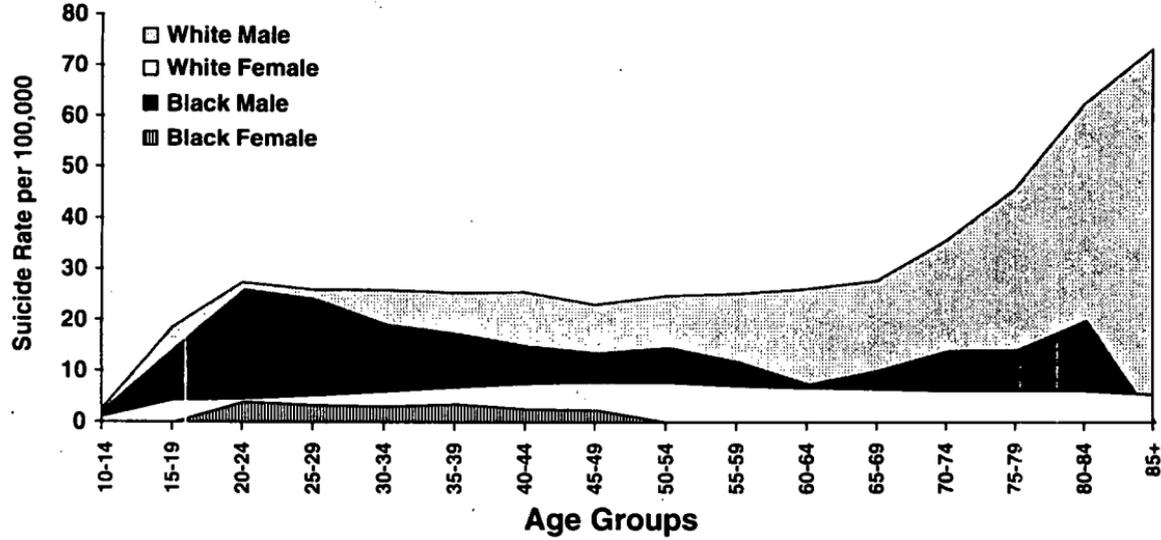
Fortunately the ground work establishing the fact that depression in late life is not normal, and that it is treatable, is in place. The *1991 NIH Consensus Development Conference on Late Life Depression* (published summary attached) identified effective treatments, which have been incorporated into the *Clinical Practice Guidelines for Depression for Primary Care Physicians*. One of the next policy and practice challenges is similar to that of all mental health treatments: How to integrate effective treatment in health care settings where primary care physicians are increasingly asked to take on more responsibilities. This task is particularly critical for the recognition and treatment of depression in the elderly, as most elderly seek help from primary care physicians and not mental health professionals.

In addition to examining the mental disorders and service use patterns among older persons who suicide, the NIMH is also supporting research to help build a basic and clinical research base about the neurobiology of aging, depression and suicide. NIMH is not alone in these efforts: We work in a coordinated manner with other NIH components in a concerted effort to apply the basic and behavioral neurosciences to disorders of brain and behavior. New technologies are helping us understand the possible biological and neurobehavioral vulnerabilities that increase risk for depression and suicide. New approaches to brain imaging are allowing us to characterize the structure and function of specific neurotransmitter systems. New approaches in molecular biology and behavioral pharmacology are allowing us to develop experimental models of these self-destructive behaviors and to pilot test potential treatments. Associations between alterations in the serotonin system and completed suicide, violent suicide attempts, impulsive disorders, and depression continue to be important avenues of investigation. Alterations in the serotonin system have also been proposed to occur with normal aging, raising the question as to whether a neurobiological vulnerability occurs with aging, which may interact with other vulnerabilities and stressors.

Suicide research must continue on many fronts. More studies utilizing the psychological autopsy method can help clarify what factors converge to create suicide risk. More research from the laboratory should help us better understand the contribution of serotonin. Studies based in hospitals and outpatient clinics, where the psychiatric diagnoses can be best characterized and where older suicide attempters can be studied, are needed. In the community setting, more research on the role of life events, service use, and patterns of depressive symptoms that appear in the elderly should be done. Finally, given our current state of knowledge about the role of major depression in late life suicide, we need to urgently find effective ways to educate older persons and their families, and health care providers who are most likely to interface with older persons (ie., primary care physicians), about how to detect and treat late life depression.

In closing, I would like to emphasize that suicide is a multi-determined event. We are still unable to adequately predict who will and who won't commit suicide. We do not know enough about what protects people from acting on suicidal thoughts. We do know, however, that most elderly suicide attempts and completions are expressions of extreme distress, and that they rarely occur in the absence of depression. Suicide is a public health issue of concern for the individual, the family, and the community. It deserves our full and active attention as researchers, clinicians, educators and policy makers. The NIH is committed to continue to pursue an aggressive program of research in this area.

Suicide Rates By Age Group, 1993



Source: National Center for Health Statistics

SUICIDE FACTS

Completed suicides, U.S., 1993

- Suicide is the 9th leading cause of death in the United States, accounting for 1.4% of total deaths
- The 1993 age-adjusted rate was 11.3/100,000, or 0.0113%
 - Only 1.4% of total deaths were from suicide. By contrast, 33% were from diseases of the heart, 23% were from malignant neoplasms, and 6.6% from cerebrovascular disease, the three leading causes
- Suicide by firearms is the most common method for both men and women, accounting for 61% of all suicides
- More men than women die by suicide
 - The gender ratio is over 4:1
 - Over 72% of all suicides are committed by white men
 - Nearly 80% of all *firearm* suicides are committed by white men
- The highest suicide rates are for persons over 65; however, it is not a leading cause of death in this age group
 - The 1993 suicide rate for white men over 85 was 73.6/100,000
- Suicide is the third leading cause of death among young people 15 to 24 years of age, following unintentional injuries and homicide. In this age group:
 - Suicide rates are lower than for any other group except children less than 14 years of age
 - The rate was 13.5/100,000 in 1993, up from 13.0/100,000 in 1992
 - The total number of deaths in 1993 was 4,849, compared with 31,102 for all ages
 - The gender ratio was 5.5:1 (men:women)
- Among young people 15 to 19 years of age the suicide rate was 10.9/100,000 in 1993
 - The total number of deaths was 1,884, compared with 31,102 for all ages
 - Rates among both young women and young men in this age group have increased since 1979; rates for young men have increased at a greater rate than rates for young women
 - The gender ratio was over 4.6:1 (men:women)
- Among young people 20 to 24 years of age the suicide rate was 15.8/100,000 in 1993, up from 14.9/100,000 in 1992
 - The total number of deaths was 2,965, compared with 31,102 for all ages
 - Rates increased in 1993 for both young men and young women
 - The 1993 gender ratio was 6.1:1 (men:women)

Research Findings

Suicide is a complex behavior. The risk factors for suicide frequently occur in combination

- Scientific research has shown that almost all people who kill themselves have a diagnosable *mental or substance abuse disorder*; the majority have more than one disorder
- Basic research has shown that alterations in neurotransmitters/neuromodulators such as serotonin can increase risk for suicide. These altered levels have been found in patients with depression, violent suicide attempts and impulsive disorders, and also in postmortem brains of suicide victims.
- Adverse life events in combination with other strong risk factors such as mental or substance abuse disorders and impulsivity, may lead to suicide. However, suicide and suicidal behavior are not normal responses to the stresses experienced by most people. Many people experience one or more risk factors and are not suicidal

More Research Findings

- Familial factors in highly dysfunctional families can be associated with suicide
 - Family history of mental or substance abuse disorder
 - Family history of suicide
 - Family violence, including emotional, physical, or sexual abuse
- Other risk factors include
 - Prior suicide attempt
 - Firearm in the home
 - Incarceration
 - Exposure to the suicidal behavior of others, including family members, peers, and/or via the media in news or fiction stories

Attempted Suicides

- No national data on attempted suicide are available; reliable scientific research, however, has found that:
 - There are an estimated 8-25 attempted suicides to one completion; the ratio is higher in women and youth and lower in men and the elderly
 - More women than men report a history of attempted suicide, with a gender ratio of about 2:1
 - The strongest risk factors for attempted suicide in adults are depression, alcohol abuse, cocaine use, and separation or divorce
 - The strongest risk factors for attempted suicide in youth are depression, alcohol or other drug use disorder, and aggressive or disruptive behaviors
- The majority of suicide attempts are expressions of extreme distress that need to be addressed, and not just a harmless bid for attention

Prevention

- Because suicide is a highly complex behavior, preventive interventions must also be complex and intensive if they are to have lasting effects over time
- Based on reliable findings from scientific research, recognition and appropriate treatment of mental and substance abuse disorders is the most promising way to prevent suicide and suicidal behavior in all age groups
- Because most elderly suicides have visited their primary care physician in the month prior to their suicides, recognition and treatment of depression in the medical setting is a promising way to prevent elderly suicide
- Limiting young people's access to firearms and other forms of responsible firearms ownership, especially in conjunction with the prevention of mental and addictive disorders, also may be beneficial avenues for prevention of firearm suicides
- Most school-based, information-only, prevention programs focused solely on suicide have *not* been evaluated to see if they work
 - New research suggests that such programs may actually increase distress in the young people who are most vulnerable
- School and community prevention programs designed to address suicide and suicidal behavior as part of a broader focus on mental health, coping skills in response to stress, substance abuse, aggressive behaviors, etc., are most likely to be successful in the long run
- All suicide prevention programs need to be scientifically evaluated to demonstrate whether or not they work.

National Institute of Mental Health

Fact Sheet:

Mental Disorders of the Aging Research Branch
Barry D. Lebowitz, Ph.D., Chief

Suicide in the Elderly

Alcohol, Drug Abuse and Mental Health Administration
Public Health Service
U.S. Department of Health and Human Services

Suicide is the eighth leading cause of death in the United States; over 30,400 people take their own lives each year. One person commits suicide every 17.3 minutes, over 83 per day. Perhaps as many as five million Americans have attempted to kill themselves. When suicide is discussed as a public health problem, emphasis is often placed upon the incidence among youth and young adults, a group accounting for 15.2% of the population and 16.2% of the suicides. However, less attention is paid to the startling fact that the highest rates of suicide actually are among the elderly, those over the age of 65. While representing only 12.4% of the population, older people take their own lives at a rate of 21%, a rate higher than found among members of any other age group in our nation.

Over the course of the century, the suicide rates for the elderly have fluctuated widely. While the long-term trend has been downward, the past decade has shown an increase, though not yet to the levels encountered in the decade between 1930-1940. As our nation as a whole ages, the elderly have become the fastest growing segment of the population. When the large group of "baby boomers" reach old age, the absolute number of elderly suicides will likely rise sharply. Experts believe that to avoid a virtual epidemic of late life suicide, each of us must be better able to identify and help the people at risk.

A profile of the older person at risk

At all ages, men are more likely than women to commit suicide. Among the elderly, however, the difference becomes even more pronounced. In the general population, suicide rates for males are about four times that of females; among the "old-old" (age 75 and over), men have rates up to 13 times higher than women. Across the age spectrum, whites are at nearly 10 times the risk of nonwhites. However, distinctions by race are substantially diminished with increased age.

Sex, race, marital status and socioeconomic status are not the only factors implicated in suicide. Indeed, the decision to take one's own life is based on a complex constellation of factors. Among the elderly, three of these other risk factors, often working together include loss, physical illness and depressive disorder.

Loss: The elderly frequently encounter multiple losses in biological as well as psychosocial arenas. Greying hair and wrinkled skin are experienced by some as a loss of vitality; retirement may mean a loss of income, power and culturally sanctioned roles. Physical relocation, whether cross-country, to a neighboring community or to a nursing facility, may radically alter social patterns and networks. Friends and family die. The loss of a spouse can be

an especially devastating event, increasing the risk for suicide by coupling loss and grief with isolation and loneliness. As a whole, the fear of becoming institutionalized or otherwise dependent on others, with the associated loss of physical integrity and autonomy, are common themes among elders who have contemplated, attempted or completed suicide.

Physical ill health: Numerous studies have found that deteriorating health is common among the suicidal elderly. The illnesses most closely linked are cancer, ulcers, brain disorders such as stroke or seizure, musculoskeletal disorders (such as arthritis), and bladder and prostate problems. For some terminally ill patients, suicide results from a reasoned choice of death over protracted illness. However, studies have shown that such circumstances are rare. The vast majority of patients with terminal illness do not choose to commit suicide, and those who are suicidal almost invariably have an associated severe clinical depression.

Depressive illness: Among the factors making the elderly vulnerable to suicide, mental illness is one of the most salient. Research has consistently shown that from 66-90% of persons taking their lives suffered from a diagnosable psychiatric illness at the time of death, most often a syndrome known as "clinical depression" or "major depression." Studies have found that up to 87% of elderly persons attempting or completing suicides were suffering from a form of this illness. Ironically, many effective treatments are available to treat depressive illness. Had their illness been detected and treated vigorously, suicide may well have been avoided.

Although substance abuse is less frequent among the elderly than among the young, it remains a major contributor to suicidal behavior. Older persons who commit suicide frequently have abused alcohol, or prescription sedatives and painkillers.

Suicide signals

Because clinical depression is so common in suicidal elderly, its early recognition can help to identify the majority of those at risk. Typical symptoms include thoughts of suicide, feelings of sadness, guilt and hopelessness, loss of interest in usually pleasurable activities, loss of appetite and energy, and sleep difficulty. In its most severe forms, the syndrome is easily recognized and should be treated by trained professionals. However, older people are often reluctant to see psychiatrists or other mental health personnel, whether as the result of fear or financial concerns. Instead, most suicidal elderly emphasize physical complaints to the exclusion of mood change, frequently visiting their family doctors for treatment of aches and pains actually symptomatic of the underlying depressive illness. Thus, exaggerated physical complaints may also be a signal of suicide risk. In fact, as many as three quarters of geriatric suicides have visited their personal physician within a month prior to the suicide or attempt.

People who make even vague comments about suicide or a desire to be dead should always be taken seriously. This is especially true for the elderly, who appear to make fewer attempts but use more lethal means to end their lives.

Studies have shown that over half of geriatric suicide victims have indicated their intent to others, but that such comments usually were not heeded. When statements about suicide are accompanied by changes in behavior, such as giving away possessions or changing a will, the risk of suicide is greatly increased.

How to help

Once identified as being at risk, the suicidal person should be evaluated professionally. In the most dire cases, when the individual is at or near the

point of harming himself, emergency rooms and hotlines are available to intervene quickly. Where time permits, evaluation and treatment are also available through local mental health centers and in the private offices of mental health professionals. However, because the elderly tend not to self-refer to either mental health professionals or suicide prevention/crisis intervention services, family members, friends and services personnel who come in contact with older persons should be particularly vigilant.

A suicidal person may resist helping interventions; hopelessness is a part of the suicidal state. Moreover, depressive illness may cloud judgment. Complicating the situation still further are the facts that treatment may be perceived by the elderly as stigmatizing or financially prohibitive. Ironically, many of the conditions that may cause older people to feel suicidal can be treated by qualified professionals. With professional help that provides hope that both physical and psychological pain will lessen, the suicidal person usually will choose life.

