

Clue In to Suicide Risk Among Elderly Patients

BY MITCHEL L. ZOLER
Philadelphia Bureau

PHILADELPHIA — Older Americans are more likely to use lethal means in suicide attempts, Patrick Arbore, Ed.D., said at a conference sponsored by the American Society on Aging.

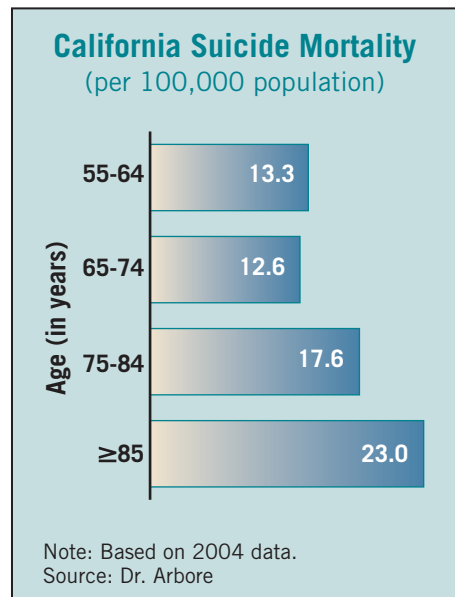
In addition, he said, the elderly are more likely to complete suicides. For every four suicide attempts among the elderly, one is completed. In the general population, for every 8-25 attempts, 1 is completed. Suicide attempts to completion are about 4:1 among the elderly, compared with a rate of about 8:1-25:1 in the general population.

In California, reported suicides in 2004 occurred in 23 per 100,000 individuals aged 85 or older, or at a rate that is about 30% higher than for the 75-84 age group. In turn, people aged 75-84 had a suicide rate about 38% higher than younger groups in the California data, said Dr. Arbore, founder and director of the Center for Elderly Suicide Prevention at the Institute on Aging in San Francisco.

However, there is no distinctive type of elderly suicide. The range of episodes among this group is the same as it is for younger people. The elderly can have protest suicides, often because of an inability to adjust to physical decline; preemptive suicides, in which a person observes and perceives the death of a loved one to be a terrifying experience and chooses to end his own life; or murder-suicides, in which a person first murders someone else (such as a spouse), then takes his or her own life.

An elderly person contemplating suicide often will see a physician before attempting the act, although suicidal ideation usually is not brought up by the patient, and the patient's depression is hidden or missed, Dr. Arbore said.

In fact, elderly patients are much less likely to communicate their depression



than are younger patients. Covert depression is especially prevalent in elderly men. Even the occurrence of psychosocial risk events—recent losses—are of limited value for predicting suicidal feelings because these events are much more prevalent in older people than in younger groups.

Assessment of an elderly person, then, should include consideration of depression, as well as cognitive function, demoralization, paranoia, substance abuse, psychopathology, personality, environment, social context, and suicide risk.

“The goal is not to predict suicide but to place a person on a risk continuum, to appreciate the basis for suicidality, and to allow for a more informed intervention,” Dr. Arbore said.

An evaluation of clients in Dr. Arbore's San Francisco program showed that changes in vision, hearing, and mobility of ten were accompanied by increases in depression and hopelessness. Furthermore, suicide risk was associated with physical illness and functional limitations and the interplay of these with depression. ■

Behavioral Therapy May Prevent Sight-Related Depression

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

An in-home program that teaches problem-solving skills to patients with age-related macular degeneration decreased the incidence of new-onset depression, a recent study suggests.

In addition, the program appeared to shorten the course of depression that did occur, Dr. Barry W. Rovner of Jefferson Medical College, Philadelphia, and his colleagues reported.

Significant gains seen at the 2-month follow-up visit had dissipated by 6 months, but the project illustrates the practicality of using behavioral therapy to prevent depression in patients with chronic illness, rather than medications to treat depression after it has occurred, they wrote (*Arch. Gen. Psychiatry* 2007; 64:886-92).

Dr. Rovner and his associates randomized 206 patients (mean age 81 years) with age-related macular degeneration in both eyes to the problem-solving treatment or to usual care. The problem-solving therapy consisted of six in-home sessions delivered by trained therapists. The sessions focused on defining problems; establishing realistic goals; generating, choosing, and implementing solutions; and evaluating outcomes.

