UNC-CH School of Social Work
Clinical Lecture Series

When is it ok to want to die?

Ethical considerations in treating depression among older adults

October 18, 2010

Lea C. Watson MD, MPH
UNC Department of Psychiatry
Lea_watson@med.unc.edu

Goals for this talk

- Review what makes late-life depression unique
- Discuss what is "treatable" and when to refer
- How not to panic when patients want to die
- Review 3 relevant cases
- Share some experiences – learn from each other
- Remind you of what you already do best

Ethics

That branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such actions.

Dictionary.com

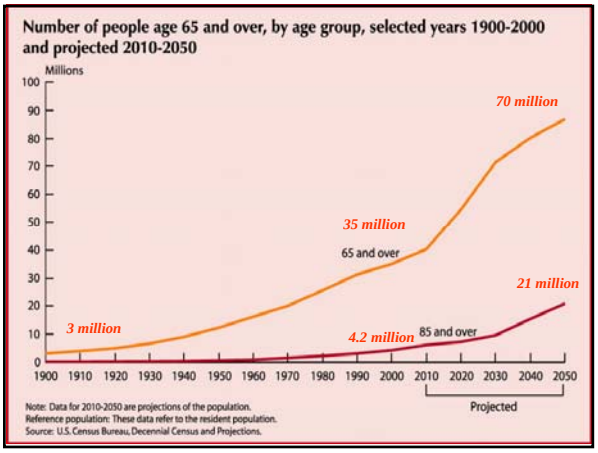
What is depression?

- NOT *occasional* sadness, grief or worry
- Feeling bad most every day, unable to enjoy things, low energy, crying, thoughts of death or wanting to die
- Disrupts normal life

"Despair beyond despair"

"In depression…faith in deliverance, in ultimate restoration, is absent. The pain is unrelenting, and what makes the condition intolerable is the foreknowledge that no remedy will come – not in a day, an hour, a month, or a minute; it is the *hopelessness* even more than the pain, that crushes the soul."

~ William Styron
(Darkness Visible: A Memoir of Madness)



The New Face of Old Age

I need now more daisies, fewer orchids
more Wednesdays and fewer Saturdays.
I need larger print, larger sizes and much larger ice cream cones.
I need shorter lists and longer vacations,
more Whitman, less Wordsworth,
needles with larger eyes, and windows with larger views.
I need more Chinese red, less Paynes gray,
more reels, fewer dirges,
more silliness and banter,
less humorless fervor,
more puddles, more stars,
more old photographs, letters, and shoes,
less hurrying, less regret
more attentiveness, and noticing.
I need more gentle adequacy,
less rigid perfection.
I need more truth-telling fairy tales
and fewer arcane philosophies.
My needs match the slowing of my step,
the quickening of my heart,
the letting go, the holding fast, and the unexpected welcoming of change.

~ c.a.armstrong

Late-life depression

- 3-5% community-dwellers
- 10% chronically ill in primary care
- 30-40% in LTC
- Minor/subsyndromal depression more common and independently associated with poor outcomes
- In primary care samples, MOST undetected

Late onset depression

- 1st episode after 60
- Alternative mechanisms
- Vascular hypothesis
- Can be concurrent with dementia
- Microinfarcts
- 20-30% post-stroke incidence
- High rate of silent stroke
- Executive dysfunction

Older adults with depression

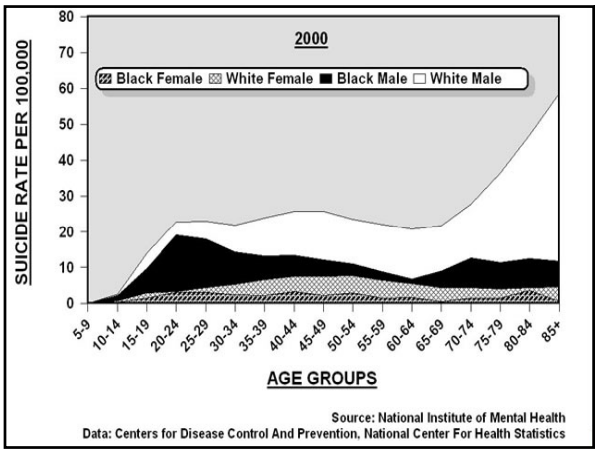
- May complain of physical symptoms such as pain, instead of “feeling depressed”
- Commonly isolate themselves, and don’t seem to enjoy anything anymore
- May also have memory issues, making it hard to tease out

Common issues in late life

- Competing medical demands
- Life transitions
- Poor insight into psychiatric symptoms
- Stigma about depression
- Goals of care may be different than younger

Risk factor for:

- Medical morbidity
- Disability
- Health care utilization
- Premature death
- Suicide



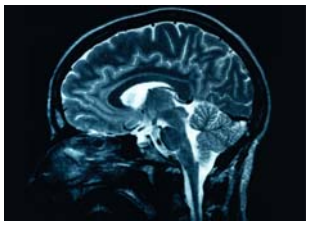
Myths

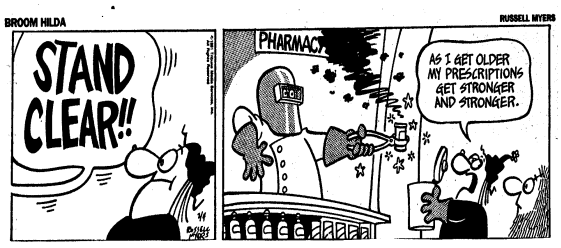
- Advancing age is an independent risk factor for depression.
- "You'd be depressed too" if you had cancer (…chronic medical illnesses)
- Fallacy of "good reasons"