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7/91

Diagnosis and Treatment of Depression in Late Life

NIH Consensus Development Panel on Depression in Late Life

DEPRESSION in the aging and the aged is a major public health problem. It causes suffering to many who go undiagnosed, and it burdens families and institutions providing care for the elderly by disabling those who might otherwise be able-bodied. What makes depression in the elderly so insidious is that neither the victim nor the health care provider may recognize its symptoms in the context of the multiple physical problems of many elderly people. Depressed mood, the typical signature of depression, may be less prominent than other depressive symptoms such as loss of appetite, sleeplessness, anergia, and loss of interest in, and enjoyment of, the normal pursuits of life. There is a wide spectrum of depressive symptoms as well as types of available therapies.

Because of the many physical illnesses and social and economic problems of the elderly, individual health care providers often conclude that depression is a normal consequence of these problems, an attitude often shared by the patients themselves. All of these factors conspire to make the illness underdiagnosed and, more important, undertreated.

During the past decade, significant progress has been made in understanding the diagnosis, treatment, and de-

sign of systems for providing service for depression in late life; however, important questions remain unanswered, and large numbers of depressed elderly people go untreated. The purpose of this consensus development statement is to examine what is known of the epidemiology, pathogenesis, pathophysiology, prevention, and treatment of depression in the elderly and to alert both the professional and lay public to the seriousness of depression in late life, to its manifestations and useful treatments, and to areas needing further study or research.

To help resolve questions surrounding these issues, the National Institute of Mental Health in conjunction with the Office of Medical Applications of Research and the National Institute on Aging of the National Institutes of Health convened a Consensus Development Conference on the Diagnosis and Treatment of Depression in Late Life from November 4 through 6, 1991. Following a day and a half of presentations by experts in the relevant fields and discussion from the audience, a consensus panel, chaired by Arnold J. Friedhoff, MD, and comprising experts in psychiatry, psychology, neurology, nursing, social work, internal medicine, epidemiology, and statistics, as well as a public representative, considered the scientific evidence and formulated a consensus statement in response to the following six questions:

1. How does depression in late life differ from depression earlier in life? What are the sources of heterogeneity within late-life depression?
2. How prevalent is depression in the elderly and what are its risk factors?
3. What constitutes safe and effective treatment for

NIH Consensus Development Conferences are convened to evaluate available scientific information and to resolve safety and efficacy issues related to a biomedical technology. The resultant NIH Consensus Statements are intended to advance understanding of the technology or issue in question and to be useful to health professionals and the public.

NIH Consensus Statements are prepared by a nonadvocacy, nonfederal panel of experts based on (1) presentations by investigators working in areas relevant to the consensus question during a 1½-day public session; (2) questions and statements from conference attendees during open discussion periods that are part of the public session; and (3) closed deliberations by the panel during the remainder of the second day and the morning of the third day. This statement is an independent report of the panel and is not a policy statement of the NIH or the federal government.

From the Office of Medical Applications of Research, National Institutes of Health, Bethesda, Md.

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Note for JAMA publication:

"Late life" has not been precisely defined in this statement, first of all because there are wide individual differences in self-perception of one's own stage of life. Secondly, the terms "late life," "geriatric," and "aged" are used differently by different investigators; thus, references to these terms do not reflect identical age periods. In general, however, the panel used "late life" to refer to individuals 65 years of age or older.

late-life depression? What are the indications and contraindications for specific treatments?

4. What are the patterns of health services use for late-life depression? What are the obstacles to the provision of adequate treatment?

5. What are the benefits of recognizing and adequately treating depression in late life? What are the consequences of unrecognized or inadequately treated depression in late life?

6. What are the most promising questions for future research?

The following is the panel's report.

1. How Does Depression in Late Life Differ From Depression Earlier in Life? What Are the Sources of Heterogeneity Within Late-Life Depression?—The term "depression" has been variably used to describe a symptom, a syndrome, or a disease. In the present consensus statement, depression is used in the broad sense to describe a syndrome that includes a constellation of physiological, affective, and cognitive manifestations. As listed in the current American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised (DSM-III-R)*, criteria for the diagnosis of depression include (1) changes in appetite and weight; (2) disturbed sleep; (3) motor agitation or retardation; (4) fatigue and loss of energy; (5) depressed or irritable mood; (6) loss of interest or pleasure in usual activities; (7) feelings of worthlessness, self-reproach, excessive guilt; (8) suicidal thinking or attempts; and (9) difficulty with thinking or concentration. Depression may range in severity from mild symptoms to more severe forms that include delusional thinking, excessive somatic concern, and suicidal ideation, over longer periods of time. The *DSM-III-R* requires the presence of at least five of the symptoms listed above for a diagnosis of a major depressive episode. Concurrent medical conditions are frequently present in elderly persons and should not preclude a diagnosis of depression.

The recognition of depression may be more difficult in late compared with early life. In the elderly age group, both clinicians and patients may incorrectly attribute depressive symptoms to the aging process. They may not fully appreciate the degree of impairment because of lower functional expectations in the postretirement years. The particular constellation of symptoms may differ because elderly persons may more readily report somatic symptoms than depressed mood. Because both the patient and the evaluating clinician are often more concerned about concurrent medical conditions, depressive symptoms may be overlooked. Finally, the concomitant presence of dementia may compromise accurate recognition and reporting of symptoms. As a result, depression is often underdiagnosed in elderly people, despite a high frequency of potentially treatable depressive symptoms.

Depression in late life frequently coexists with multiple chronic diseases and disabilities, for example, cancer, cardiovascular disease, neurological disorders, various metabolic disturbances, arthritis, and sensory loss. These conditions create psychosocial concerns, medical and physiological burdens, and functional disabilities that may directly contribute to the pathogenesis of depressive symptoms as well as complicate treatment. However, cur-

rent data indicate that depressive symptoms may respond to treatment in many of these patients.

Depression in late life occurs in the context of numerous social, developmental, and biological diversities. Advancing age is accompanied by loss of important social support systems due to death of spouse or siblings, retirement, or relocation of residence. At the biological level, there is variability in the regulation of homeostasis, organ system reserve, immunologic responsiveness, and body composition. These sources of heterogeneity have major implications for risk of illness, diagnosis, and treatment. For example, levels of antidepressant drugs and toxic metabolites may be disproportionately increased in the "old-old," making this subgroup particularly vulnerable to adverse side effects.

The presentation of the depressive syndrome may be heterogeneous with regard to constellation of symptoms, age at onset, and course. For example, elderly depressed patients may have experienced their first episode of depression either early or late in life. There is some evidence to suggest that late-onset depression is associated with a lower frequency of family history of depression but a higher frequency of cognitive impairment, cerebral atrophy, deep white matter changes, recurrences, medical comorbidity, and mortality. A combination of cross-sectional and longitudinal studies will be required to clarify the underlying biology and natural history of various subtypes of depression, including early- vs late-onset depression in elderly persons.

Despite an intensive search for biological and structural correlates of late-life depression, no specific diagnostic test can be recommended for clinical practice. Impaired dexamethasone suppression of the hypothalamic-pituitary-adrenal axis is observed in late-life depression but is not sufficiently specific to have diagnostic use. Similarly, response to thyroid-stimulating hormone, platelet monoamine oxidase activity, and platelet imipramine and α_2 binding may be altered nonspecifically in a subset of patients. Clearly, further research is needed to refine diagnosis; at the present time, an attentive and focused clinical interview remains the mainstay for the evaluation and diagnosis of depression.

2. How Prevalent Is Depression in the Elderly and What Are Its Risk Factors?—According to the Epidemiologic Catchment Area Study, depressive symptoms occur in approximately 15% of community residents over 65 years of age. The prevalence of major depression among the elderly living in the community is usually estimated at less than 3%. The rates of major or minor depression among elderly people range from 5% in primary care clinics to 15% to 25% in nursing homes. The rates of new cases of depression in nursing homes are striking: 13% of residents develop a new episode of major depression over a 1-year period, and another 18% develop new depressive symptoms.

Estimates of the frequency of depression in the elderly exhibit wide variability due to the source of the sample, definition of depression, method of assessment, and experience of the rater. Epidemiologic studies provide critical information on the magnitude of depression in the general population and on the treatment patterns among depressed elderly. There is a sharp drop in the rates of

treatment of depression among the elderly compared with younger adults. By one estimate, only about 10% of the elderly who are in need of psychiatric treatment ever receive this service.

The major social and demographic risk factors for depression in the elderly are generally similar to those of younger age groups: women; the unmarried, particularly the widowed; those with stressful life events; and those who lack a supportive social network have elevated rates of depression. In elderly people, the co-occurrence of physical conditions (eg, stroke, cancer, dementia) and depression has been confirmed in numerous studies. Although depression may be an effect of such coexistent disorders, it might also enhance vulnerability to certain illnesses, particularly of the immune system.

The course of depression in elderly people is similar to that in younger people. Recurrence is a serious problem—up to 40% of people continue to experience depression over time.

Longitudinal studies show that mortality rates by suicide and other causes are higher among elderly persons with depression compared with their nondepressed counterparts. This increased mortality cannot be completely accounted for by sociodemographic factors and preexisting physical illnesses. Some studies suggest that depression may increase the risk of death in unknown ways.

The rate of completed suicides for older people was higher than that of the general population in 1988. For example, although suicide rates in the general population were 12.4/100,000, rates in 80- to 84-year-olds were 26.5/100,000 persons. Elderly white men are at highest risk. More than three fourths of these persons had visited a primary care physician within the month before their suicide. Generally, they were suffering from their first episode of major depression, which was only moderately severe, yet the depressive symptoms went unrecognized and untreated.

3. What Constitutes Safe and Effective Treatment for Late-Life Depression? What Are the Indications and Contraindications for Specific Treatments?—Given its pernicious effects, most agree that a major depressive episode or recurrent depressive illness requires treatment in all age groups, including the elderly. What is not as readily apparent is the need for treatment of less severe or reactive depressions. These conditions negatively affect quality of life and are associated with increased risk of comorbid medical illnesses and clinical depression. Consequently, they should not be discounted as "normal and acceptable" features of aging and do warrant the early attention of clinicians.

The goals of treatment for depression include (1) decreasing symptoms of depression, (2) reducing risk of relapse and recurrence, (3) increasing quality of life, (4) improving medical health status, and (5) decreasing health care costs and mortality. The two major categories of treatment for depression include biological therapy (eg, pharmacotherapy, electroconvulsive therapy) and psychosocial therapy. At the present time, by far the largest body of data is available for biological therapy. Clearly, more research is needed for psychosocial as well as combined biological and psychosocial therapies. These studies should address compliance, side effects, quality of life, and

relief of depressive symptoms; they should also identify which subgroups of patients are more likely to benefit from specific therapies.

Pharmacotherapy: Treatment of Acute Depression.—There is now evidence from approximately 25 randomized, double-blind trials that antidepressants are more effective than placebo in the treatment of acute depression. Approximately 60% of patients clinically improve, but many of them retain significant residual symptoms.

Available information from randomized, controlled clinical trials in elderly patients is meager compared with that for younger patient groups. The number of patients in research studies drops off sharply after the sixth decade of life. There are very few studies of treatment of depression in the very old (80+ years), one of the most rapidly growing segments of our population. Therefore, clinical recommendations are primarily extrapolated from experience with young or middle-aged adults or based on a small number of elderly patients. There also is little research with elderly medically ill depressed patients; therefore, available evidence may be difficult to generalize to typical elderly patients presenting for treatment in clinical settings.

Most of the antidepressants are thought to be equally effective in elderly adults. The most commonly used and studied antidepressants have been nortriptyline and desipramine because they have a more favorable side effect spectrum than traditional antidepressants such as amitriptyline and imipramine. Most clinicians avoid these latter two medications because they cause significant orthostatic hypotension, which can lead to falls and fractures, and because elderly patients are especially sensitive to their anticholinergic, cardiovascular, and sedative side effects.

Based primarily on clinical experience, many clinicians favor the newer antidepressants trazodone, bupropion, and fluoxetine because they have fewer anticholinergic and cardiovascular side effects. Contrary to widespread clinical opinion, the use of monoamine oxidase inhibitors, especially phenelzine, has been generally found to be safe and effective, but they have not been widely used for the treatment of geriatric depression.

There also is little known about patient factors that predict response, including clinical symptoms, demographics, subtype, comorbidity, or radiologic findings. However, there is considerable evidence that response depends on adequate length of treatment, dose, and blood level of medication. Significant antidepressant response in elderly patients often occurs later than in younger patients and requires at least 6 to 12 weeks of therapy.

Full clinical response is primarily dependent on achieving therapeutic doses that produce adequate blood levels. The measurement of plasma levels in elderly patients is even more important than in younger patients because of the increased importance of attaining appropriate therapeutic levels but remaining below levels associated with toxicity. Medication compliance by elderly people is especially important and difficult. It has been estimated that 70% of patients fail to take 25% to 50% of their medication. Lack of compliance, producing wide fluctuations in plasma levels, has been shown to be predictive of poor outcome.

Maintenance Treatment.—There is an increasing recognition that the majority of major depressions are recurrent; therefore, the central issue in treatment is the prevention of recurrence. Although there are relatively few clinical trials of maintenance treatment in elderly patients, continuation of antidepressants has been shown to confer significantly greater protection against recurrence than placebo. Although clinicians often reduce doses during the maintenance phase, preliminary evidence suggests that continuation of the dose and plasma level that was effective in the acute treatment phase offers increased protection against recurrence. Evidence suggests that treatment should be maintained for 6 months after remission from a first episode of major depression and 12 months or longer after a second or third episode. Approximately 80% of patients maintained on doses that lead to their recovery maintain their remission over extended follow-up.

Electroconvulsive Therapy.—Electroconvulsive therapy (ECT) has an important role in the treatment of depression in elderly adults. The most recent study conducted by the National Institute of Mental Health indicated that patients over 61 years old constitute the largest age group who receive ECT. The evidence for short-term efficacy of ECT is strong. However, relapse after effective ECT is frequent, and alternative treatment strategies, including maintenance ECT or maintenance antidepressants following ECT, require further study. Electroconvulsive therapy is often stated to be safer than antidepressants, although this has not been documented in controlled trials. Limited data suggest that advancing age heightens the probability of transient post-ECT confusion, especially in the very old. Additional risk factors include receiving psychotropic medication during ECT, concurrent major medical illness, and preexisting cognitive deficits.

Psychosocial Treatments.—A comprehensive system of care necessitates the inclusion of psychosocial treatments because of the broad range of functional and social consequences of depression in elderly people. Biological treatments will not be able to resolve all of the problems associated with depression in the elderly. For example, significant and continuing life events, altered life roles, lack of social support, and chronic medical illnesses might well require psychosocial support and new coping skills. Also, some patients will strongly prefer nonbiological interventions, and others will not be suitable for biological treatment because of side effects, interactions between drugs, and comorbid medical conditions.

