Preventing Suicide Among Elderly Patients

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The rate at which elderly Americans commit suicide is nearly 50% higher than that of the general population. And, though most of these seniors visit a health care provider within six months of committing the act, the opportunity for prevention often is missed.

Suicide, defined as intentional self-killing, is a substantial risk for elderly Americans—particularly elderly men. Older men are more likely to commit suicide than any other demographic group in this country and abroad, and the rate of suicide within this group is rising.

Clinicians who care for this group of patients face many challenges. Although most elderly Americans who commit suicide warn of their suicidal impulses and visit a health care provider within six months of committing the act, clues to their suicidal thoughts often are overlooked. The opportunity for screening, risk detection, and suicide prevention provided in this final outpatient or clinic visit, therefore, is missed—possibly because of misconceptions on the part of the clinician about suicide and suicidal patients.

This article seeks to dispel some of these misconceptions and, in doing so, to eradicate many of the potential barriers to suicide risk assessment and treatment. It discusses how to use suicide screening tools and assessment guides to detect, evaluate, and manage suicidal risk in patients; describes cultural differences that may be relevant to suicide risk; and relates some of the oversights in risk management that can lead to patient loss and legal liability.

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THE EXTENT OF THE PROBLEM

Overall, the rates of death by suicide for Americans aged 65 and up and those aged 85 and up are 16 per 100,000 and 19 per 100,000, respectively—compared to 11 per 100,000 in the general population.[1] From 1972 to 1999, suicide rates among adults over the age of 65 increased in 22 countries, with Eastern European countries and Finland having the highest rates (ranging from 24 to 42 per 100,000).[2] About 1% of elders who attempt suicide die by suicide within the year and 3% or more do so within the next three to eight years.[3] Approximately one in four suicide attempts by elders is fatal because these people use highly lethal methods and intend to die.[1]

In the case of suicide, due diligence requires clinicians to recognize risks and take preventive action. Frequently, we can identify the most common risks and take appropriate precautions accordingly. Unfortunately, the standards for reasonable care of suicidal patients are neither stated clearly nor applied consistently.[4] A clinician meets the standard of care by showing adherence to the assessment, screening, treatment, and management strategies that a reasonably prudent clinician would exercise under similar circumstances.[5] There are, however, some well recognized causes for malpractice claims that would fall under the general heading of assessment, communication, or management failures, and clinicians are taken to court in perhaps 5% or 6% of suicide cases (Table 1).[5]

Continued on page 35

Continued from page 32

Table 1. Well recognized causes for malpractice claims[5]

Assessment
- Failure to screen, evaluate adequately, predict, or identify suicide risk
- Failure to document a comprehensive evaluation and recommend referrals for psychological evaluation
- Failure to observe and monitor suicide intent and risk consistently

Communication
- Failure to notify physician and health care team of patient's mental health symptoms or effectiveness of treatment (if physician response is too slow or fails to remedy the problem, the assessing clinician needs to consult supervisors and seek a solution)

Management
- Failure to place patient in secure environment
- Failure to control, supervise, or restrain patient appropriately
- Failure to follow policies and procedures regarding suicide management

CLOSE-UP ON GERIATRIC SUICIDE

Of 100 consecutive, elderly patients (64 women and 36 men) referred to a liaison psychiatric service for care after a suicide attempt, the mortality rate was 12% per year—15.1% for men and 10.3% for women.[6] In this group, 53 patients were widowed, 29 were married, nine were single, seven were divorced, and two had an unknown marital status. The mean age was 75.8 years. More than half of the patients (55) had a past psychiatric history, and nearly one third (31) reported previous suicide attempts. In the latter group, 16 had made more than two prior suicide attempts.

Drug overdose was the suicide method most commonly attempted (by 87 patients), followed by jumping from a great height (five patients), critically cutting themselves (two patients), or breathing in carbon monoxide (two patients). A retrospective review of these cases showed that 40 of the patients had a high intent to die, 23 had a medium intent, and 28 had a low intent.[6] Elders who attempt suicide have a high relative risk of death in the next three and a half years—1.88 for men and 3.48 for women.