At the 2-month follow-up visit, 11 patients in the active group had developed depression (9 major and 2 minor depression). In the control group, however, 23 patients developed depression (14 major and 9 minor), which is a significant difference.

The lower incidence of depression appeared related to an ability to maintain favorite activities. Patients who received the therapy were almost 50% less likely to have given up a valued activity than were those who received usual care, the investigators noted.

Patients in the therapy group also reported improved scores on a scale measuring subjective visual function, despite the fact that they did not show objective improvement in visual acuity. Control patients reported a decline on the subjective visual function scale.

By 6 months, however, those differences had disappeared: Twenty percent of the treatment group and 26% of the control group had developed a depressive disorder. The difference was driven by more new-onset depression in the active group between 2 and 6 months. “This suggests that additional problem-solving therapy treatment may have been necessary to prevent depression in these subjects,” Dr. Rovner and his associates said.

They did note after 6 months a significant difference in the course of depression that had developed at the 2-month visit. Only 4 of the 11 depressed patients in the active group remained depressed at 6 months, compared with 16 of the 22 depressed controls, they noted.

Rather than viewing the short-lived effects of the treatment as a failure, health care professionals should consider the study in light of the possibilities it engenders, Dr. Charles R. Reynolds III and associates wrote in an accompanying editorial (*Arch. Gen. Psychiatry* 2007;64:884-5). In patients with chronic illness, it may be better to prevent depression than to wait until it occurs.

“For many patients, taking an antidepressant medication to prevent depression when they don't feel depressed may be a hard sell,” wrote Dr. Reynolds of the University of Pittsburgh, and his colleagues. “Teaching those more effective coping skills through the use of a brief, depression-specific, behaviorally oriented psychotherapy may be more acceptable to both patients and health care professionals.” ■

β-Carotene Does Not Improve Short-Term Cognition

BY MARY ANN MOON
Contributing Writer

The antioxidant β-carotene does not improve cognitive performance among healthy older men in the short term, according to a subgroup analysis of data from a longitudinal study.

These findings add to the growing list of study results concluding that counteracting long-term oxidative stress with antioxidants doesn't appear to protect against cognitive decline. However, it is still possible that long-term treatment with β-carotene may confer “modest” neuroprotection, reported Francine Grodstein, Sc.D., and her associates in the Physicians' Health Study (PHS) II.

The PHS II is an ancillary study

of the Physicians' Health Study, a randomized clinical trial assessing whether vitamin supplements prevent cancer and cardiovascular disease. Cognitive evaluations were added to the trial to assess any cognitive impact of supplementation. The PHS II study extended the follow-up on a subgroup of 7,641 male physicians (average age 73 years) from 1997 through 2003, and also added 7,000 new recruits aged 55 and older in 1998-2001.

Dr. Grodstein and her coinvestigators assessed cognitive outcomes for 2,989 subjects who took placebo and 2,967 subjects who took β-carotene for various durations that ranged from 2 months to 20 years. Verbal memory, immediate and delayed recall, category fluency, and

mental state were assessed.

β-Carotene yielded no cognitive benefits in subjects who had taken it for 3 years or less, according to Dr. Grodstein of Har-



β-Carotene had no benefit for those taking it less than 3 years.

vard School of Public Health, Boston, and her associates.

However, subjects who had taken β-carotene for at least 15 years showed better scores on several cognitive measures than did those who had taken placebo. “In general, the effect of long-term beta carotene treatment was comparable to delaying cognitive aging by 1 to 1.5 years,” the researchers said (*Arch. Intern. Med.* 2007;167:2184-90).

Nevertheless, in a subset of 4,074 subjects who had further cognitive assessments 2-4 years later, these differences were found to be not statistically significant.

Regarding this last finding, Dr. Kristine Yaffe of the University of California, San Francisco, said in an editorial accompanying this report, “it is curious that the authors

minimize the results for approximately 4,000 men who had repeated cognitive testing.”

Dr. Yaffe noted that “several trials have examined relatively long durations of antioxidant exposure (up to 10 years) and failed to find an effect of treatment on cognitive outcomes” (*Arch. Intern. Med.* 2007;167:2167-8).

“For the clinician, there is no convincing justification to recommend the use of antioxidant dietary supplements to maintain cognitive performance in cognitively normal adults or in those with mild cognitive impairment. Furthermore, there is new concern that high-dose antioxidant supplementation, including beta carotene, may have adverse health consequences including mortality,” Dr. Yaffe said. ■