There is only a handful of controlled studies on the efficacy of psychosocial interventions with elderly people dealing primarily with cognitive behavior therapy, behavior therapy, interpersonal therapy, and short-term psychodynamic therapy. These treatments are all moderately effective and have durable effects with outpatient volunteers in comparatively good physical health. There are no clear comparisons with placebo or pseudotreatment control groups, with the old-old, or with medically ill elderly.

Marital and family interventions have not been adequately studied. Marital therapy has been found to be effective in treating depression in younger adults, and social support is a particularly important factor for elderly people. There are some promising strategies for treatment of family care givers of the frail elderly, who themselves

often experience high levels of burden and are highly vulnerable to depression.

A number of problems in the use of psychosocial treatments require study. Many elderly people do not see themselves as depressed and/or will not admit to it and reject referrals to mental health professionals. Special effort might be needed to engage these individuals in treatment. Patients with significant physical illness and disabilities (eg, visual and hearing impairment) and cognitive impairment may require special approaches. Special consideration should also be given to the dissemination of any programs that prove effective so that therapists and care givers to the elderly are sensitized to the ability of elderly people to respond to active psychosocial interventions. Senior centers, nutrition programs, volunteer services, and other community-based programs should be integral components of any comprehensive psychosocial intervention system.

Special Populations.—The evidence is contradictory concerning whether concurrent medical illness has an adverse effect on response to pharmacotherapy. Although medical comorbidity probably results in increased vulnerability to side effects, vigorous but careful treatment is still indicated. However, there are very few controlled trials of treatment of secondary depressions after the medical condition is stabilized. Also, patients with known brain lesions should be treated with the same guidelines and doses as patients without known brain lesions, except as specifically contraindicated. Based on the limited data available, these patients can be expected to respond as well as patients with primary depressions.

The prevalence of major depression in nursing home populations is high and is generally unrecognized and untreated. These patients respond equally well to standard doses of antidepressants, although their medical fragility can lead to treatment-limiting side effects in as many as one third of these patients.

About 800 000 persons are widowed each year, most of whom are old and experience varying degrees of depressive symptoms. Most do not need formal treatment, but those who are moderately or severely dysphoric appear to benefit from self-help groups or various psychosocial treatments. Remarkably, a third of widows and widowers meet criteria for a major depressive episode in the first month after the death, and half of these remain clinically depressed 1 year later. These depressions respond to standard antidepressants, although there is limited research as to when in the course of these depressions antidepressant medications should be instituted or how medications should be combined with psychosocial treatments.

4. What Are the Patterns of Health Services Use for Late-Life Depression? What Are the Obstacles to the Provision of Adequate Treatment?—The majority of older adults living in the community (approximately 85%) are seen by a primary care physician at least once a year, yet, at the same time, it is known that there is considerable unrecognized, undiagnosed, and untreated depression among these people. Why is this so? A number of factors are implicated. There is first the stigma attached to mental illness and psychiatric treatment, a stigma still powerful among the elderly and often shared by members of their family, friends, and neighbors. There is also the

character of the condition itself: depressed older people may not report depression because they have no hope for help.

There are "ageist" attitudes among health care providers: sometimes these attitudes are expressed in a relative unwillingness to listen to older people, and sometimes ageist attitudes are reflected in professional pessimism, in the belief that depression is a natural accompaniment of old age, and in actual aversion to having older people as patients.

Older people often do not present their complaints to their primary care physicians in ways that make the diagnosis and treatment of depression straightforward. If the clinicians recognize that their patients are depressed and do need treatment, the intervention may often be limited. There also are problems of compliance: older patients and their families may not understand depression and its course and the importance of taking medications as prescribed. Or, they may become noncompliant because of drug-induced side effects.

Other factors may compromise the prescribed medical regimen: concurrent medical illnesses can interfere with the antidepressant response or the attainment of adequate dosages. Alcoholism and other substance abuse may undercut pharmacotherapy; unhappy life events—bereavement, poverty, isolation—may adversely affect the patient's motivation to comply.

There are many other obstacles in the way of patients receiving the care they need. There is the lack of linkages between the health care, mental health, and social service systems and the diversity of the professionals staffing these systems—primary care physicians, psychiatrists, psychologists, nurses, social workers, pastoral counselors, and the like. There also is the complexity of the systems, with different gates to service, eligibility requirements, funding streams, and methods of payment. These characteristics of our service systems make the search for help an onerous journey and one beyond the capability of many older people.

Although the picture can be a bleak one for the depressed older person in the community, there are even more immediate treatment needs among those in long-term-care settings. For example, among the 1.5 million older people living in nursing homes, the prevalence of depression is high. Despite the special vulnerability among the old in nursing homes and despite the federal regulation that a facility must ensure that "A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services," few nursing homes have the staff capability to intervene in appropriate and timely fashions. In the nursing home, as in the community, depression goes unrecognized, undiagnosed, and untreated.

There are fiscal problems also: high copayments and constraints on reimbursement may limit the interest of providers and institutions in Medicare patients. In the long-term-care system, the requirement that there be appropriate treatment for patients with psychological problems does not carry with it funding for the treatment.

The central role that families play in the lives of the majority of older people has been well documented by researchers and is a fact well known to clinicians accus-

tomed to having older patients brought to them by concerned spouses, adult children, and other relatives. Particular attention must be paid to the elderly without families. Essential functions performed by families on behalf of functionally dependent elders (the orchestration of services, help with activities of daily living, etc) must be taken over by others (eg, staff and volunteers of neighborhood-based social agencies).

What can be done to ensure that depressed older people have access to the mental health care they need?

- All health care providers should participate in continuing education programs designed to increase their knowledge about, and skill in, recognition of depression and their skill in initiation of treatment. These educational programs should include attention to ageist attitudes. Particular emphasis should be placed on necessity of referral to mental health specialists at various points in the treatment continuum.

- Resources must be invested in outreach and case-finding initiatives to address the current fragmentation within our system of providing care, making case recognition a feasible goal. Special efforts should be directed at outreach and case identification in minority communities, where the elderly may have particular problems in securing the help they need. The professionals cannot wait for depressed older people to come to them; they must instead be active and aggressive in their efforts to reach those in need of help. Multidisciplinary research and treatment teams are recommended to address the critical needs of depressed elderly people.

- Training programs for care providers, including nursing staff and "hands on" staff, in both community and institutional settings must be directed at identification of the behavioral manifestations of depression and improvement of the care provided.

- Innovative models for outreach and the provision of social services, including adult day care and senior citizens programs, should be encouraged, and information about them should be disseminated to professionals and other staff engaged in provision of mental health services to the elderly.

5. What Are the Benefits of Recognizing and Adequately Treating Depression in Late Life? What Are the Consequences of Unrecognized or Inadequately Treated Depression in Late Life?—The ability to think, to feel, to interact with others, to share a sense of purpose, to work, to love, to experience gratification, to care for others, and to maintain self-responsibility are precious human attributes that elderly people strive to maintain. In few circumstances are these elements of our experience and capacity so broadly and deeply challenged as with depressive disease.

Depression in mild and severe forms afflicts substantial numbers of our elderly population. Failure to realize that their despair is an illness deprives the person of insight into his or her condition and prevents seeking of help. The unwitting acceptance by society of depression as natural to aging closes the door of opportunity for gaining effective intervention.

There are clear and specific benefits to recognizing and treating depression in older people. The evidence to date, though not always specifically derived from the elderly, is

compelling in the following ways: (1) Treatments of demonstrated efficacy in young and middle-age adult cohorts are also effective in elderly cohorts; (2) ECT and drug treatments can be safely administered to most patients with advantageous benefit/risk ratios; (3) psychosocial aspects of care are essential, and preliminary study of some forms of psychosocial therapy supports their use; and (4) depression tends to be long-lasting in elderly adults, even when it begins in the wake of serious personal loss or physical illness, and the mortality rate is high. A wait-and-see approach is not tenable in moderate and severe depression and may be undesirable even in mild cases. Treatment will not be effective in all cases, but the majority will receive substantial therapeutic effect with the following benefits:

- Partial or complete remission of the broad range of symptoms associated with depression.
- Amelioration of pain and suffering associated with physical illnesses.
- Enhancement of general mental, physical, and social functioning and personal well-being.
- Minimization of cognitive disability, a particular fear in the elderly.

Put simply, depression can ruin a person's life, but treatment is effective.

What are the consequences of failure to recognize and treat depression in elderly people? Many of our senior citizens will live their final years in despair and suffering without any appreciation of their affliction or the understanding and comfort of those most dear to them. Professional help is not often sought or offered, and depression is not likely to be brief. The likely consequences are loss of personal happiness and severe strain on living circumstances. Depression may trigger a shift from home to a nursing facility or may shift the person from a warm and respected friend or loved one to an isolated individual with lost status. Untreated depression costs money because physical illnesses require more medical services, living arrangements become institutional, and employment is lost. These costs should be substantially preventable with presently validated case recognition and treatment techniques. New research data are needed to extend these techniques and to measure social and economic benefits of treatment. Personal benefits of symptom reduction are well documented and compelling.

6. What Are the Most Promising Questions for Future Research?—The questions for future research are 12-fold:

- Improve diagnosis and identification of those elderly persons most likely to benefit from specific treatments—biological, psychosocial, or combinations thereof.
- Clarify the relationship between subcortical brain abnormalities, depressive and cognitive symptoms, and early- vs late-onset depression in the elderly.
- Clarify the pharmacokinetic changes in the very old and the prognostic value of metabolic subtyping.
- Clarify the cause-and-effect relationship between depression and medical illness.
- Initiate prospective cross-sequential studies to identify general risk factors (including life stress and specific illnesses and disabilities) and their relationship to the course of depression.

- Study the basis for differential occurrence of depression and suicide rates in demographic subgroups.

- Determine whether ECT is effective as a continuation and maintenance treatment in late-life depression.

- Study the treatment of pathological grief. Which psychological and pharmacological treatments are effective, and when in the course of grief should they be used?

- Conduct clinical trials and observational studies of treatment in the very old, the elderly in minority and underserved communities and in institutional settings, and the elderly with medical illness.

- Develop and evaluate psychosocial treatments that are specifically linked to the needs of the elderly. Determine how psychosocial and biological treatments may complement or provide alternatives to each other.

- Develop demonstration projects focused on innovative models of providing care, particularly those that emphasize coordinated services and outreach efforts to depressed elderly people.

- Carry out long-term clinical trials with broad-based assessment of outcome (including economic and social impact) to determine the extent to which effective recognition and treatment benefit patients and society.

CONCLUSIONS AND RECOMMENDATIONS

1. Depression in late life occurs in the context of numerous social and physical problems that often obscure or complicate diagnosis and impede management of the illness. There is no specific diagnostic test for depression, so that an attentive and focused clinical assessment is essential for diagnosis. Because elderly depressed people often do not present themselves for evaluation or because their depressive symptoms are not typical, the illness is underdiagnosed and undertreated. This is particularly true when it is secondary to physical illness, even though these secondary depressive symptoms also respond to treatment.

2. Estimates of depression in elderly people vary widely as a function of setting, threshold of diagnosis, and definition of depression; however, there is a consensus that the size of the problem is underestimated. The highest rates are found in nursing homes and other residential care settings. Risk factors appear to operate similarly in young and old, although the hallmark of depression in older people is its comorbidity with medical illness. The course of recovery and frequent recurrence is similar in young and old; however, suicide is dramatically increased in elderly depressed, as is mortality from other causes.

3. Depressed elderly people should be treated vigorously with sufficient doses of antidepressants and for a sufficient length of time to maximize the likelihood of recovery. Maintenance treatment with antidepressants should be continued with the same doses that produced remission of the acute episode. Electroconvulsive therapy is often effective for depression in the elderly but is generally underused or unavailable. Psychosocial treatments can also play an essential role in the care of elderly patients who have significant life crises, lack social support, or lack coping skills to deal with their life situations. These approaches may also be indicated in patients who cannot or will not tolerate biological treatments.

4. The system of care currently provided to elderly

depressed persons is inadequate, fragmented, and passive; ageist attitudes among some health care providers compromise their ability to recognize depression in their elderly patients and to intervene in an appropriate and timely fashion. The prevalence of depression is particularly high among patients in nursing homes, but staff in many of these facilities are not equipped to recognize or treat depressed patients.

5. Families and primary care physicians remain at the front line in recognizing depression and facilitating patient access to professional help; however, large numbers of elderly people live alone, have inadequate support systems, or do not have contact with a primary care physi-

cian. The isolation of these individuals compounds their depression, and specialized efforts are needed to locate and identify them and to provide in-home care relevant to their needs. Although lack of services is a major problem, a greater problem may be our inability to provide services to those community-dwelling elderly people who need them the most.

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Speakers were:

Charles F. Reynolds III, MD: "Overview: Diagnosis and Treatment of Depression in Late Life"
Dan G. Blazer II, MD, PhD: "Epidemiology of Depressive Disorders in Late Life"
Eric D. Caine, MD: "Clinical and Etiological Heterogeneity of Mood Disorders in the Elderly"
Burton V. Rafter, MD, MPH: "Depression: Diagnosis and Comorbidity"
Barry J. Gurland, MD: "The Impact of Depression on Quality of Life of the Elderly"
Elaine Murphy, MD: "The Course and Outcome of Depression in Late Life"
George S. Alexopoulos, MD: "Biological Correlates of Late Life Depression"
Andrew F. Leuchter, MD: "Brain Structural and Functional Correlates of Late Life Depression"
Linda K. George, PhD: "Social Factors and Depression in Late Life"
Paul T. Costa, Jr, PhD: "Depression as an Enduring Disposition"
A. John Rush, MD: "Overview of Treatment Options in the Depressed Elderly"
Carl Salsman, MD: "Pharmacological Treatment of Depression in the Elderly"
James M. Pareil, PhD: "Pharmacokinetics of Therapeutics, Toxic Effects, and Compliance"
Harold A. Sackeim, PhD: "The Use of Electroconvulsive Therapy in Late Life Depression"
Linda Teri, PhD: "Cognitive-Behavior Therapy With Depressed Older Adults"

George Niederehe, PhD: "Psycho-social Therapies With Depressed Older Adults"
Eliot Frank, PhD: "Long-Term Prevention of Recurrence in the Elderly"
Sidney Klerman, MD, PhD: "Meta-analysis on the Diagnosis and Treatment of Depression in Late Life"
Joel B. Greenhouse, MPH, PhD: "Meta-analysis Review From a Psychiatric Statistical Perspective"
Lon S. Schneider, MD: "Meta-analysis Review From a Clinical Researcher Perspective"
Gary L. Gottlieb, MD, MBA: "Barriers to Care of Older Adults With Depression"
Yvette Cornwell, MD: "Suicide in the Elderly"
Sidney Zisook, MD: "Diagnostic and Treatment Considerations in Depression Associated With Late Life Bereavement"
Ira R. Katz, MD, PhD: "Depression in the Residential Care Elderly"

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Senator REID [presiding]. Dr. Rosenberg.