COMMON RISK FACTORS

Among older patients who commit suicide, common risk factors include living alone or being socially isolated; physical illness; bereavement; prior suicide attempts; and feelings of hopelessness, helplessness, futility, or worthlessness. Since the list of recognized suicide risk factors has grown quite extensive, it's difficult to attend to all potential attitudinal, situational, and demographic clues to patient suicide risk—though the risks that have been verified empirically warrant particularly close attention (Table 2).[5,7–9]

After his 1996 review of 12 studies of hospital suicides, Draper suggested that suicide is the outcome of an interaction between such factors as isolation, loneliness, family conflict, and symptoms of physical illness.[9] Alcoholism, loss, loneliness, failure to adapt to aging, and such mental health disorders as depression also increase the risk of suicide.[5,7–9] In fact, Conwell and colleagues observed that 90% of all older adult patients who committed suicide had an identifiable psychiatric diagnosis (typically a mood disorder), and another 28% had a substance abuse disorder (mainly alcohol).[10] Of note, few patients who die by suicide (14%) are in contact with psychiatric services.[7] This means that nonpsychiatric health care providers can play an important role in preventing suicide.

Regrettably, many health care providers fail to screen for or detect suicide risk, focusing solely on their elderly patients' physical problems or medications but neglecting to ask, "How are you feeling inside?" In the six cases of community suicide on which Finkel and Rosman reported, four of the patients had visited their primary care provider within 48 hours of death, and all of the patients' physicians expressed surprise at their patient's death.[7]

Most suicide attempts are accompanied by psychological distress, which Shneidman labeled "psychache."[11] Psychache, which is defined as "the hurt, anguish, or ache that takes hold in the mind," often emerges during a crisis triggered by stressful life events.[11] Only a small minority of all cases involving excessive psychological pain result in suicide, but every case of suicide stems from excessive psychache. Suicide is essentially a "drama of the mind driven by the pain of negative emotions and frustrated psychological needs."[11] The clinician who focuses on the patient's emotional pain ("What hurts?") and intervenes therapeuti-

cally often can improve quality of life and prevent suicide.

WHY RISK MAY BE OVERLOOKED

Factors complicating early recognition of suicidality (the occurrence of suicidal ideation or behavior) among older adults include presence of physical illness, stereotypes about aging, heterogeneity of patient populations, and reticence on the part of the patient to disclose suicidal ideation—perhaps out of a fear of becoming a burden to others.[12,13] Compounding the problem, clinicians often discount patients' suicide messages or assume that depression is part of normal aging or is untreatable.

Clinicians need to be aware of how such misconceptions about aging can diminish the value of their assessment. It's particularly critical to pay attention to suicide messages and comments about the wish to live or die (Table 3).[14] Frequently overlooked messages concerning a patient's inability to adjust to multiple stressors or unbearable psychological or physical pain may indicate suicidal risk or depression among older adults.

Suicide prevention depends upon early detection and risk reduction through the treatment of physical and psychiatric disorders, lessening of social isolation, improvement of resources, enhancement of self-esteem, and discovery of meaning or satisfaction in life. Although there's controversy about the motives of elderly adults in seeking help, most people tell friends and health care professionals about their suicidal ideas before they attempt suicide.

Such obvious suicide messages as "I want to die; I don't want to live"—and even the more subtle message, "I'd be better off dead"—should be considered red flags. These messages indicate danger and deserve to be discussed and evaluated.[13,14]

Table 2. Empirically verified single risk factors for suicide[5,7–9]

- Psychiatric diagnosis of depressive illness
- Alcoholism or drug abuse
- Suicidal ideation, talk, preparation
- Prior suicide attempts
- History of using lethal suicide methods
- Isolation, living alone, loss of support
- Hopelessness
- Cognitive rigidity
- Being an older, white man
- Family history of suicide
- Work, economic, or occupational problems
- Marital problems or family pathology
- Stressful life events
- Anger, aggression, irritability
- Serious physical illness (such as cancer, cardiorespiratory disorder, HIV, or renal disease requiring dialysis)

THE ROLE OF PHYSICAL ILLNESS

Physical illness is a major trigger for elderly suicide when it involves loss of mobility, independence, control, attractiveness, or self-esteem. Suicidal patients often present their physical symptoms to the clinician and expect the clinician to investigate and uncover underlying emotional pain and suicidal impulses. Elderly adults who stop eating or fail to follow prescribed life saving medical regimens (such as taking insulin for diabetes) may be attempting, indirectly, to commit suicide.

