

# 'Rational Suicide' Talk Increasing Among 'Healthy' Elderly

Deborah Brauser  
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NEW ORLEANS — The incidence of healthy elderly patients raising the issue of "rational suicide" is on the rise, and clinicians need to be prepared to address it.



Dr Robert McCue

Here at the American Association for Geriatric Psychiatry (AAGP) 2015 Annual Meeting, a session dedicated to the issue aimed to provide guidance to clinicians who may be faced with elderly patients expressing a desire to die by suicide while they are still relatively healthy and cognitively intact.

The concept of suicide based on reasoned decision has been gaining acceptance, particularly in terminally ill patients. But what about older people who are concerned about their failing bodies and feel that their life is already complete?

"The possibility of rational suicide is not discussed much in the psychiatric profession. Our patients may have information about it and may have opinions, but we have no training about this at all," session moderator Robert McCue, MD, clinical associate professor of psychiatry at New York University (NYU) School of Medicine, in New York City, told conference delegates.



Dr Meera Balasubramaniam

"I don't think we talk about it because it's not clear how we fit it in within our modern practice of medicine," added Dr McCue.

Following the session, Meera Balasubramaniam, MD, MPH, clinical assistant professor at NYU, told *Medscape Medical News* that the session was not about whether physicians should or should not be involved with assisted suicide.

"Our main focus was on the fact that more and more individuals are expressing the wish to end their lives when they're doing well, and we're often called upon to see these patients," Dr Balasubramaniam.

"So what should be the process for interacting with them, and what's the right intervention?"

### **Enough Is Enough**

The session opened with presentations of cases of elderly individuals who went on to commit suicide. The first presentation included clips from a televised video interview of a smiling 83-year-old woman who said she was not depressed but had had many operations during the past 10 years, "and that's enough, I think."

She added that she was going to be taking barbiturates and had made several specific plans, including a decision as to who would take her dog. "I think my friends will understand. People should have the right to go with dignity," she said on camera.

The second case involved an 87-year-old man who had had two strokes, and his vision was deteriorating rapidly. He jumped out a window after leaving behind an organized note and after having made detailed arrangements for the distribution of his money.

The third case involved a frail woman who petitioned Dignitas, a not-for-profit assisted suicide organization in Switzerland.

"All three of these cases could be construed as rational acts," said Dr McCue. "They weren't impulsive, and in the first and third cases, they spoke to the media ahead of time and had a lot of discussion with friends and family first."

He noted that the term "rational suicide" was first used in an article by David J. Mayo, PhD, that was published in the *Journal of Medicine and Philosophy* in 1986. Since then, the concept has been written about frequently.

Dr McCue said that the term is usually used with regard to a person with free choice, sound decision-making skills, and what they consider an unremitting, "hopeless" physical condition.

He reported that in Switzerland, euthanasia is illegal, but assisted suicide is legal, including assisted suicide by nonphysicians, "if there is no selfish motive." Thus, Dignitas' not-for-profit status.

In other countries, such as the Netherlands and Belgium, euthanasia is legal. Although not yet a law, a 2010 call for allowing all Dutch people older than 70 years "who feel tired of life" to have the right to professional assistance in ending it is currently in legislation.

In the United States, euthanasia is illegal, but assisted suicide is legal in Vermont, Washington, and Oregon.

Although approximately 90% of individuals who die by suicide have a clinically diagnosed psychiatric disorder, "no study has found that 100% of suicides have a psychiatric illness. And I've not been trained about non-psychiatrically ill suicides," said Dr McCue.

"This puts a burden on us and makes us wonder how we're going to treat someone who may not have an illness. How do you approach someone like that?"

### **Dying on Their Own Terms**

In her talk, Dr Balasubramaniam presented cases of two elderly patients, an 88-year-old man and a 93-year-old woman, with no signs of mental illness who came to her practice and mentioned wanting to die on their own terms.

"I've had three near falls this month. How should it make a difference to anyone if I go at 93 or at 95?" the woman is reported to have said. The man noted that he would rather "die a year early than too late."

"What should we do during our diagnostic considerations?" asked Dr Balasubramaniam. "Is suicidal ideation a marker of underlying mental illness? Is it reflective of aging or physical illness? Or is it a rational, reasonable response to the situation at hand? And is it justified to jump to psychiatric hospitalization — what would be the goals of treatment?" She also wondered how clinicians should integrate their own feelings into treatment. Regarding the two patients she presented, after several discussions, neither patient ended up being hospitalized or following through with suicide. "But overall, there are so many questions and things we all need to think about."



Specific Trauma Types Linked to Late-Life Suicidal Thoughts



### Homicide, Suicide Risk 'Overlooked' in Dementia Patients

Elissa Kolva, PhD, from the Colorado Blood Cancer Institute, in Denver, noted that lessons can be culled from research into psycho-oncology and palliative-care psychology, including the following guiding principles:

- Conduct a thorough assessment;
- Determine whether suicidal ideation is independent of a psychiatric diagnosis;
- Realize that "rational doesn't mean untreatable";
- Explore the motivation for the expressed ideation; and
- Identify areas for interdisciplinary intervention.

Dr Kolva noted that having a bad social support system or worrying about being a burden to loved ones is often cited as a reason for suicidal ideation.

Possible interventions could include meaning-centered psychotherapy, dignity therapy (which stresses improving quality of life and connection to family), social work for increased resources, or even spiritual options.

## **Guidelines Needed**

Although the symposium was the last presentation on the last day of the meeting, it was full of audience members eager to ask questions and share their own experiences during the question and answer session.

The first conference delegate asked that this be the first session next year and noted that he has had case after case of patients refusing treatment "because they want to be done." He added that it is important to help them to get to a place where that is a rational and ethical decision.

However, the next commenter disagreed vehemently, stating that "suicide is almost always wrong. When it's your time, you'll go. Otherwise, it complicates things too much for doctors."

Dr McCue noted that the session was not about taking a stand or defending one position over another.

"But people really should begin thinking about all this. And through that, hopefully there will be some evolved guidance for mental health professionals who deal with older people who talk about wanting to end their lives when they see fit to do it. Whether or not an organization says there's no such thing as rational suicide, our patients often feel differently," he said.

"Right now we really don't have much guidance in the field, but I'd say, let's open up discussion, including discourse and varying opinions. And maybe out of that, there will be some consensus on how to approach patients like this."

*Dr McCue, Dr Balasubramaniam, and Dr Kolva report no relevant financial relationships.*

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