STATEMENT OF DR. MARK L. ROSENBERG, M.D., DIRECTOR, NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL, CENTERS FOR DISEASE CONTROL AND PREVENTION, ATLANTA, GA

Dr. ROSENBERG. Senator Reid, I am Mark Rosenberg, the director of the National Center for Injury Prevention and Control in Atlanta. I do want to bring you greetings from Atlanta. As the world knows, that is the place where CDC is located and other events are going on.

I also want to say that if you believe that our elders are too old to keep them from suicide, then you probably believe that Carl Lewis is too old to jump. [Laughter.]

I want to start with three points. The first is someone from the U.S. Patent Office said in the early 1900's that "We can abolish the Patent Office because everything has already been invented."

The second statement was made by Thomas Watson, the president of IBM in the 1950's. When asked what he thought the international market for computers would be, he said, "Well, computers are basically going to be machines to handle huge data sets and they'll be used for international demographic comparisons. So how many will we be using around the world? Three or four."

Finally, someone has just written a book called "The End of Science," who says "Everything to be discovered has been discovered."

I think none of these are true. I think that science holds tremendous, tremendous potential to make things better in this area of elderly suicide. I think that's something we need to keep in front of us squarely as we proceed. I'd like to give you some ideas of how it can be applied and some of the excitement of discovery that lies ahead.

CDC has a center that's interested in suicide. It's the National Center for Injury Prevention and Control. We look at all sorts of injuries, unintentional injuries like car crashes, falls, drownings, and fire deaths and intentional injuries or violence that includes interpersonal violence like youth violence and sexual assault as well as self-directed violence or suicide. That's how CDC comes to look at the problem of suicide.

Injury is such a large problem, 150,000 deaths a year, and for young people more lives are lost from injuries than all diseases combined.

CDC's new name, in fact, is prevention. Our name has been changed from the Centers for Disease Control to the Centers for Disease Control and Prevention. It's been changed that way to recognize that what we really do is translate knowledge into action. We deliver. We work closely with NIH and I guess you might say that NIH discovers and CDC delivers. CDC is the Nation's prevention agency and we are out to save lives.

For too long, suicide has been something that's been kept in the closet and I think we, as a Nation, have not delivered on our potential for prevention in the area of suicide.

I'd like to talk today about making a difference in the lives that all of us working together can save.

Suicide is a public health problem and it's a public health problem among older Americans because these lives can be saved. It's just that simple.

Suicide rates, as you've heard, among older Americans have exceeded those for younger age groups for many decades. However, since 1980, after a long period of gradual decline, elderly suicide rates have increased dramatically.

What can we do about it? Let me share with you CDC's public health approach to suicide prevention because I think it helps to bring together a lot of what you have heard about today and a lot of what you will hear today. This is basically called the public health approach. I'd like to share this with you.

It's really very simple. It has four steps and we ask a question at each of these four steps. It's really outlining a scientific approach. It's what we mean by science.

The first step is surveillance. It asks, "what's the problem?" You describe not one case or two cases or ten, but you describe 100 cases, 1,000 cases, 10,000 and 100,000 cases and you look for patterns. You look and ask the questions a good reporter might ask, some of the questions you've heard answered today: "What, where, when, how, and who."

The second step, you ask the question, "What's the cause? What are the risk factors, why was it this older person and not that one, why her father and not mine?" That's the question here. "What puts people at risk? What's the cause?"

Then you go to step three, identifying what you can do about it, identifying interventions. You take what you know about the patterns, you take what you know about the causes, and you ask, "What could make a difference? What could change the outcome here?" Then you try those out and you test them. We have to know what works.

Finally, you take those interventions that you know will work and will make a difference and you apply them. You take the knowledge off the shelves, out of the journals, and you put it into practice. You start to communicate with people, you start to work with communities and identify the resources you need to get those programs up and make them accessible and widespread.

Let me just go through some of those steps and tell you what we're trying to do about it at CDC. The first step, surveillance, is actually the same step that made CDC famous for helping to eradicate smallpox.

Senator REID. Dr. Rosenberg, you're going to have to speed things up, we wanted each of you to try to give us what you have in 5 minutes and we have a series of votes. We apologize and we didn't plan on the votes, so you're going to have to speed this up.

We will make the full text of all your statements a part of the record.

Dr. ROSENBERG. Let me, if I can, take another 2 minutes, and I will finish.

In terms of the risk factors, I think we've heard a lot about the risk factors of mental illness and depression. They're very, very important but it's not the whole picture and we think you need to expand the picture of risk factors to look beyond those that affect the individual like mental health, mental illness, and depression, the

feelings of loneliness and hopelessness and personal loss. We need also to look at the social environment.

As Dr. Clark mentioned, ageism, discrimination, prejudice, social isolation, access to quality health care, jobs, or school for the elderly, and geographic mobility are all part of the risk factors in the social environment.

Finally, we need to look at the physical environment. What are the risks to people in the physical environment from easy access to the means of suicide medication, guns, and other lethal means.

The point here is that suicide has many risk factors beyond depression and mental illness and it brings us to the third step, which is what works. Again, if we look at the risk factors, each risk factor suggests something that we can do. We can design interventions that impact on all of these.

You've heard about some of the interventions that can address the individual risk factors, general education, medical care, treatment of depression, but there are also risk factors in the social environment that we can change.

We can develop community gatekeepers who identify the elderly at risk, who connect them through crisis hotlines, who connect them to fight ageism and depression. We can do something about the physical environment as well.

The point is it's not a question of either treating the mental illness and depression or changing things in the social environment, it's really a question of both. It's not one or the other, it's this and that and this.

Finally, I just wanted to close by saying that this perspective, I think, provides a strong framework for understanding the problem and understanding how much better we can do in the solution. If we work together, we can understand much more and do much better in preventing suicide among these very important, yet vulnerable members of our society.

I do want to commend the members of the committee for taking up this challenge. It's not time to close the Patent Office, the answers have not all been discovered. Suicide among our elders is not a fact of life, it is a problem that we can solve.

[The prepared statement of Dr. Rosenberg follows:]



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STATEMENT

BY

MARK ROSENBERG, M.D., M.P.P.

NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL

CENTERS FOR DISEASE CONTROL AND PREVENTION

BEFORE THE

SPECIAL COMMITTEE ON AGING

U.S. SENATE

JULY 30, 1996

Thank you, Mr. Chairman and members of the Committee, for this opportunity to bring you the public health perspective on suicide among older Americans. My name is Dr. Mark Rosenberg, and I am the Director of the National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC) in Atlanta. NCIPC's mission is to improve the health of Americans by preventing premature death and disability caused by injuries, and reduce the human suffering and medical costs associated with these injuries. NCIPC addresses a wide spectrum of injury control, including work on motor vehicle-related injuries, falls, fires, drowning, poisoning, violence prevention, and suicide, as well as work in the area of acute care and rehabilitation to mitigate the consequences of injury.

As you may know, CDC was responsible for identifying the emerging trend of rising suicide rates among older Americans. As the nation's prevention agency, CDC has taken a leadership role in monitoring and addressing the problem of suicide and attempted suicide in the United States. Using the public health approach, we are working to describe the problem, understand the causes, develop and evaluate interventions, and communicate information about the problem and solutions to the public and prevention professionals.

Suicide among older Americans is an important public health problem, made all the more alarming because it can be prevented. In other words, there are ways of successfully treating or

otherwise addressing the risk factors (e.g., depression, isolation, pain) that may be associated with this problem.

Suicide rates among older Americans have exceeded those for younger age groups for many decades, however, since 1980, after a long period of gradual decline, elderly suicide rates have increased dramatically. A recent *Morbidity and Mortality Weekly Report* published by the CDC, based on vital statistics data from CDC's National Center for Health Statistics, found that the suicide rate of Americans 65 and older increased 9 percent between 1980 and 1992. Nearly 74,675 Americans age 65 or older killed themselves from 1980 through 1992 - 19 percent of the 384,262 suicides in that period (figure 1). Elderly Americans make up about 13 percent of the country's population but account for about 20 percent of all suicides.

Men committed 81 percent of suicides among the elderly. Their rate rose from 34.8 suicides per 100,000 in 1980 to 38.4 suicides per 100,000 in 1992. Firearms were the most common method of suicide, used by 74 percent of men and 31 percent of women. Other methods for suicide among older Americans include hanging, overdose, and inhalation of carbon monoxide. Suicide rates are highest in the Western states, with Nevada leading the nation.

Although the reasons for this sharp increase are not clear, depression, living longer with chronic illness, and the

increasing social isolation of the elderly may play a role in the growing numbers of elderly Americans who take their own lives. In addition, alcohol abuse and substance abuse can dramatically raise the suicide risk because these are potent disinhibiting agents that foster impulsive and dangerous acts. Older Americans who contemplate suicide may have made previous suicide attempts or have expressed suicidal wishes to those around them within the 6 months prior to an attempt. Many have contact with a physician in the month before a suicide. In many instances, these health care providers are unaware of the extent of the problem, are unsure how to communicate with older persons suffering from depression and do not know how to identify and refer these individuals for additional help.

THE PUBLIC HEALTH APPROACH

Ultimately, CDC's goal is to reduce the incidence of suicide by applying a scientific, goal-oriented approach to identifying and implementing effective prevention strategies -- what we refer to as *the public health approach*. The public health approach to suicide prevention combines four fundamental activities: *surveillance* to identify patterns and epidemics of suicide and the differential rates of suicide; *research* to identify the chain of causes leading to suicide; the *design and evaluation of interventions* to interrupt this chain and prevent suicide; and the *implementation of programs* consisting of proven interventions

(figure 2). Part of the strategy in implementing programs is to transfer knowledge and skills in prevention to public health practitioners in communities.

Integration among these components is important. Surveillance often provides information; hypotheses are often generated and tested during evaluations of interventions; and programs frequently provide a source of data for surveillance. Though they are integrated, I will discuss each component separately:

Surveillance

CDC gathers and publishes data on trends in the number and rates of suicide by age, sex, race, and method of suicide. These data are based on information from death certificates, and are obtained by CDC's National Center for Health Statistics through a cooperative agreement with states. This provides a surveillance mechanism used to identify and characterize selected problems. Surveillance is characterized by the collection, analysis, and interpretation of health related information that is used for planning, implementation, and evaluation of public health programs.

For surveillance purposes, suicidal behavior is measured on a continuum of seriousness from merely thinking about self-

destruction to actually completing the act. Suicide attempts resulting in no or very minor injury are almost impossible to monitor. However, most deaths from suicide are regularly documented and reported.

In an effort to describe the problem, CDC's surveillance activities include an ongoing series of surveillance summaries. This year, the National Center for Injury Prevention and Control published Suicide in the United States, 1980-1992 that examined trends in suicide mortality among all age groups. In addition, NCHS regularly publishes monthly data on suicide mortality in the Monthly Vital Statistics Reports, available through November 1995, and more detailed information in annual publications. One of the difficulties in conducting surveillance of suicide and suicide related behavior is the lack of standardized definitions of key concepts. Although there is a wide spectrum of behaviors associated with suicide, we only have standardized and consistently collected data on completed suicide.

Although CDC has basic information about completed suicides, the scope of our understanding is limited. Moreover, suicides are just the tip of the pyramid in regards to the problem of suicidal behavior as a whole. CDC estimates that for every 1 completed suicide there are 9 suicide attempts with injuries and 22 total suicide attempts overall. Suicide attempts cost approximately \$56.4 billion annually in health care costs. Although CDC is

monitoring trends in elderly suicide, we would like to do more to monitor and describe the problem of nonfatal suicide attempts among the elderly.

Research

To understand the causes of suicide, research on risk factors has shown that characteristics for suicide among older persons differ from those among younger persons. The risk factors for suicide among older persons include alcohol abuse, depression, greater use of highly lethal methods, and social isolation. In addition, older persons make fewer attempts per completed suicide, have often visited a health care provider shortly before their death, and have more physical illnesses and affective disorders. The most recent of NCHS' National Mortality Followback Surveys included special samples of elderly and of deaths due to suicide. Data from this survey will be available next year, and will be an important new source for data on these risk factors.

Understanding the etiology of suicide is essential to implementing the public health approach. Designing and implementing effective interventions depends upon identifying modifiable risk factors. To identify such risk factors, hypotheses about causal relationships must be generated and tested using appropriate methodology. For suicide, case-control methodology is useful in studying self-reported suicidal thoughts

and behavior within population-based cross-sectional survey designs.

Standardized terminology and measurements for assessing the reliability and validity of research findings is critical to advancing the understanding of suicide etiology. Development of standard definitions is difficult, however. Not only do researchers disagree about the meaning of existing terms used to describe suicide and suicidal behavior, but our relatively undeveloped understanding of suicide and suicidal behavior means that related concepts are correspondingly undeveloped and ambiguous. As further research helps to refine our understanding of suicide and suicidal behavior, it will in turn lead to more concise definitions of important concepts.

Another barrier to suicide research is the fear that asking questions about suicidal thoughts and behaviors may upset respondents. Although some respondents may become upset by such questions, there is no theoretical basis or empirical evidence to suggest or support the notion that asking questions about suicide will cause suicidal behavior. Furthermore, numerous research and intervention efforts have been completed without any reports of harm. In order to develop interventions, strong scientific research must progress while maintaining ethical standards of avoiding harm.

Intervention Development and Evaluation

After causal relationships are established, interventions are developed and evaluated. Although the public health perspective recognizes the importance of secondary and tertiary prevention of suicide-related injuries, the ultimate goal of public health is primary prevention.

Interventions may affect the sequence of causes leading to suicide at several points (figure 3). For example, an intervention that attempts to improve mental health may interrupt this sequence before a person even begins thinking about suicide. Thus, it serves as primary prevention of suicidal thoughts, suicidal behavior, suicidal injury, and suicide. Crisis intervention and referral is primary prevention for suicide, but it may be secondary and tertiary prevention for suicidal thoughts and behavior. Designing an effective intervention involves specifying how the intervention will interrupt the causal sequence. Implementation must be consistent with this specification, yet in practice, it often is not. Reasons for this deviation may include insufficient resources and inadequately trained workers.

Evaluation is an essential component before interventions are broadly implemented. In this era of limited resources, identification of effective programs will prevent wasteful spending of time and money. Programs should be evaluated for

effectiveness using appropriately collected baseline, process, and outcome measures. CDC has a long and successful track record of implementing and evaluating prevention programs that work.

Once an intervention has been designed and evaluated, it can be implemented on a larger scale. Interventions that have already been implemented should continue to be assessed regarding their ability to achieve primary prevention goals. Even though few have been evaluated, numerous prevention programs have been implemented by federal, state, and local agencies and by community-based organizations.

Program Implementation

We need to do a better job of evaluating strategies that show potential for preventing suicide among the elderly. Possible interventions include:

- **Community Gatekeeper Training.** This type of gatekeeper program provides training to community members such as care providers, clergy, police, merchants, and recreation staff, as well as physicians, nurses, and other clinicians who see older patients. This training is designed to help these people identify older persons at risk of suicide and refer them as appropriate.