Researchers consistently report increased suicide risk for people with HIV or AIDS, certain cancers, or such neurologic conditions as multiple sclerosis.[15] When an older patient presents with physical symptoms, the clinician needs to ask how discouraged or frustrated the patient feels and what the patient will do if things don't get better. Often, the clinician who evaluates a patient for anxiety, depression, and suicidal tendency and improves pain and symptom management can reduce that patient's suicide risk. Frequently, supportive interventions can help terminally ill patients find meaning in their lives and reduce their suicidal impulses.[13,16]

ADDRESSING COMORBIDITIES

Elderly patients require a complete evaluation for coexisting medical or psychological conditions. Over 35% of depressions among elderly people are due to electrolyte imbalance, renal or thyroid dysfunction, neoplasms, bacterial infection, pulmonary problems, such neurologic disorders as Parkinson's disease, or adverse effects of medication.[17–19] Because depression often is linked with substance abuse, a detailed history should include prescribed and over-the-counter medications and alcohol consumption.

Alcoholism may be overlooked when such symptoms as alcohol-induced falls; insomnia; depression; or loss of memory, libido, and cognitive functioning are attributed mistakenly to normal aging. For

Continued on page 39

Continued from page 36

this reason, depressed elders require a thorough physical examination with complete blood count, electrolyte level, and thyroid function studies.[17]

THE GENDER DIFFERENCE

In other countries, old age is consistently associated with increased rates of suicide, regardless of gender.[12] By contrast, in the United States, women's suicide rates peak in middle age and remain relatively stable thereafter, while men's suicide rates increase with age.[12]

In most countries, including the United States, the suicide rate for men is three times higher than it is for women.[20] Although this gender difference isn't well understood, a review of sociologic literature by S. Stack suggests that alcohol abuse may be one reason for men's higher rates.[21] Another possible explanation is that women have stronger religious attachments than men, a broader range of coping skills, wider social networks, and more negative attitudes toward suicide.[22] Women are also more likely than men to recognize the warning signs of depression or suicidal risk, to seek help, and to view nonfatal suicide attempts as acceptable.[22] Furthermore, they tend to have a weaker intent to die than do men.[16] Fatal suicide attempts seem linked to such antecedents as depression, hopelessness, anger, psychiatric diagnoses, physical problems, work problems, or the death of a significant other.[5] These factors appear more important among older men than women.[5]

Gender also appears to be a major factor in the choice of suicide method. Traditionally, women have used less lethal methods (for example, poisons and pills), and men have used more lethal methods (for example, firearms). Since 1980, however, firearms have become the method of choice for both men and women.[1]

Although Asians tend to be viewed, erroneously, as a homogeneous group, differences in the cultural acceptance of suicide exist among different Asian cultures.[26]

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CULTURAL INFLUENCES

Clinicians who understand cultural aspects of suicide risk can improve their screening, assessment, risk management, and treatment procedures. Hence, they often can prevent suicide.

Cultural sensitivity is the extent to which ethnic or cultural characteristics—norms, values, behavioral patterns, and beliefs of a specific population and their relevant historical, environmental, and social forces—are incorporated into the design, delivery, and evaluation of health promotion and suicide prevention efforts. Although the determinants of and barriers to healthy behavior may not always differ among racial or ethnic populations, these aspects of culture must be taken into account.

Few studies have investigated the association between ethnicity and suicide. With the growing influx of immigrants—and, in particular, Asians—to the United States, this issue requires our attention. In the United States, a much greater proportion of elderly Chinese and Japanese women commit suicide than do elderly women in other ethnic groups.[23,24] Generally, elderly Asian males also have high rates.[22,23,25]

For instance, in traditional Japanese myth and legend, as well as in the history of kamikaze pilots, suicide is looked upon as acceptable and even honorable. Furthermore, by traditional Japanese values, being useful to one's society is a part of being worthwhile.[26] This social viewpoint may predispose an individual from that culture to feel worthlessness or shame if they become disabled or less productive. By contrast, the Chinese and Filipinos, most of whom are Catholic, may have strong cultural or religious reasons for avoiding suicide.

