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# Depression and Dementia: What Clinicians Need to Know (Part 2)

Assessing risk for suicide in depressed elderly patients with dementia is of great importance to healthcare professionals or caregivers who regularly see patients from this population. This part of a three-part series on depression and dementia takes a look at the risk factors and danger zones for suicide in these patients, and goes on to discuss available non-pharmacologic depression therapy.

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As we saw in Part 1 of this article,<sup>1</sup> the clinical picture of depression in the elderly, particularly when associated with dementia, is very complex and demands a rigorous evaluation.<sup>1</sup> In this installment, we will round off the patient evaluation with a thorough assessment of suicidal risks, and explore the various non-pharmacologic treatment options.

## Suicide

Older adults, whether patients themselves or caregivers of patients with dementia, are at a higher risk for suicide than are people in other age groups. With very few exceptions, suicide rates in countries throughout the world rise during the course of life to peak in old age for both men and women (Figure 1). As a rule, older adults do not convey the message that there are desperate as easily as the younger population, and are very serious in their attempts at suicide. The ratio

between attempts and completed suicide is 4:1 in older adults as opposed to 20:1 in the general population and 200:1 in young women.<sup>2</sup>

In this light, it becomes even more important for family physician to assess for risk of suicide with suspected or confirmed depression. This screening can be achieved through direct questioning about feelings of hopelessness or about thoughts of dying or suicide.<sup>3</sup> There are 10 well-recognized risk factors in suicide that form an easy-to-remember acronym: SAD PERSONS (Table 1).

## Risk Factors in Suicide

**Sex.** The suicidal risk is higher in men than in women. As a rule, there are three to four times the number of suicides in men than there are in women.

**Age.** As mentioned above, the risk for suicide augments with age. In women, the rate reaches its peak at the age of 75 years and over

(30 suicides per 100,000 women). In men, the rate peaks in this same age group (75 suicides per 100,000 men). The World Health Organization (WHO) found that, in 98% of the countries of the world, the highest rates of suicide, in men and women, are in those 75 years of age and older.<sup>4</sup> For the past 10 to 15 years in North America, 25% of all suicides were committed by people aged 65 years and over.

**Depression.** The presence of clinical depression or major affective disorder plays a major role in the risk for suicide. For a list of symptoms of depression, refer to Part 1 of this article<sup>1</sup> for the useful acronym, SIG E CAPS.

**Previous attempt.** As a rule, and if all ages are examined together, there is about 10 times the number of suicidal attempts than suicides. However, as a particular sub-group, those that have made a previous suicidal attempt (even if this attempt occurred many years ago) are 10 times more likely to die as a result of suicide than is the population in general.

**Ethanol.** Alcohol seems to play a role in the majority of suicidal attempts. It can be used as an auto-medication in an attempt to counteract psychic distress, and always leads to a lowering of judgement. Chronic alcoholism or, worse, a recent return of alcoholic problems, is very serious and family physicians should never hesitate to assess this situation with their elderly patients. It is likely that a chronically alcoholic elderly male patient who says he is suicidal represents a clinical situation of the utmost urgency.

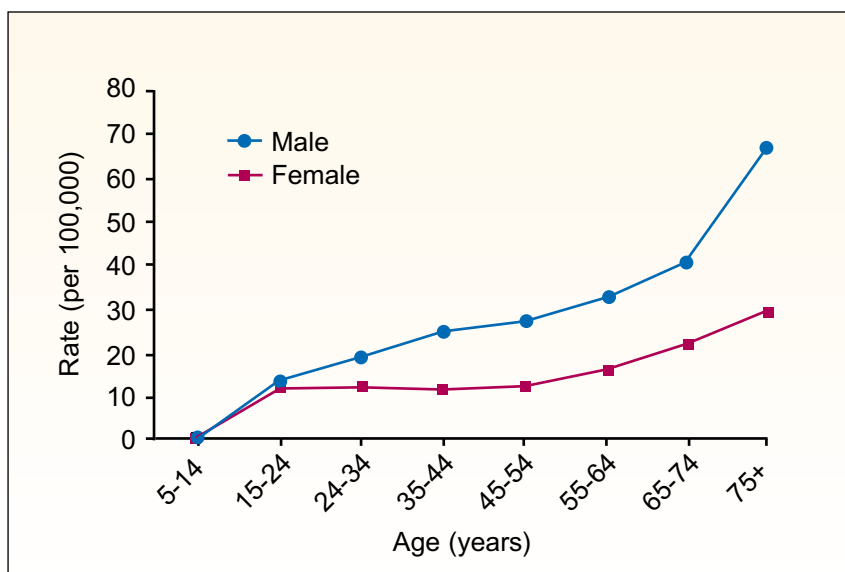


Figure 1. Suicide rates worldwide in 1995 by gender and age – WHO.