- **General Suicide Education.** Programs need to be developed and evaluated that provide older Americans with facts about suicide, alert them to suicide warning signs, and provide information about how to seek help for themselves or for others.
- **Screening Programs.** Screening involves the administration of a survey instrument to identify high-risk individuals in order to provide more detailed assessment and treatment. Repeated administration of the screening survey instrument can be used to measure changes in attitudes or behaviors over time, to test the effectiveness of an employed prevention strategy, and to obtain early warning signs of potential suicidal behavior.
- **Peer Support Programs.** These programs, which can be conducted in community-based or other settings, could be designed to foster peer relationships among older persons at high risk of suicide or suicidal behavior.
- **Crisis Centers and Hotlines.** While less-likely to be used by older persons, these programs primarily provide telephone counseling for suicidal people. Hotlines are usually staffed by trained volunteers. Such programs may also offer a "drop-in" crisis center and referral to mental health services.

- **Means Restriction.** This prevention strategy consists of activities designed to restrict access to common means of suicide, such as firearms and drugs.
- **Intervention After a Suicide.** We need to evaluate strategies that help individuals to cope with the crisis sometimes caused by one or more suicides in a community. They are designed in part to help prevent or contain suicide clusters and to help older Americans effectively cope with feelings of loss that come with the sudden death or suicide of a peer. Preventing further suicides is but one of several goals of interventions made with friends and relatives of a suicide victim--so-called "postvention" efforts.

Because current scientific information about the efficacy of suicide prevention strategies is insufficient, one intervention strategy cannot be recommended over another. However, CDC offers several general recommendations. First, suicide prevention programs should be linked as closely as possible with professional primary care providers and mental-health resources in the community. Second, communities should not rely on only one prevention strategy. Certain strategies tend to predominate among prevention efforts, despite limited evidence of their effectiveness. Promising but underused strategies should be incorporated into current programs where possible. Third, it is important to incorporate evaluation into new and existing suicide

prevention programs when practical. Evaluation should include measures of, or closely associated with, the incidence of suicidal behavior.

Although a knowledge base for making programmatic decisions is growing, the need to evaluate interventions is critical. There is simply insufficient scientifically based, quantitative information for making decisions about where to spend precious resources. Nonetheless, we must maintain ongoing interventions and develop new ones. Finding the balance between service delivery and evaluative research involves difficult choices. It is important to note, however, that effective service delivery requires interventions that have been well planned, well executed, and carefully evaluated.

Nationally, numerous organizations are implementing an array of promising suicide prevention interventions. However, there is a need to develop, implement, and evaluate new innovative suicide interventions. Individual interventions are the foundation of most suicide prevention programs, yet it is preferable for prevention programs to move toward multifaceted approaches that include numerous interventions and multiple segments of the community. Community organization and networking should be vital components to any suicide prevention effort. CDC recommends that communities organize before they find they are in the midst of a crisis. Such preparation and implementation may reduce the

likelihood of suicide clusters and may reduce endemic suicide rates among our older population.

The role of the aging network is critical to implement suicide prevention programs. The aging network, consisting of 57 State Units on Aging, 670 Area Agencies on Aging, 221 tribal organizations, as well as caregivers and volunteers serve on the front lines all across the nation with elderly persons on a daily basis and often have direct contact with and can assist in identifying and treating suicidal or depressed seniors.

In addition, programs administered under the Older Americans Act through the Administration on Aging, which provide critical daily home and community based services to individuals 60 and over such as congregate and home delivered nutrition, information and referral, legal and ombudsman services, and many others provide good opportunities to improve health of older Americans, prevent depression and isolation and provide peer support on a regular basis.

WHAT ELSE IS CDC DOING ABOUT THE PROBLEM OF SUICIDE?

CDC is collaborating with the Indian Health Service to evaluate three suicide prevention programs in Native American communities that were implemented by community members. The project involves evaluation of suicide surveillance, implementation evaluation, and outcome evaluation of these multi-faceted suicide prevention

programs. This project is nearing completion with early indications being that one of the interventions has resulted in a six-year period without any suicides in the target population. This program may serve as a model that can be implemented in other Native American communities around the nation.

Communication is fostered by periodic publication of articles seen by those in public health and the public through the media. CDC also helps disseminate information through several community organizations and academic institutions.

CDC is helping to initiate suicide prevention activities through various means. These include NCIPC's sponsoring meetings of local, state, and federal public health officials to develop a strategy that would enable agencies at all three levels to enact a working suicide prevention program. CDC has also worked with the Health and Human Services' Regions VIII and X to develop plans for comprehensive suicide prevention activities.

Most of CDC's work in the area of suicide prevention, which represents the ninth leading cause of death in the United States, has been conducted by a few of our staff who are also assigned to work in other areas of injury prevention for part of their time. In the future, CDC hopes to extend its efforts to evaluate promising interventions and prevention strategies in the area of suicide among the elderly, and disseminate information to

communities about the magnitude, causes, and prevention of injuries resulting from suicide and suicidal behavior. CDC may also expand its surveillance efforts to include injuries resulting from nonfatal suicide attempts.

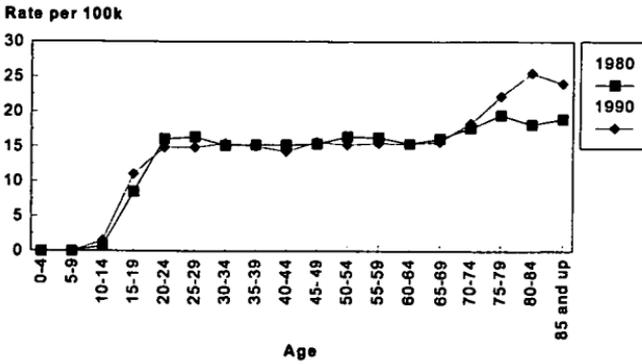
Conclusion

The public health approach to suicide prevention is being adopted by a variety of federal, state, and local agencies and community-based organizations. While minor progress has been made, further development of public health oriented suicide prevention programs with evaluation components is essential. Surveillance efforts, especially of suicide-related injuries, must be further developed and refined. Research into causes of suicidal thoughts and behavior has only begun to uncover modifiable risk factors. New innovative interventions need to be developed and evaluated. Adequate resources need to be allocated for all of these activities and for broad implementation of proven interventions.

The public health perspective provides a strong framework and rationale for developing and implementing suicide prevention programs. While suicide prevention efforts have progressed, the framework suggested by the public health perspective has not been fully implemented. Suicide prevention in the United States needs more planning, coordination, and resources. With these, the public health perspective can be used to reduce the emotional and

economic costs imposed on society by suicide and suicidal behavior among the elderly.

Figure 1. Suicide rates for the U.S. Population by age, 1980 and 1990



**Data Source: Centers for Disease Control and Prevention/National Center for Health Statistics: National Vital Statistics System

Figure 2. The public health approach to injury prevention

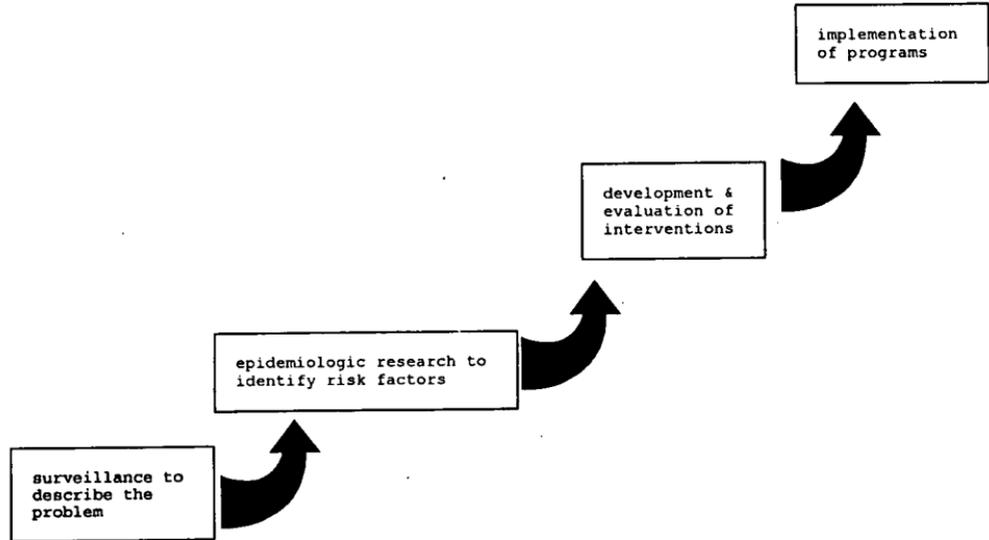
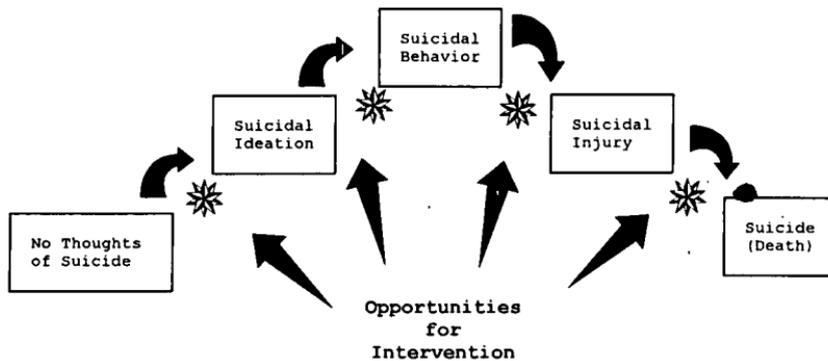
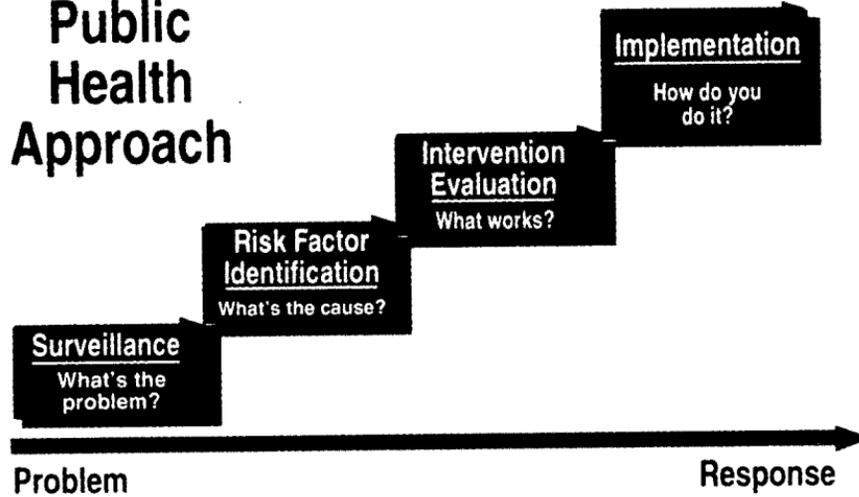


Figure 3. Steps in progression toward suicide and opportunities for intervention



Public Health Approach



Senator REID. We appreciate very much your testimony.

Let me also say so you understand the procedure here. We have a large committee, what everyone says and the questions that you answer will be published and that's one of the purposes of this hearing so that we preserve what each of you have said so that other members and staff can go over this.

We apologize. As indicated, we didn't know there was going to be a series of votes today. We have a number of members of the committee, including Chairman Cohen and I, who have a number of questions we will submit to you in writing and we would appreciate your getting back to us with those answers as soon as you can.

Thank you very much.

I'm going to excuse myself but in the process, I would like panel three, Dr. Katz, Dr. Richman, Ray Raschko, and Betty Munley to take their places here so that when the Chairman gets here, he can go right to work.

The committee stands in recess. [Recess.]

The CHAIRMAN [presiding]. The committee will come back to order.

I hope those who have just completed Panel 2 can remain for a few moments. I did have a few questions I would like to pose to you for my own edification and certainly for the record. I understand Senator Reid indicated he would be submitting several questions for the record. For those of you who can remain, we'll complete this panel and then I'll call you back.

Our third and final panel is going to talk about strategies and interventions that can prevent elderly suicides from occurring.

First, we will hear from Dr. Ira Katz, a geriatric psychiatrist and Professor of Psychiatry at the University of Pennsylvania Medical School, who will also be representing the Geriatric Psychiatry Alliance Program to Increase Public Awareness about Mental Health in the Elderly.

Next, we will hear from Dr. Joseph Richman, a psychologist and Professor Emeritus of Psychiatry at Albert Einstein College of Medicine who will talk about his clinical work with suicidal elderly and their families.

Then we will hear from Ray Raschko, director of Elder Services at the Spokane Community Mental Health Center who will talk about the Gatekeeper Program to identify and address the elderly.

Finally, we will hear from Betty Munley, coordinator of The Senior Connection Program, Crisis Call Center in Reno, NV.

Dr. Katz, would you begin, please?

STATEMENT OF DR. IRA KATZ, M.D., PROFESSOR OF PSYCHIATRY, UNIVERSITY OF PENNSYLVANIA MEDICAL SCHOOL, PHILADELPHIA, PA

Dr. KATZ. Mr. Chairman, to begin, on behalf of all of us who work with and for the elderly, I want to thank the committee for its work over the years and to state our sense that our country would be diminished if this work could not be continued.

When older people kill themselves, it is because they are experiencing or anticipating intolerable suffering. NIMH-supported research has demonstrated that those older individuals who commit suicide had almost always been clinically depressed. The depres-

sion interacts with the losses, discomforts, diseases and disabilities that are common in late life to amplify suffering, and all too commonly, to precipitate suicide.

Because depression is a treatable illness, this is a hopeful finding. By ensuring that late life depressions are recognized and treated, we should be able to prevent suicide.

Additional research findings demonstrate that we are currently missing opportunities to save lives by preventing suicide among older patients in primary care. First, researchers, including those on the last panel, have shown that about 35 percent of older individuals who commit suicide have seen their primary care doctors within 1 week and 75 percent within 1 month of their death.

Second, a recent Harris poll, commissioned by the Geriatric Psychiatry Alliance has shown that although late life depression usually occurs in the context of chronic physical illness, 93 percent of Americans believe that this type of depression is an inevitable reaction to these other conditions rather than a treatable illness in itself.

Third, although it has been established that late life depression can be treated effectively and safely by both medications and short-term psychotherapy, only one case in six of those seen in primary care currently receive adequate treatment.

Fourth, research conducted in Sweden in the 1980's demonstrated that an educational program about depression for general practitioners improved the diagnosis and treatment of depression in primary care and that, as a result, it significantly decreased the frequency of suicide. In fact, it cut it down by half.

To make the benefits of this knowledge available to older Americans, the American Association of Geriatric Psychiatry, a 1500-member organization dedicated to improving care of the elderly and the treatment of late life mental disorders, mobilized academic investigators, practitioners, and corporate sponsors to form the Geriatric Psychiatry Alliance and to implement educational campaigns on late life depression directed toward both primary care providers and the public.