Diego and colleagues studied cultural factors surrounding suicide in Asian and white elderly adults living in Los Angeles County during a five-year period.[26] They reviewed the county coroner's investigative reports on the suicides of 48 Asians and 48 whites aged 65 or older. They found significant differences ($P < .05$) between the two groups with regard to living situation. The majority of Asians (50%) were living with their children, whereas relatively few whites (2%) were. The authors suggest that the Asian tradition of filial piety still was being obeyed in this country, which fails to support the notion that acculturation increases the suicide rate.

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Table 3. Patterns and examples of messages indicating high risk of suicide[14]

Pattern	Messages*
Unbearable psychological pain: Flight from pain or emotional states; thoughts that suicide solves urgent problems or rectifies injustice; other motives	"I'm depressed. I have a fear of the future; I feel down and will kill myself." "I want to be dead; sleep—never wake up. I want relief from physical and psychological pressure." "I've had these terrible headaches for decades and no one cares or helps treat the pain; I think I'd be better off if I were dead."
Interpersonal relationships: Unresolved problems, needs, and frustrations that are obvious and overwhelming	"I've seriously considered cutting off my hand to kill myself to make amends for causing my wife's abortion." "I wanted to kill myself because I couldn't live with my wife and I could not live without her—then she died. Now, I know my life is over and suicide is the only way."
Inability to adjust: Perception of self as weak, inferior, and unable to adapt	"I want to end it all because I can no longer handle everyday problems."
Cognitive constriction: Evidence of adult trauma; intoxicated by emotions, constricted logic, and perceptions	"If you send me home, I'll kill myself." "I'd be better off dead. I've plans to slit my wrists. I'm losing it; I feel high too much."

*These were extracted from patient comments about suicide notated in the medical record of veterans who had completed suicide and were compiled as part of a study comparing comments of veterans who had completed with comments of veterans who had attempted suicide.[14]

ASSESSING RISK AND LETHALITY

The first step in assessing a patient's suicide potential is establishing a rapport—however challenging this may be in emergency departments, clinics, or settings in which assessment time is severely limited. It's helpful to find a quiet and private setting for the interview. The clinician can say, "I'm very worried about your emotional distress and pain, and I want to help you find a way to reduce your distress."

The next step is to take a history including risk factors, psychological pain, previous attempts, and details of a suicide plan. Medical diagnoses with a high risk of suicide include head, neck, or GI cancer; HIV; cardiopulmonary disorders; and early dementia. Take note of such warning signs as command hallucinations, paranoid or persecutory delusions, depression with psychotic features or suicidal intent, substance abuse tendency, depression with a history of impulsiveness or violence, acute agitation or anxiety with suicidal ideation, panic disorder with marked agitation or anxiety, clearly stated intent to die, and psychotic or manic episodes that are difficult to manage.[27] Patients with such characteristics require further evaluation and often pharmacologic intervention.

Although the clinician focuses on the patient's emotional pain, the questions must be framed in such a way as to uncover the details of the patient's suicide plan (for example, "What would you do? How? When?"). A suicide plan's lethality, or potential to cause death, is rated by the clinician as high, moderate,

Continued on page 47

Continued from page 40

or low according to its relative danger and immediacy. Suicide attempts by gun, knife, hanging, jumping, suffocation, or carbon monoxide poisoning are highly lethal.

The clinician estimates the lethality of potential suicide behavior based on information about the patient's past attempts, current intent (to die or to survive), and suicide plan (intended method and strategy for action). The more lethal these variables are, the higher the patient's risk. A 65-year-old man with a precise and immediate plan to shoot himself would be a high risk. Risk would be moderate or lower given a less lethal method (for example, attempted overdose with a few aspirin or death by cutting wrists). Other lethality considerations include mental status and whether the patient has made any plans for rescue.

All references to suicide should be taken seriously. Any person with a suicide plan or thoughts of suicide should receive a psychiatric evaluation. If the suicide plan is lethal and immediate ("I'll shoot myself with a gun tonight; I have the gun and bullets"), such evaluation should be performed without delay and should include questions about anger and potential to harm or kill others.

SUICIDE SCREENING INSTRUMENTS

Evaluating patients for suicidality is challenging because suicidal behaviors are so variable. Determining risk requires skill, experience, and intuition. Screening tools can help identify patients at risk, but they can't capture all of the individual and cultural variables. Nonetheless, suicidologists agree that a clinical interview and a review of high risk indicators that may be captured in a screening tool are critical steps in performing such an evaluation.