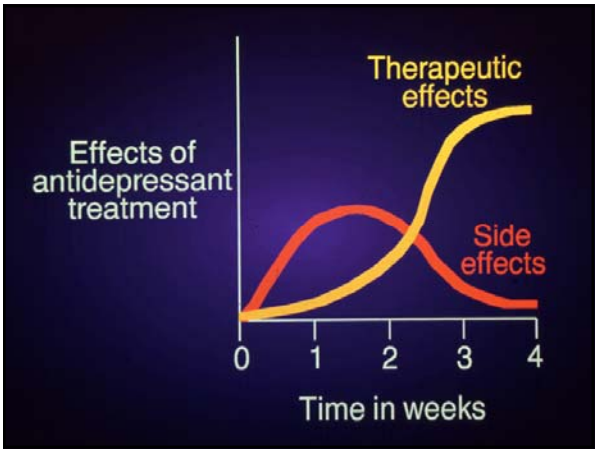
Treatment

- Anti-depressants equally efficacious
  - TCA's have more potential risks
  - SSRI's associated with falls in NH, SIADH
  - Work best in tx-naïve
  - →85 respond differently
- Effective Psychotherapies:
  PST, CBT, IPT, brief, family
- Bright light
- ECT

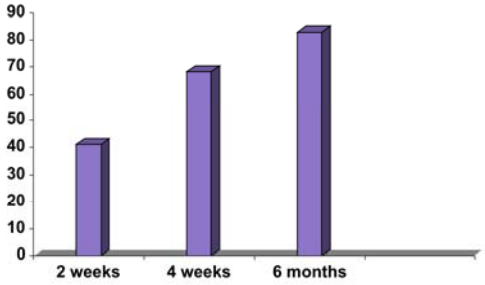
Older brains are sensitive to medications





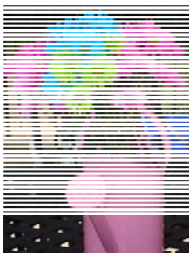


Time to discontinuation of anti-depressants in primary care



Depression Care Manager

- Educates the patient about depression
- Supports antidepressant therapy
- Coaches patients in behavioral activation and pleasant events
- Offers a brief (6-8 sessions) course of counseling, such as Problem-Solving Therapy
- Monitors depression symptoms for treatment response
- Completes a relapse prevention plan with patients



Things patients say…

"I wish I could just vanish…"

"I wouldn't care if I didn't wake up in the morning.."

"My family would be better off without me…"

"I've lived too long…"

"I have a loaded gun in the bedside drawer that I plan on using tonight"

"IT'S SO UNFAIR – SHE DOESN'T DESERVE TO DIE. I NEVER THOUGHT THIS WOULD HAPPEN."

96-year-old husband speaking about impending death of 92-year-old wife

"I'VE HAD A GREAT LIFE, I'M READY TO GO. DYING IS JUST A NATURAL PART OF LIFE."

Self-determination

the ability or right to make your own decisions without interference from others

Ann

70's, single female previously healthy and quite active

No psychiatric history

Had brain tumor removed, no malignancy – "cured"

Now weak, mildly disfigured, unable to taste or see as well as before (but can still do both)

She refuses to participate in rehab. and is losing weight "to go ahead and die"

Requests hospice care

Jack

86 yo married male, recently widowed, and with multiple medical problems that limit his quality of life

Previously very successful academic, having thrived his whole life on being "productive"

Now feels he has nothing to live for and wants to stop all his medications so it will "kill him"

from this…

to this ?

Herb

89 yo male caring for severely demented wife at home

No previous depression

Health is good, family is helpful

Sleep and appetite very poor with noted weight loss

Feels like death would be a "friend"

Ann

When you can't see your way out of the woods…

With much encouragement from her family, and a deal with her docs that we would revisit the plan in 2 months, Ann agreed to take antidepressants "to see if I can recover some function – but I'm not hopeful."

She experienced dramatic improvement in mood/appetite – and once her weight came up, she was able to fully engage in rehab. She is nearly back to baseline.

Jack

Measures of success…

Jack (after one year) refused to try meds, and was resistant to "talk therapy." He, however, continued to seek psychiatric services – but would not "comply" with recommendations. I quit making them, and now just listen (stopped my own resistance).

He still wants to die, but is no longer suicidal. He takes his life-preserving cardiac meds.

Herb

One of the antidepressant "miracle stories"…

Herb thinks I'm a hero, and routinely tells me so – because I gave him an anti-depressant that "got my life back." He continues to be the sole caregiver for his (NH –level dementia) wife – with remarkable good cheer. He does water aerobics, plays pool and enjoys a weekly beer with his buddies. He recently told me he'd like to travel again and feels he has a "lot of life left."

The middle way

- Not dichotomous issue on treatment
- Meet patient where they are
- Compassion changes the brain
- Pain ≠ suffering
- Pain X resistance = suffering
- focus on the resistance when you can't change the pain

ALLOWING DEATH TO OCCUR IS NOT CAUSING DEATH TO HAPPEN

Your difficult cases

What made it difficult?

How (or) did you tolerate the discomfort?

How (or) did it get resolved?

Creative problem-solving – share stories