Over the past 6 months, we comprehensively reviewed research in this area and translated findings into a brochure for the public, a print media briefing, numerous radio and television interviews, summaries of knowledge in this area for primary care providers, and an update of recent research findings for those with specific interest in this area. We also established a toll free telephone number, 1-888-INFOGPA, to provide information to primary care providers and the public.

We are now entering a crescendo phase in our activities and realistically look forward to having a significant impact.

We are conducting this program to increase knowledge on the part of potential patients, their families, and their physicians because we know that depression is not an inevitable or an irreversible part of either aging or physical illness. We also know that treatment can reduce suffering, disability, utilization of health care services, and health care costs as well as suicide rates.

As psychiatrists with expertise on depression in late life, we have an optimistic view of the aging process and a conviction that older people can lead meaningful and pleasurable lives in spite of signifi-

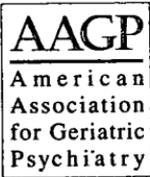
cant medical illness and disability if, but only if, depression is recognized and treated.

We present our initiative on late life depression to you as an example of a private sector response to a major public health problem. However, the severity of the linked problems of depression and suicide in late life also demand public action.

We urge that you consider both increased Federal support for NIMH research on depression and suicide in the elderly and legislation to ensure that Medicare coverage for the treatment of late life depression receives parity with that for other serious and life-threatening diseases.

Thank you.

[The prepared statement of Dr. Katz follows:]

Prevention of SuicideThrough Education on Late Life Depression

Testimony of Ira R. Katz, MD, PhD
of the
Geriatric Psychiatry Alliance
before the
Senate Select Committee on Aging

July 30, 1996

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Annual Meeting:
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March 1998

Publications:
*American Journal of
Geriatric Psychiatry and
Geriatric Psychiatry News*

Post Graduate Courses:
1996 Board Review
Fall 1996 Practice
Management Workshops

Mr. Chairman and Members of the Committee:

I speak here as co-Chair, together with Dr. George Alexopoulos from Cornell University, of the Initiative on Late Life Depression of the Geriatric Psychiatry Alliance.

When older people kill themselves it is because they are experiencing or fearing intolerable suffering. Research involving psychological autopsies, supported primarily by the National Institute of Mental Health, has demonstrated that older individuals who kill themselves are almost always clinically depressed. The depression interacts with the losses, discomforts, diseases, and disabilities that are common in late life to amplify suffering, and, all too commonly, to precipitate suicide. Because depression is a treatable illness, this is a hopeful finding; by ensuring that late life depressions are recognized and treated, we should be able to prevent suicide.

Additional research findings demonstrate that we are currently missing opportunities to save lives:

Researchers, including those on the last panel, have shown that approximately 35 % of older individuals who commit suicide have seen their primary care doctors within one week, and 75 %, within one month of their deaths.

A recent Harris poll commissioned by the Geriatric Psychiatry Alliance has shown that, although late life depression, usually occurs in the context of chronic physical illness, 93 % of Americans believe that this type of depression is a normal response rather than a treatable illness.

Although it has been established that late life depression can be treated effectively and safely by both medications and short term psychotherapy, only one case in six of those seen in primary care currently receive adequate treatment.

Research conducted in Sweden in the 1980's demonstrated that an educational program for General Practitioners about depression improved its diagnosis and treatment, and that, as a result, it significantly decreased the frequency of suicide.

To make the benefits of this knowledge available in America, the American Association of Geriatric Psychiatry, a 1500-member professional organization dedicated to improving the care of the elderly and the treatment of late life mental disorders, mobilized academic investigators, practitioners, and corporate sponsors to form the Geriatric Psychiatry Alliance and to implement educational campaigns on late depression directed toward both primary care providers and the public. Although these campaigns began earlier this year, they, in fact, continued the process of applying knowledge gained through research that led to the 1991 NIH Consensus Development Conference on the Diagnosis and Treatment of Late Life Depression. Over the past six months, we comprehensively reviewed research in this area and translated findings into a brochure for the public that is appended to this testimony, a print media briefing, numerous radio and television interviews, summaries of knowledge in this area for primary care practitioners, and an update of recent research findings for those with specific interest in this field. We also established a toll free telephone number (1-888-INFOGPA) to provide information to primary care providers and the public. We are now entering a crescendo phase in our activities and realistically look forward to having a significant impact. We are conducting this program to increase knowledge on the part of potential patients, their

families, and their physicians because we know that depression is not an inevitable or irreversible part of either aging or physical illness. We also know that treatment can reduce suffering, disability, utilization of health care services, and health care costs, as well as suicide rates. As psychiatrists with expertise on depression in late life, we have an optimistic view of the aging process and a conviction that older people have an impressive ability to lead pleasurable and meaningful lives in spite of the stresses of aging and medical illness, if, but only if, depression is recognized and treated.

We present our Initiative on Late Life Depression to you as an example of a private sector response to a major public health problem. However, the severity of the linked problems of depression and suicide in late life also demands public action. We urge that you consider both increased federal support for NIMH research to further increase our knowledge of depression and suicide in the elderly and legislation to ensure that Medicare coverage for the treatment of late life depression receives parity with that for other serious and life threatening diseases.

The CHAIRMAN. Thank you very much, Dr. Katz.
Dr. Richman.

**STATEMENT OF JOSEPH RICHMAN, PROFESSOR EMERITUS OF
PSYCHIATRY, ALBERT EINSTEIN COLLEGE OF MEDICINE,
BRONX, NY**

Mr. RICHMAN. Thank you.

I have devoted my recent career to helping despairing old people who, bereft of hope and sick in mind and soul, see no way out but suicide. Few people have remained untouched by the suicide of others. Whenever I present on the topic, I conduct an informal poll by asking how many people have had a suicide among family members or friends. The majority always raise their hands.

That is an informal census and I am not a research scientist. However, it demonstrates how widespread is the tragedy of suicide and how many people are affected by it, especially the relatives.

The actual suicide rate must be far greater than the official one. As my more sophisticated research colleagues have demonstrated, most elderly people who commit suicide suffer from a treatable, mental illness, especially depression.

I can confirm directly that suicide in the elderly is treatable and preventable. For the past 30 years, I have been treating suicidal patients and their families of all ages. I attribute my success in treating this problem, including the elderly, to the harmonious integration of practice and research, of art and science.

The longer I have been a therapist, the more does research fall into place in my work, albeit enriched and modified by direct, human experience. The best research scientist in this area is one who has been or is a successful practitioner as well as a scientist.

The following is based upon the principles of successful treatment. By successful, I do not mean that the patients merely survive, but that their lives become richer and more meaningful. How does this happen and why?

First, because symptoms and depression are relieved; that is primary. Second, I work with the family. Consequently, the patient and the family are helped to deal with problems in living that they mistakenly considered insoluble. A major outcome is an increased sense of family belonging and a broader social cohesion.

Third, is the recognition by the therapist that suicide is a family affair and that the entire family is under stress and often feels trapped. Fortunately, just as the depression and despair of the individual suicidal patient can be relieved, the hopelessness and helplessness of the family can be alleviated.

Fourth, is the recognition by the therapist that the family is a healing resource, not only a problem. That is because, I believe, of the central role of continuity in maintaining personal adjustment and growth. The breakdown of continuity is one of the main reasons for suicide and other forms of violence.

Family treatment with the suicidal elderly helps to maintain pride in the traditions of the family and in handing down a secure heritage for future generations. The implications are that the medical and all the health professions must broaden their concept of treatment for the suicidal elderly to encompass the family and social network.

When a suicide has occurred, a combination of bereavement support groups and family counseling can help heal the wounds and draw the survivors closer together and in this sense, the death will not have been entirely in vain.

More social and government support is needed to identify elderly people at risk and set up outreach programs, which have proven their effectiveness. More trained and experienced professionals are needed, more educational programs are needed, especially those that can reach the family.

I am particularly grateful to this committee because of its potential influence. I regularly search the professional literature for articles on suicide, including sources from all over the world. The literature reveals that the United States is the world's leader in this field. Therefore, support for our suicide research, prevention, and treatment efforts furthers the role of the United States in the affirmation and enrichment of life for the growing numbers of elders in the future.

My last point is that with increasing longevity, people are remaining active, healthy, and competent for a longer and longer time. The day will come when Strom Thurmond will be considered too young to head a committee.

[The prepared statement of Dr. Richman follows:]

THERAPY WITH OLDER SUICIDAL PERSONS AND THEIR FAMILIES

Testimony Before The Senate Special Committee On Aging, July 30, 1996

Joseph Richman, Ph.D.
Professor Emeritus
Albert Einstein College of Medicine

I come here as a spokesman for the despairing old people who, bereft of hope and sick in mind and soul, see no way out but suicide.

Few people have remained untouched by the suicide of others. Whenever I present on the topic, I conduct an informal poll by asking how many people have had a suicide among family members or friends. The majority raise their hands. That is an informal census; however, it demonstrates how widespread is the tragedy of suicide, and how many people are affected, especially the relatives. The actual suicide rate must be far greater than the official one.

As my research colleagues have demonstrated, most elderly people who committed suicide suffered from a treatable mental illness, especially depression. I can confirm directly that suicide in the elderly is treatable and preventable. For the past 30 years I have devoted my professional life to treating suicidal patients and their families. The following is based upon what I consider successful treatment. By that, I do not mean that the

patients merely survive, but that their lives become enriched and more meaningful. Why does that happen?

First, because symptoms and depression are relieved. Second, the patient and family are helped to deal with problems in living that they mistakenly considered insoluble. Third, the recognition that suicide is a family affair, and that the entire family is under extreme stress and feels trapped. Fortunately, just as the depression and despair of the individual patient can be relieved, the hopelessness and helplessness of the family members can be alleviated. Fourth, the recognition that the family is a healing resource, not only a problem. That is because of the central role of continuity in maintaining personal adjustment and growth. The breakdown of continuity is one of the main reasons for suicide and other forms of violence. Family treatment with the suicidal elderly helps to maintain pride in the traditions of the family, and in handing down a secure heritage for future generations. The implications are that the medical and all the health professions must broaden their concept of treatment for the suicidal elderly to encompass the family and social network.

When a suicide has occurred, a combination of bereavement support groups and family counseling can help

heal the wounds and draw the survivors closer together, so that the death will not have been entirely in vain.

More social and government support is needed to identify elderly people at risk for suicide, and to set up outreach programs, which have proven their effectiveness. More trained and experienced professionals are needed. More educational programs are also needed especially those that can reach the family.

I am particularly grateful to this committee because of its potential influence. I regularly search the professional literature for articles on suicide; including sources from Canadian, French, German, Spanish, Italian, and Scandinavian books and journals, as well as the United States. The literature strongly suggests that the United States is the world's leader in the study and treatment of suicide in the elderly. What we do in our research and treatment efforts has an impact upon the entire world. Therefore, support for our suicide research, prevention, and treatment efforts furthers the role of the United States as the world's leader in the affirmation and enrichment of life for the growing numbers of elderly in the future.

The CHAIRMAN. How about to run for President? [Laughter.]
Mr. Raschko.

STATEMENT OF RAY RASCHKO, DIRECTOR OF ELDER SERVICES, SPOKANE COMMUNITY MENTAL HEALTH CENTER, SPOKANE, WA

Mr. RASCHKO. Thank you.

I'm here today to talk to you about an intervention strategy that is really the creature of an Area Agency on Aging and a mental health system who pooled their resources, their money, under the Older Americans Act, under Federal mental health block grant monies, under State mental health monies to create a system targeting high risk, older people who live in the community.

By high risk, I mean generally people who have moderate to severe, highly interrelated physical, mental, emotional, and other problems, especially a lack of a support system, which I'll get to in a moment.

Suicidal older people share characteristics with high risk elders, one of the most important which is, and it almost operates as if it was a law of human nature, and that is, first, they do not self-refer for care in the community. That is a very important point. They do not self-refer.

Second, those who are at risk in our communities for suicide and other horrendous kinds of problems, if they do get help, they get it because somebody else gets it for them. You heard it today. You heard from support systems.

The problem is that increasing numbers of older people in our society do not have that support system available to them to assist them in accessing resources that may be available in the community. In fact, the United States Census Bureau recently reported that the fastest growing population of babyboomers are single people—people who are single, people who are divorced, and people who never married. They are not preparing the kinds of support systems to access them to care in the future so long as our care systems remain as passive as they are.

Those are the two laws that I think are operating in our community. So when you have a program that says, and the legislation says, we want this to go to the people who need it the most, knowing full well that those who needed help the most in our communities would be the last ones to let us know they needed assistance, suicidal elderly in particular, we set about to try to figure out a way that we might first identify high risk older people, including suicidal older people.

I think the first issue in providing care is initially, people have to be identified and we cannot simply rely on families and others, although that is an important source of identification, but we need to develop other means of doing this in our communities, much like the schools operate for high risk children and the workplace increasingly operates for high risk adults. The people we're talking about are isolated in apartments and homes throughout our communities and are not self-referring.

However, we did note that not everybody is 100 percent isolated and that they had some contact with somebody in the community. For example, just last week, a postal carrier in our community who

had the same route for many years noticed one of the people he delivered mail to was looking physically rundown, was not as alert as he had been. He talked to him a little bit and suggested the man might want to get out more. He just sits in his window and kind of looks for the mail to come each day.

The man says he's seen everything, done everything, and really doesn't need to get out, but the carrier was very concerned about him and made the referral to us. It took us about two home visits to discover a man who was not only very depressed, but was highly suicidal. He would never on his own have called us to inform us of that fact.

Not everyone is 100 percent isolated, so beginning about 15 years ago, I went to our local utility company, which provides natural gas and electricity to about 50,000 customers and told them of our concern, that we wanted to see people who were very high risk, people who would not call us on their own, and we needed them to help us to do what a good family would, do if somebody had a family that was concerned enough to call us.

We were not asking them to tell us about people they weren't seeing already. These were people they had contact with, either through meter readers, customer contact people, and so on. We began what we called a gatekeeper identification system in our community. Since that time, I have added fuel companies, housing authority apartment managers, banks, I mentioned the post office, and the list is about 14 or 15 public and private businesses and agencies.

We've been educating them because I believe, besides educating primary care physicians, one of the research results that has come to us is that, for example, of those who were referred by gatekeepers, 22 percent did not have a physician who might refer them and 33 percent had not seen a physician in more than 3 months. So we have this population in our community that are very high risk, that do not have the traditional ways in which they can be identified and referred.

Second, it is one issue to adequately identify people, and I think we've been doing a fairly good job of this in our community for some time, both through traditional means, relatives, physicians, hospitals as well as gatekeepers, but then to have a relevant response system, I think, is most crucial to be able to respond in a relevant way.

I won't take much of your time because it's in my written testimony, but the issue of being very proactive, making the kinds of home visits that are necessary, having crisis intervention available on a 24-hour basis, having crisis respite available where we can put trained workers into a home with a suicidal person which is much cheaper than a hospital, much more acceptable to an older person, to be with 24 hours a day at our expense while we take them through a crisis situation and prepare for a long-term care plan.