There are many suicide screening tools that are brief, easy to administer, and efficient to use in a busy clinical practice (Table 4).[28–32] These questionnaires identify patients who need clinical evaluation and provide objective evidence of suicide risk.

A common screening tool is the 30- or 10-item Geriatric Depression Scale (GDS), which asks yes or no questions.[28,32] It's important to use a screening tool designed for elderly patients because other depression screening inventories often consider as indicators of depression symptoms that may be common in older patients with physical diseases (such as insomnia, appetite loss, and poor concentration).

Another popular questionnaire, the Beck Depression Inventory (BDI), surveys patients about the severity of their symptoms (for example, anorexia, weight loss, fatigue, sadness, and thoughts of suicide).[29] It includes two questions about suicide. Bear in mind that the somatic items on the BDI can confound the diagnosis of depression in elders because they are associated with aging and physical illness. This copyrighted instrument can be purchased from the American Psychological Association by licensed psychologists or physicians.[29]

The Beck Hopelessness Scale (HS) also is used frequently as a screening measure.[30] Routine use of the HS can improve documentation and detection of suicidal behavior, as it helps the clinician monitor effectiveness of depression treatment.[30]

Although the BDI[29] and GDS[28,32] screening tools are some of the most popular and help detect depression and suicide risk, other scales, such as the Suicide Intent Scale (SIS)[31] and the Scale for Suicide Ideation (SSI),[31,33] may be useful. If a patient has attempted suicide previously, the SIS gathers data about this attempt. The SSI, on the other hand, explores current thinking about suicide.

DIAGNOSING SUICIDALITY

Experts agree that no single sign or symptom predicts suicide, though hopelessness is a useful indicator.[5] Many elderly, suicidal patients, however, don't have the classic symptoms of major depression, a history of prior suicide attempt, or a high risk suicide plan. In elders, reports of chronic, unrelieved pain or other symptoms and difficulty adjusting to aging are common symptoms of suicide risk. Differential diagnosis should include dementia and adverse effects of medication.

Elderly people are often reluctant to disclose depression or other emotional symptoms spontaneously and so must be asked. Once the clinician recognizes that a person is suicidal, the goal is to diagnose and treat the psychiatric or medical conditions that underlie the suicidality.

SUICIDE RISK MANAGEMENT

Just knowing that a patient is at risk for suicide isn't enough. It's essential to monitor suicidal patients and, to the degree that it's possible, reduce their risk.

Most hospitalized veterans commit suicide by hanging or jumping, while outpatients also use guns and overdose.[14,34] Safeguarding hospitals to reduce opportunities for hanging or jumping, removing potential methods (that is, guns and other lethal items) from the pa-

Table 4. Suicide screening instruments[28–33]

Instrument	Characteristics	Scoring
Geriatric Depression Scale[28,32]	This is an easily administered, 30-item tool with yes-no answers or a 10-item short form. It omits somatic symptoms and was designed specifically for older adults.	Each yes answer accrues one point and the score is totaled. For the long form, a score of 10 or less is normal.
Beck Depression Inventory[29]	Patients rate cognitive, affective, and somatic symptoms on a brief, easily administered, 21-item self-report scale.	A score of 10 or lower is normal. Cognitive/affective items are the best indicators of depression in physically ill patients. The total score is a sum of zero to three points per item.
Hopelessness Scale[30]	This 20-item, true-false scale of self-report statements is arrayed within three factors: feelings about the future, loss of motivation, and future expectations. It can help clinicians differentiate suicide threateners, suicide attempters, and control patients. It has an internal consistency of 93%, a 91% sensitivity for inpatients, and a 94% sensitivity for outpatients. Some experts argue that it's a better index of suicidality than depression scales.	Each item marked in the direction of pessimism receives one point. The sum indicates suicidality among adults, but reliability for adolescent minority females lacks verification.
Suicide Intent Scale[31]	This 15-item, structured clinical interview helps clinicians assess the severity of psychological intent to die at the time of a recent suicide attempt. Items include thoughts and behavior surrounding the attempt, attitudes toward living and dying, and relationship to substance abuse. It measures intensity and pervasiveness of death wishes.	This instrument uses a three-point rating scale. Although it has been used largely as a dependent variable, it has been able to predict eventual suicide among attempters.
Scale for Suicide Ideation[31,33]	This 19-item scale helps clinicians determine the degree of current thinking about suicide. Items are answered in a structured clinical interview and include frequency and duration of control over suicidal wishes, characteristics of a contemplated attempt, purpose of an attempt, details of method, and strength of wish to live or die.	This instrument uses a three-point rating scale. Reliability and construct and concurrent validity have demonstrated its usefulness.