**Rational losses and loss of rationality.** An individual's losses can include, among others, the death of a friend or a family member, a feeling of loss of usefulness, loss of vigor and loss of self-esteem. These all are important factors. Loss of rationality refers here to the deficiencies in judgement that will appear in early dementia, particularly affecting the frontal lobes (often the case in Alzheimer's disease).

**Social deprivation, solitude.** An absence of familial support or community ties play a role in elevating risk for suicide. Living alone, and solitude in general, become risk factors.

**Organized plan.** A very precise and organized plan of suicide should send important signals to family physicians and other health-care professionals.

**No spouse.** Although it is mentioned above that solitude is, by itself, a risk factor, the specific absence of a spouse or a loved one is also an important, separate risk factor. It is important to remember that the absence of a spouse can be the cause or consequence of depression.

**Sickness.** The co-existence of physical illnesses, particularly chronic medical illnesses and, even more important, medical illnesses associated with pain, are of the utmost importance in establishing risk for suicide.

### Danger Zones

In addition to the risk factors outlined above, there are several well recognized "danger zones" associated with suicide. These can be understood as follows:

**The "three month" law.** There is a clear danger of recurrence three months after a first suicidal attempt. Psychological factors may be at work here. In the few weeks following a suicidal attempt, the mobilization of physicians, care providers, friends and family members is usually quite impressive to the patient. After a while, this activity and interest often "cools down," leading to a return of feelings of solitude and despair.

**The "one month" rule.** This is an *absolute* rule that must never be forgotten by any

Table 1

Risk Factors for Suicide:  
SAD PERSONS acronym

- Sex
- Age
- Depression
- Previous attempt
- Ethanol
- Rational losses and losses of rationality
- Social deprivation and solitude
- Organized plan
- No spouse
- Sickness

professional caregiver. In the case of a suicide of an elderly patient with or without dementia, the risk for suicide is immense in the few following weeks in *everyone* who has been in contact with the patient in question. When someone has emotional, professional, sympathetic or empathetic ties with someone who has committed suicide, pessimistic reflections (*e.g.*, on the meaning of life) can be provoked. Anyone who is somewhat fragile at that time (for whatever reason) is seriously at risk for suicide. This includes all other patients of the unit if the patient was in a hospital or a nursing home, as well as family members, friends and all the clinical caregivers.

**The anniversaries law.** Wedding anniversaries, birthdays or death anniversaries of a loved one, as well as special holidays like Christmas, have a great psychodynamic importance in suicide risk.

**The post-surgery law.** Within the elderly population, the risk for suicide increases following a surgical intervention (even relatively small surgical interven-

tions) and clinical situations (*e.g.*, infections) that take a long time to heal.

### Treatment

It is important to keep in mind the treatment goals for depression in any elderly patient.<sup>5</sup> These include eliminating or decreasing depressive symptoms, reducing the risks of a relapse or the eventual recurrence of a depressive episode, and increasing the quality of life for the patient. It should not be forgotten that, in elderly patients, the proper management of depression also improves general medical health status.

### Non-pharmacologic Therapy

Families of patients with dementia carry a heavy burden, and fragile relatives may develop psychiatric disorders, such as depression. The benefits of reassurance, information, support and, at times, psychotherapy are obvious for family members. Furthermore, these frequently result in delayed institutionalization of the patient.

Patients with depressed symptoms early in their dementia may respond, depending on their capacity for insight and the nature of their problems, to psychotherapeutic techniques such as counselling, insight-oriented psychotherapy, life review and reminiscence therapy. These are interpersonal approaches, practiced in individual, group or family settings, that help to clarify issues, relieve social isolation and address grief reaction. Cognitive therapy that helps revise mal-

adaptive thinking, perceptions, attitudes and beliefs also can be very useful.<sup>6</sup>

Symptoms of depression that occur later in dementia are more likely to respond to reality orientation techniques in an individual or small group setting. Behavioral therapy will help modify problematic behaviors by manipulating the environment. Other approaches, including relaxation techniques, music and art therapies, and even aromatherapy, can be useful.

Physicians should encourage their patients suffering from dementia, and elderly caregivers, to participate in activities offered by local senior centers or volunteer groups. Participation in daily living activities, such as shopping, social activities and entertainment, also should be encouraged. Of course, and as usual, the local Alzheimer Society remains an exceptional source of support.

In the third and final installment of this article in the next issue of *The Canadian Alzheimer Disease Review*, we will take a detailed look at the different pharmacologic treatment options for depression in this patient population.

#### References

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