Those kinds of things are available in our community and we provide that to suicidal older people, as we have the kind of interdisciplinary effort because what you have here are people often who have multiples, the core morbidity, the different problems they have, is such that we need to take a case manager, a nurse, our

psychiatrist makes home visits, most of the time they are in the home seeing people, evaluating and treating. We even have a pharmacist on staff who can make sense out of all the kinds of medications people have and deal with their primary care physician.

My bottom line here really is that the issue of access to care is a terrible problem in our country, but I think when it comes to older people who are isolated, the issue of identification is the first issue and access becomes a secondary issue because people have to first be identified before you can get access to services, and then a very proactive response system.

Thank you.

[The prepared statement of Mr. Raschko follows:]

SPOKANE MENTAL HEALTH

July 30, 1996

Testimony of Ray Raschko, MSW, Director of Elder Services, Spokane Mental Health, regarding suicide and the elderly. Presented to the United States Senate Special Committee on Aging.

Introduction

Postal carrier is concerned because Mike looks physically run-down. His clothes are dirty, and he is unshaven. He sits in his chair in the front window and stares. Earlier, he talked to him about getting out, and he claimed he has seen everything, has done everything and does not need to get out. On the initial visit, the clinical case manager found Mike to be highly suicidal.

Howard, age 83, lives alone after losing his wife in January. He has had colon cancer and is in the beginning stages of dementia. Howard was pulled over by the police while driving and his license has expired. He is very depressed and stated to a utility company meter reader he "did not want to go on." The utility company meter reader called Elder Services.

George's wife, age 78, is in the hospital. She has hyponatremia, which is not life-threatening. She will be released soon. George is feeling hopeless and helpless. He is currently talking with the chaplain at the hospital. George says he should "just take his wife home and kill them both." The hospital is also concerned that George may go home alone and harm himself. Emergency Services made the referral to Elder Services.

All of the above referral source employees had been trained as a gatekeeper through a structured case finding component of Elder Services designed to identify isolated, at-risk community-dwelling older adults who do not self-refer and/or do not have a support system able and willing to refer and access them.

THEORY AND PHILOSOPHY

In the field of aging, it has long been argued that low utilization of mental health and other community services by at-risk elders is due to problems of access. This access problem is viewed as a primary problem and resources such as telephone information and referral, public education, transportation and even most forms of case management in the aging system have been committed to

overcoming problems of access. The underlying assumptions have been that older adults, including those who are suicidal, know they have serious problems, want assistance for those problems, but do not know how or where to get assistance.

It has been our long-term experience that high-risk, home-dwelling, suicidal, depressed, demented, substance abusing and other seriously disturbed elders do not self-refer for community services. If they do become identified and referred for services, it is almost always because someone else—spouse, child, other relative, physician, hospital, etc.—identifies them as being in need and assists them in overcoming problems of access. With one-third of all elders living alone and most severe mental health problems having an onset in late life, it is very understandable that lack of self-identification, the resulting low utilization of services and the epidemic of elder suicide, is as pervasive as it is.

Elder Services has collected referral data regarding its interdisciplinary clinical case management component for the past 12 years. Data for 1993 reflected previous years and less than 1% of all elders referred and admitted to this program were self-referred.

Community mental health providers share responsibility for low utilization, partly because the system is passive and in waiting to be contacted, has screened out the most at risk, especially those with no support system.

More traditional case finding efforts in aging and mental health have succeeded in attracting older people who can seek help on their own or those with family supports. The expectation is that those in need will call and ask for help or that a family member will do it for them. Such efforts, even when supplemented by sophisticated public information techniques, have not been successful in reaching isolated elderly, including suicidal elders.

Elder ServicesTable 1. 1993 Admissions to Interdisciplinary In-Home Clinical Case Management Program

<u>Referral Source</u>	<u>Number</u>	<u>Percent</u>
Gatekeepers	335	37
Physicians and Hospitals	275	31
Area Agency on Aging Funded Programs	119	13
Relatives, Friends and Neighbors	112	12
Other Community Agencies	63	6
Self	10	.1

It was a major premise when creating and organizing Elder Services that target populations who live alone and/or have no or an inadequate support system must first be identified to the system before problems of access and service delivery can be addressed. Traditional case finding efforts have succeeded in locating higher-functioning elders who are able to seek help on their own and at-risk elders with positive family supports. In almost all areas of the United States today, persons who are at risk who do not have a positive support system become progressively worse until their lack of self-care, inability to care for their living environment and/or the resulting behavioral states, make them visible enough to be removed from the community. A major conclusion we derived from the above is that service delivery problems can more easily be overcome when systems of care initiate both active, as well as passive referral/intake procedures in order to identify the most at-risk community-dwelling elders.

THE GATEKEEPER CASE FINDING COMPONENT

In addition to the access problems inherent in the system of care, there are reasons caused by the very problems that at-risk elders suffer from, which helps to account for their resistance to intervention. Resistance is often a cover for pervasive feelings of shame, suspicion and fear. Denial and lack of insight renders people incapable of acknowledging problems. It is in the very nature of the problems people suffer from—memory loss, depression, anxiety, paranoia, suicidal thinking—that render them incapable of insight, understanding and acting.

The American school system, both public and private, plays a "gatekeeping" role in identifying at-risk children, especially when parent(s) or parent(s) surrogates are unable or unwilling to do so. In the last several decades, we have experienced a considerable increase in the number of employee assistance programs in the workplace. One function of these programs is to identify troubled adults who do not self-identify, whose families are unable to convince them to seek help and whose work performance is being seriously affected. The gatekeeper component created by Elder Services is an attempt to organize a system of identification that functions for isolated at-risk community-dwelling elders as the schools and the workplace function for younger persons.

Gatekeepers are trained staff and employees of businesses and organizations considered to be nontraditional referral sources. Since 1979, these businesses and organizations in Spokane, Washington, have been convinced of their importance in a community-based long-term care system and have been trained on an annual basis to assist in identifying and referring isolated elders. Training manuals, videos and a curriculum have been developed to provide training concerning cognitive, emotional, behavioral, and other signs and symptoms that would indicate an elder is at risk of not being able to remain at home or may be suicidal. As of 1995, the gatekeeper component consists of the following businesses, agencies and organizations:

1. Customer contact and meter reader employees of major electrical and natural gas utilities, as well as employees of companies that sell other forms of energy such as furnace oil.
2. Installers and other employees of the local cable television company.
3. Tellers and other personnel from several banks.
4. Letter carriers from the United States Postal Service.
5. Resident apartment managers in housing authority, as well as private housing.
6. Police and sheriff department personnel.
7. Code enforcement and other staff of city and county government.
8. Emergency medical response teams of the various fire departments.
9. Ambulance companies.
10. Residential property appraisers from the county assessor's office.
11. Bus drivers from the city transit company.

It is essential that a gatekeeper component be "owned" and operated by the system of care and not by any one member organization or business.

The underlying theory and philosophy for establishing a gatekeeper component to identify the isolated elderly is supported by past research. It has been shown that an active case finding component can overcome the shortcomings of passive case finding systems in locating such isolated, severely impaired elders.

Establishing a gatekeeper component as part of a service delivery system requires a systematic, ongoing community organization effort. Most corporations and organizations are extremely willing to allow access to their employees. Periodic scheduled training, communication after referral and the system's ability to relevantly work with highly resistant elders are essential to maintaining a gatekeeper component.

INTERDISCIPLINARY CLINICAL CASE MANAGEMENT

The interdisciplinary clinical case management component of Elder Services has 24-hour, seven-day a week crisis intervention available in crisis/emergency situations for all elders whether or not they are active or enrolled. This is available to all referral sources. In a nonemergent referral, a clinical case manager and a team leader nurse conduct the first home visit within two days. The first task is to gain acceptance, engage the older person and begin the in-home evaluation. Sometimes several home visits are often necessary to simply gain admission. Perseverance is a key intervention technique. The initial team of case manager and team leader have become highly skilled in engagement and establishing positive relationships. We expect resistance and most often see it as a cover for anxiety, fear, suspicion, depression, etc. If clinically possible—in some cases of demented leaders, this ability has been lost—this relationship provides the conduit for the evaluation, care plan and continuity of care. We have six teams, each comprised of three clinical case managers and one team leader.

A full-time psychiatrist is available and rotates through the six teams. The psychiatrist makes home visits with team members and provides additional evaluation and treatment. The psychiatrist provides a great deal of consultation to primary care physicians. The six team leaders have a special role vis-a-vis the clinical case managers. They do not carry a separate caseload, but field train clinical case managers, accompany them at initial intake and subsequent home visits, provide daily backup,

but above all, add an important interdisciplinary element to the service delivery system. Resident physicians from Family Medicine—a residency program of the University of Washington—provide 10 hours a month wherein they make home visits with clinical case managers and provide added evaluation and treatment. In addition, a pharmacist is available to consult regarding the many medication problems elders can be faced with.

It has been our experience that clinical case management as a service is more effective when the case manager is also a skilled relationship builder and counselor, as well as being a service broker, linker, advocate and coordinator.

Based on the evaluation, a service/treatment or care plan is developed. Elements include medical, psychiatric, socioeconomic, environmental manipulation and medication modalities. When support systems exist, family conferences are held.

The local Area Agency on Aging provides most of the funding for Elder Services, and we are an integration of aging and mental health services. Elder Services is the lead or focal point agency in developing a system of community-based, long-term care. A network of preventive, supportive and rehabilitative in-home services can be delivered. Sixteen written coordination and referral agreements with other agencies, most of which are funded by the Area Agency on Aging, have been negotiated. These agreements detail each agency's role, referral mechanisms, methods of resolving problems and how training and other resources are shared. In addition to the core services provided by Elder Services, those most often utilized by clinical case managers are personal care/home-maker services, home health services, in-home nutrition services, day health/day care, support groups, respite care and physician services.

The clinical case management program we have developed includes the following elements:

1. Active identification of the target population (gatekeeper). This is in addition to accepting referrals from traditional sources.
2. Crisis intervention available on a 24-hour, seven-day a week basis.
3. Interdisciplinary in-home evaluation and care planning.
4. Family and support system conferences.
5. Supportive therapy.

6. Coordination and brokering of services.
7. Advocacy.
8. Continuity of care.

RESEARCH ON THE GATEKEEPER CASE FINDING SYSTEM

Spokane County has a population of 361,364, approximately 62,000 are 60 years of age and older. In a recent study conducted by the Washington Institute for Mental Illness Research and Training, gatekeepers identified 41% of the total referrals to Elder Services in 1994-95. Gatekeepers also identified a distinct group of at-risk older adults in need of a variety of mental health and other supportive services. Gatekeeper referred elders were more likely to be socially isolated, economically disadvantaged and less likely to have a physician. They also had significantly greater service needs (e.g., case management, psychiatric services, respite, etc.) than elders referred by other sources. These results indicate that gatekeepers are identifying a distinctive at-risk population of community-dwelling elders, including those who are suicidal. Of those persons identified to be at risk for suicide, gatekeepers identified 39%, medical referrals accounted for 32% and "other" sources identified 28%. Although they accounted for the identification and enrollment into services of almost four out of 10 persons at risk for suicide, gatekeepers were not more likely to identify elders at risk of suicide than were other categories of referral sources, but those who were identified by gatekeepers would probably not have been identified at all had the gatekeeper system not been in existence.

The sample of older adults in the study represented a group of at-risk community-dwelling older adults who were referred to Elder Services because of psychiatric symptom levels, crisis events, and/or major life stressors that were negatively influencing their ability to remain safely in their homes and community. Thus, the entire sample represented a group of frail, at-risk elders in need of intervention. These individuals are not representative of the general population of older adults living in the community. The purpose of the study was to examine suicide risk among this population of high-risk elders. Gatekeepers play a key role in the identification of a sizable proportion of high-risk suicidal older adults. A completed suicide may have been the final outcome for some of these older adults without the intervention by a gatekeeper. Thus, it was concluded that the gatekeeper model is an effective method for reaching isolated adults who are not found through traditional referral sources. Early identification is especially critical for those individuals at suicidal risk.

Some of the conclusions of the study were:

Overall, nonsuicidal and suicidal older adults differ in a number of important ways. Older adults identified as at risk of suicide were more likely to be younger (60-69) and less likely to be among the oldest-old (80+) than nonsuicidal elders. They were more likely to be separated or divorced, but less likely to be widowed than nonsuicidal elders. Consistent with other research, suicidal elders were more likely to suffer from depression and anxiety. They were less likely to have a diagnosis of dementia, schizophrenia and other psychiatric diagnoses.

The suicidal risk group was more likely to experience a number of life stressors that may have contributed to their overall suicide risk than the nonsuicidal group. Suicidal elders had higher mean levels of emotional disturbance and were more likely to have emotional problems that negatively impacted upon their lives.

Suicidal elders had higher ratings of social isolation than the nonsuicidal group. These findings underscore the significance of social isolation in the lives of the suicidal sample. Living alone and suffering a relationship loss are two clear indicators of social isolation which in this study were found significantly more often in the suicidal sample. Third indicator, family conflict, could also result in alienation and isolation. Interpersonal loss or conflict often result in feelings of loneliness, alienation, hopelessness and helplessness. Substance abuse was also more likely to affect the lives of the suicidal sample. The use and abuse of alcohol and its link to depression and suicide warrants further study in this population.

The final finding is that suicidal elders were more likely than nonsuicidal elders to have medical problems that significantly impacted their lives. They were more likely to have a physician and to have seen him/her in the last three months than nonsuicidal elders. This finding is consistent with other studies that have found that suicidal elders are not isolated from the health care system.

The study also found that living alone, depression, anxiety disorder, emotional disturbance, the negative impact of medical problems, family conflict and relationship loss in one's life, and the availability of a physician predicted suicide risk.

Most suicidal elders have a professional medical contact which provides an opportunity for identification, referral and treatment by the medical provider. However, elder persons are often reluctant to discuss emotional issues with professionals and primary care physicians. Yet, many suicidal individuals provide warning signs of suicidal behavior and intent. Primary prevention programs to educate and train physicians and other allied health professionals about suicide and aging, along with efforts to destigmatize mental illness are critical.

Finally, suicide rates in Spokane County were compared with Washington State from 1980-1990 to demonstrate the probable impact of the Gatekeeper Program on reducing overall suicide rates in Spokane County.

Completed suicide rates among persons 60 and over in Spokane County were compared with rates in Washington State from 1980 to 1990 (the Gatekeeper Program was established in 1978 and grew steadily throughout the 1980s). Suicide rates were averaged over a five-year period to compensate for idiosyncratic yearly fluctuations at the county level and compared the first five years (1980-1985) to the second five years (1986-1990). The results indicate that the state suicide rate increased significantly from the first to the second five-year period while the opposite trend was seen in Spokane County. Indeed, between 1985 and 1990, the median geriatric suicide rate among those 60 years of age and older in Spokane County was the lowest of any comparable area in the state of Washington (16/100,000 versus 26/100,000).

The development of multidisciplinary or interdisciplinary programs aimed at identifying a population of suicidal and at-risk older adults are greatly needed. The results of this study suggest that the gatekeeper model is a critical component of an effective service delivery program for suicidal elders whose likelihood to self-refer and/or accept help decreases as they move from suicidal thought to action.