Continued on page 53

Continued from page 48

tient's home, and closely supervising potentially lethal medications are essential precautions. Others include acting promptly to improve management of pain, depression, and other symptoms that may decrease the quality of life.

When a patient clearly has a high risk profile with an immediate and lethal plan, hospitalization is recommended. Individuals with a more moderate risk profile often can stay at home, with friends or family maintaining a suicide watch and helping them weather emotional crises.

Cognitive behavioral therapy and family therapy have been successful in treating psychiatric disorders among suicidal older adults. One systematic review of randomized clinical trials involving adults has shown that cognitive therapy is effective—and may be more effective than drug treatment alone for mild to moderate depression.[35] Cognitive behavioral therapy focuses on such dysfunctional beliefs as hopelessness or helplessness and encourages the patient to reexamine these beliefs while exploring new thinking patterns and problem solving techniques.

To save the life of a suicidal patient, the clinician must discover and reduce the emotional pain and explore options to suicide. Because most suicidal people have a firmly held belief that they cannot or will not pull out of their current misery, the clinician's goal is to redefine that which seems intolerable: Through empathy, caring, consultation, and referral for mental health counseling, the clinician may transform the patient's will to die into a will to live.

Biomedical treatments include pharmaceuticals to treat the underlying psychiatric disorder (be it depression, anxiety, or substance abuse) and, possibly, electroconvulsive therapy (ECT). Systematic reviews of randomized clinical trials have found that antidepressant therapy is effective in treating all grades of depression and ECT has been effective in treating acute depressive illness.[35]

Clinicians have a critical role to play in providing teaching, counseling, referrals, and support to patients and their families and in improving the health care team's communication about mental health problems. Although medical, psychological, and nursing literature contains many references to the teaching, support, and advocacy functions, the potential importance of clinicians in these roles is not widely accepted by consumers or even health care providers themselves.[36] Clinicians see themselves as being responsible for teaching patients, answering their questions, and giving them emotional support throughout their treatment, but they often fail to enact this role effectively. Research has shown that many suicidal patients' needs for information and support have not been met during the process of diagnosis or treatment.[5] Moreover, reasonable levels of support clearly are correlated with less depression and fewer suicidal impulses.[36]

To identify, intervene, educate, and counsel suicidal patients effectively, clinicians must sharpen their observational skills and take extra time with anyone who appears discontent, withdrawn, or depressed. By encouraging patients to talk and by functioning as an empathic listener, they may help reduce the patient's tension or depression and encourage help seeking behaviors.

THE CLINICIAN'S CHALLENGE

Evaluating a suicidal patient is a challenging endeavor that requires keen assessment skills and the ability to detect emotional symptoms that the patient may not report spontaneously. The clinician must be able to recognize and evaluate suicide risk, document and report the suicide potential, and advocate for treatment. To obtain treatment for a patient, nonphysician providers often must negotiate with other professional caregivers who may not recognize the suicide risk. A thorough and concise evaluation provides a foundation for organizing a collaborative treatment approach and for providing the necessary safeguards.

Elderly people with diverse medical and psychiatric diagnoses require comprehensive mental health assessment. Screening tools can help clinicians detect suicide risk, particularly when the patient fails to disclose it. Clinicians must remain vigilant and routinely screen elders in primary, chronic, and specialty care lines for suicide risk. When risk is detected, clinicians need to take precautions to safeguard the environment, remove potential means of committing suicide, and monitor suicide risk.

An empathic clinician—who routinely explores the elderly patient's emotional pain, encouraging a therapeutic dialogue about emotional distress—can identify suicide risk and take steps to create a safe environment, improve treatment of physical and psychiatric disorders, and help the patient consider alternative solutions to suicide. ●

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