The CHAIRMAN. Thank you very much, Mr. Raschko.
Ms. Munley.

STATEMENT OF BETTY MUNLEY, COORDINATOR, THE SENIOR CONNECTION PROGRAM, CRISIS CALL CENTER, RENO, NV

Ms. MUNLEY. I would like to thank you very much for having me here and I'll be very brief because I know you're watching the voting.

You have my testimony in writing, but let me reiterate some of the things these gentlemen said. Nevada has the fastest growing senior population in the country. Unfortunately, we also have the highest suicide rate.

The CHAIRMAN. What's going on out there is what I want to know?

Ms. MUNLEY. We're trying to figure it out too, Senator. We have very little that we are doing about it at this point, we're just beginning.

The Crisis Call Center is the first call for help. Last year, we received over 2,000 calls from seniors and their families but only 3 were suicidal. That points up what these gentlemen and everyone else has said—seniors don't call for help. They don't think depression is something that is a medical illness. They feel it can't be treated and they should just snap out of it.

Of course, they are told that by physicians. They'll go in to a physician and say, I'm not eating well, I'm not sleeping well, I just don't care about anything. They'll run a group of physical tests on them and say, there's nothing wrong with you. Well, there is something wrong with them and we are not recognizing it.

We need to recognize those signs of suicide and we need to confront them. Just by asking a senior, are you thinking of suicide, you're not going to drive them into it. You're going to have them say, yes, and you're going to be able to give them the referral to a system to help them. The system is not always in place because we don't have the money for it.

We need to look at everything. We need to educate people, seniors are not to be thrown aside. Old age isn't a disease. We need to stop treating it as such. Depression is not normal; we need to recognize that. Just because you're older, doesn't mean you have a right to be depressed.

We are devaluing seniors because we do not look at their suicide as something that is losing a potential. We need to encourage them to become active, we need to be out there talking to them and listening, not just talking, listening.

[The prepared statement of Ms. Munley follows:]



The Chinese symbol for Crisis
Means Danger and Opportunity

Crisis Call Center

Certified by the American
Association of Suicidology

P.O. Box 8018
Reno, Nevada 89507
(702) 784-8085
Fax (702) 784-8083

Care & Share

The Senior Connection

702 Plumas
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(702) 348-8585
Fax (702) 348-0970

July 30, 1996
TESTIMONY for
THE SENATE SPECIAL COMMITTEE ON AGING

SUICIDE

Officially, more than 30,000 people commit suicide every year....but the actual number may be 3 to 5 times higher.

Suicide is the second leading cause of death among college students after accidents. The suicide rate for children 10 to 14 has more than doubled over the past 10 years.

The suicide rate among people 65 and older rose 9% between 1980 and 1992 after a 40 year decline. Americans 65 and older make up about 13% of the population but account for 20% of the suicides nationwide. In Nevada, seniors 65 and older make up about 12% of the population, but account for 36% of the suicides.

The population at highest risk for suicide in the United States is the elderly white male. Three fourths of suicides are white males. The majority of persons who commit suicide see a physician prior to the attempt. Seventy five percent of senior suicide victims visited a physician within one month of death, and 30-50% see their doctor within a week of suicide.

According to the American Society on Aging, one older person is a suicide victim every 1 hour and 23 minutes. The ratio of attempted to completed suicides for the elderly is 4:1 compared to 8:1 for those under age 65. When the old attempt suicide they will more likely die than those of other ages. Likely reasons for this greater probability of death among the old include the use of more lethal methods, living more in social isolation, greater motivation to die when an attempt is made and poorer recuperative powers.

It should be noted that the figures for elder suicides are very probably underestimations since "passive" or "silent" acts such as discontinuation of medication or other life sustaining substances are often a reflection of suicidal ideation, but are difficult to quantify.

MOTIVATIONS FOR ELDERLY SUICIDES

Reasons for elderly suicide are rarely singular. That is, there are usually a number of interacting factors that contribute to suicidal ideation. Suicide is not likely to be impulsive among the old.

Among the most common factors in suicide among the old are:

1. Depression
2. Poor physical health.
3. Loss of a spouse/ significant other or friend(s).
4. Lessened role in society and the resultant feelings and effects (e.g. retirement which often produces status changes, loss of income with its security and independence, feelings of obsolescence, role loss, purposelessness, being a burden, loss of control over one's life).
5. Social isolation.
6. Living alone.
7. Negative societal attitude toward the elderly.

Today, depression is a popular disorder and while it may not be more common than in the past, more people are willing to admit to it, talk about it and seek treatment. The exception to this is the elderly.

Those 60 and older grew up at a time when depression was looked on as a sign of weakness or of laziness. The elderly do not consider depression a medical illness which can be treated.

Doctors do not help matters when they fail to look beyond physical complaints and fail to ask questions which might reveal depression as the real cause of the elders symptoms.

Doctors will work-up patients for all kinds of physical illnesses and then tell the senior he can't find anything wrong with them. On the other hand, the doctor and others may recognize an older person is depressed and then try to explain it away by saying there is no reason to feel that way and to just "snap out of it".

According to the National Institute on Mental Health, 3% of those 65 and older are clinically depressed, 7-12% suffer from milder forms of depression that impair their quality of life and 20-40% of nursing home patients are severely depressed. The American Society of Aging estimates that at least 4.8 million seniors 65 and older suffer from clinical depression which goes undiagnosed and untreated.

It is said that an elders first depression is often his last depression.

OPPORTUNITIES FOR PREVENTION

1. Nearly all suicidal elderly exhibit warning signs of their suicidal ideation and intent in their statements, behavior and/or the situations in which they are found. Most often, many of these warning signs are exhibited to a number of people on more than one occasion.
2. Although suicidal individuals usually feel their situation is nearly or completely hopeless and that they have few or no options to solve their problems and end their pain, virtually all are ambivalent about their suicide. They want to die, but they also want to live. They just don't see how they can do so.
3. The majority of suicidal individuals, particularly the older person, visit a physician a short time prior to their suicidal action. Training to increase awareness of elderly suicides and sensitivity to its possible existence in patients should be required among all medical professions.

WHAT CAN BE DONE

Measures to combat the motivations to elderly suicides should lessen the likelihood among the elderly. Such measures would include:

1. Encouraging active and meaningful participation either in new or the same areas of earlier life.
2. Maintaining close family ties and relations with other individuals and groups.
3. Correcting even minor physical ailments.
4. Encouraging physical activity and exercise.
5. Increasing economic security and income.
6. Effecting societal attitude changes toward the aged and aging.
7. Effecting training in the medical professions in geriatric health.

Active search for the suicidal elderly is necessary because the elderly rarely seek help from suicide prevention centers and other crisis intervention services or mental health services in general. Increasing the awareness of the elderly to the availability of such services may help reverse these tendencies. Outreach programs seem critical for prevention.

IN SPECIFIC CIRCUMSTANCES

1. Learn the warning signs and **TAKE THEM SERIOUSLY**. Don't be afraid to ask about suicide directly if you suspect it. You will not cause the person to commit suicide or think about suicide by mentioning it.
2. **LISTEN**. Avoid being critical or punishing. Be reassuring and positive. Don't taunt or dare the individual about suicide.
3. Seek the assistance of the elder's social support group --family, friends, clergy, etc.--to aid the individual.
5. Above all, seek the help of mental health professionals, crisis intervention centers, suicide prevention centers and community mental health clinics.

Care and Share, The Senior Connection through the Crisis Call Center, does regular outreach to several retirement centers in the Reno-Sparks area as well as periodic outreach to the northern Nevada rural areas through the senior centers.

The National Center for Health Statistics and the centers for disease control recently have utilized a statistic called "Years of Life Lost Before Age 65" The YPLL emphasizes deaths among younger persons. Therefore only those younger than 65 are a "loss" to society. I am quite sure that there is no intention to devalue the lives of those over age 65, however, that is exactly what it does.

Suicide represents a premature death on the part of any individual who chooses to take their own life. The loss of lives to suicide at any age is tragic. This no less true when the suicide is 18 or 87. No measure of the loss can adequately indicate the actual "cost" to society or the family. Whether it is economic, emotional or any other dimension. Devaluing this age group and their potential for contributing to society is shortsighted particularly in light of the fact that it is the fastest growing population in the United States.

The CHAIRMAN. Thank you very much, Ms. Munley.

I'm going to pose some questions to the panel that preceded as well and you can answer for the record or come forward if need be.

I was curious in the case study that Dr. Clark mentioned where Mrs. Jones' father was a suspected suicide. We had a witness this morning, Ms. Workman, who testified that because her grandfather and father both were suicides she was concerned that it may run in the family. Is there any research that's been done to suggest that perhaps there is a genetic predisposition to suicidal feelings?

Mr. CLARK. Yes, some of the most valuable and important work that our own National Institute for Mental Health is funding these days is looking precisely into these questions.

My own reading of the literature suggests that the illnesses that are almost always implicated in suicides, depressive illnesses, manic depressive illnesses, alcoholism, drug abuse, and schizophrenia do show some genetic susceptibility. In families where these illnesses run in several generations, suicides are more likely to bunch up.

There is also a question about whether there are characterological elements—impulsivity, aggressiveness—latent in some people that are brought forward in, for example, an acute depressive illness that might be more direct biological manifestations of suicidal behavior. All this is frontier, research frontier territory.

The CHAIRMAN. Any explanation to date as to why suicide is so much higher among men than women? After all, if we talk about loneliness, isolation, loss of associates, family, et cetera, it would seem to apply to women more than men. Is it a cultural thing? What, if any, studies have been done to identify why males are more susceptible?

Mr. CLARK. I think it's a great mystery. We do know that in most countries of the world, the male rate is much higher than the female rate, although there are a few countries where it equalizes out, but generally it's higher.

As you say, the female rates for depression are much higher than the male rates, though males die by suicide much more often. So there is a paradox here that we can theorize and speculate about, but I don't think we have a biological understanding of that yet.

The CHAIRMAN. Also, one thing that's been curious to me at least in listening to the last two panels, is we talk about this being a family affair, and indeed it is, but we had examples this morning from the first panel in which we saw some very loving daughters trying to work with their fathers and yet that was insufficient.

It seems to me that the loving family is not going to be enough. There has to be a lot of education on the part of the medical profession to reinforce the need for a family support intervention because I think that most sons and daughters find themselves in a very difficult position in trying to urge a mother or father, particularly a father, to seek some sort of help.

Most fathers would resist and resent and we didn't get into the entire issue. I used to be the vice chair of the Intelligence Committee, but in telling with the intelligence community as to whether those individuals whose very lives set up a protective mask to hide a number of their activities as such and develop a persona which

is designed to be as flat and neutral as possible about their existence is another special category we have to deal with.

Families alone will not be sufficient. You must have the direct intervention of the medical community and reinforce each other in that regard.

I have one other quick question, I want to ask you before I yield to Senator Reid. Yesterday's Post carried a story about a woman who was assisted with her suicide by Dr. Kervorkian and apparently there is some question now as to whether or not she had multiple sclerosis but, in fact, may have been suffering from depression. Does that story surprise you at all, Dr. Clark?

Mr. CLARK. No, not at all. Some of the people in Dr. Caine's department, Dr. Comwell most notably, have highlighted the problem of elderly persons asking for assistance in dying under the mistaken belief that they're dying and the question about whether there are actually more of those kinds of cases than people who are genuinely terminally ill.

I think those of us who have hospital-based contact or hospice contact with the terminally ill know that the great majority of terminally ill patients never become suicidal. Some do, but the great majority never do, not in normal development of terminal illness.

Good studies suggest that most of the terminally ill patients who become suicidal in their thinking or in their behavior are experiencing a reversible depression. If the depression is addressed and treated in a short period of time, the people whose physical condition has not changed one iota are glad they didn't die, are sort of amazed that they had wanted to die, and are very, very grateful that people recognized and treated the depression.

The CHAIRMAN. Senator Reid and I were talking on our rush back from the floor about this issue of psychological profiling which you, Mr. Raschko and Ms. Munley, probably engage in, as well as the medical profession, and I'm sure there are some studies that have been done to say these are the key signs to look for.

I was thinking about it in the context of the pain and suffering of the family members who say, "Isn't there something we should have recognized or something we could have done." Senator Reid mentioned a gesture by his father. In retrospect, was that a sign? I talked about my father who gave me his ring rather than giving it in his will. He gave it to me when I turned that magical 50 some years ago, but nonetheless, I asked was that a sign?

So we're all left to say, were there things that we should have recognized. It's a very tough issue to deal with as far as family members who are left with the guilt and anxiety and the sleepless nights, saying was there something that he or she did that I wasn't sensitive enough to.

I think we've got to spend a lot more time on the issue of profiling before we can say these are the only signs or the critical signs. There may be more subtle things that we have to look to.

Sorry for carrying on, but Senator Reid? I'm rushing because the vote is coming up.

Senator REID. Senator Cohen, let me just say to Betty Munley from Reno, NV, all the panelists who have appeared here, this wasn't the model of how a hearing should be held, but we held it, as I indicated, in Senator Cohen's absence. We will prepare a

record, your full statements will be included in the record, and as the time goes on, this will be the basis for beginning good work on a legislative level for suicide of elders.

I want also to spread on the record the fact that even though this wasn't a perfect hearing modelwise, it's a hearing we would not have held had it not been for the leadership of Senator Cohen. Senator Cohen has been a leader in the Congress during his entire time here and one of my sad feelings this past month or two has been the fact that our country, the State of Nevada, will no longer have his leadership.

Senator Cohen and I come from different parts of the country. He's on the far eastern coast of the country; I'm on the far western coast of the country. He's a Republican; I'm a Democrat, but I say publicly and loudly, we need more Bill Cohens in the Congress and in public service generally. I would hope that his model of public service will be followed by many others.

Senator Cohen, thank you very much for holding this hearing and I have a number of questions that I want to submit in writing to all the panelists, and I would hope they would get back to us as quickly as possible and make the record complete.

The CHAIRMAN. Thank you very much. I might say, as I pointed out in my opening remarks, we would not have had this hearing but for Senator Reid because he felt so strongly about the need for us to bring this to public light.

You had your hand up and wanted to make a comment?

Dr. ROSENBERG. I did want to make one last point and I know it's unusual for the Senators not to have the last word.

The CHAIRMAN. We're going to have the last word. [Laughter.]

Dr. ROSENBERG. I would disagree with the Honorable Senator Reid from Nevada. I do think this was an ideal hearing. I think this was a hearing where you took something that was personal and meaningful to you and very painful and instead of hiding it and putting away, you brought it out into light and started to ask some real hard questions. You transformed something that was very painful and difficult into something that will bring new life and new hope to people.

I think that is an ideal hearing. I think that's a wonderful hearing. I think for all of us on this side, we want to thank you very much.

The CHAIRMAN. You do have the last word.

The committee will stand adjourned.

[Whereupon, at 12:07 p.m., the committee was adjourned, to reconvene at the call of the chair.]



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