Suicide in later life: The elephant in the room?

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Suicide in Later Life

• How common is it?
• What explains it?
  • Individual and cultural factors
• Theories of suicide-relevant to older persons?
  • Risk factors for late life suicide
    • How can it be treated?
• Suicide among veterans
How common is later life suicide?

- 20% of suicides involve older persons; they comprise 13% of the population
- 14.7/100,000 vs. 10/100,000 for general population
- Older men are disproportionately represented
  - Ages 66-74 30/100,000
  - Ages 75-84 42/100,000
  - Ages 85+ 55/100,000
- Women ages 66-85+ < 10/100,000
- Census Bureau data—older suicides increased disproportionately during the pandemic—why?
How common is later life suicide?

• **Ratio of attempts to successful suicides varies by age**
  – Attempts are more common among young adults (200:1) vs. older adults (4:1)
  – Attempts are more common among women
  – Gender differences in attempts are less so in young adulthood and later life
    • Older (Caucasian) men are most successful
    • Lethality favors older men (firearms, hanging) – lessens chances of survival
    • Older women (poisoning, gas, OD of medication)
  – This is not the case for African American, Hispanic, and Asian men- successful suicides peak between ages 15-44, declining thereafter
    • more common in Asian and Latin cultures
    • Explanations? -family is central, beliefs about acceptability
Key Concerns in understanding later life suicide:
Societal/ cultural factors

- Multitude of causes- not a normal response to stress/loss
- Ageism, stereotyping of older persons
  - Principle of compensation
  - Regressive intervention
  - Quality of life - Our Personal Equation in defining the line of unbearability
  - Feeling forgotten, disenfranchised, my life does not count
  - Cultural beliefs that suicide is acceptable increases suicide, especially when family troubles/dishonor or financial difficulties are present (cultural script)-less so for illness (2020 study)
- Industrialized society emphasizing individualism
  - Retirement equals being no longer productive
  - Protestant work ethic internalized by older generations
  - Leisure is something to feel guilty about
  - One should be able to control one’s own life
- Age segregation – implicit and explicit
  - Loneliness, poor health
  - Lack of social support
  - Acknowledgement of older suicide as a social problem requiring our attention
Key Concerns in Understanding later life suicide:
Personal factors

• **Grief and loss**
  – Narcissistic losses
  – Irreplaceable losses
  – Bereavement overload
  – disenfranchised grief-relevant to survivors as well (stigma)

• **Making Faulty assumptions about suicide:**
  – Suicide is not a permanent solution to a temporary problem in later life- many problems in later life are permanent ones
    • Widowhood, ill health, institutionalization, mandatory retirement
  – Suicide prematurely cuts short a full life- less relevant to older persons
  – Things will get better; think of your responsibilities to others- relevant to older persons?
  – Suicides are attempts to call attention to a problem- a means of communication –all suicide attempts are “failed suicides” in later life
Theories of Suicide - Relevant to Older Persons?

- **Biological predisposition to suicide** - evidence is lacking
- **Societal** - altruistic, egoistic, fatalistic, anomic (Durkheim)
- **Psychoanalytic** - suicide represents a lack of ego strength, dominance of death instinct, suicide is homicide turned around 180 degrees
- **Learning** of aggressive behavior directed to self, suicide is modeled via family history
- **Social change** - lack of societal awareness of issues pertaining to life and death
- **Cognitive** - emphasis on perception of self/world
  - Helplessness, hopelessness
  - Losses are overwhelming/lack of coping resources
  - Loss of self though retirement, widowhood, illness, institutionalization
  - Lack of control over important matters in one’s life
Risk factors for later life suicide

• **Fundamental, contributing, precipitating causes of suicide:**
  - **F-Early life experiences** – the glass is always half empty (early childhood trauma)
  - **C-Unsettled life pattern** that works against one (marriage, job, relationships)
  - **C-Perturbation/disturbance** with life (reaction to, precursor of)
  - **C-Constriction/narrowing** of thinking (isolation from others)
  - **P-Perception** that suicide will end pain and isolation

• **Physical illness** that is life-threatening, or chronic, gets worse, or painful (chronic lung disease, CHF)
• **Depression** (dysphoria, bipolar illness),
• **High neuroticism, low openness to experience, perfectionistic**
• **Hospitalization** for physical/psychiatric illness

• **Alzheimer’s disease per se is not a risk factor**
  - Suicide pacts among older couple- caregiver kills AD sufferer and then himself
  - Relevance of Mild Cognitive Impairment—may lay the groundwork for later suicidal ideation
  - Assisted suicide- Kevorkian’s first patient was a 48-year old women recently Dx with Alzheimer’s
  - 30% of middle age/older persons (N =730) consider suicide/are at least ambivalent if faced with a Dx of AD
    - Religious beliefs, being a burden, embarrassment, quality of life, end suffering, loss of valued cognitive skills
    - Caregivers are at risk just as older persons more generally
Risk factors for later life suicide

• Classic qualitative study by Miller (1979)
  – Psychological autopsy of 300 older male suicides
  – 8 factors:
    • Reactions to physical illness (heart attacks, cancer)
    • Reactions to chronic mental illness - cause/effect?
    • Threat of extreme dependency/institutionalization
    • (recent) Widow(er)hood
    • Retirement
    • Pathological personal relationships (abuse, marriage)
    • Alcoholism/drug use
    • Multiple factors
2015 study-Univ of Rochester

• Attributions/reasons why- 101 older adults in emergency rooms for suicide attempts
  – Desire to escape
  – Lessened functioning/loss of autonomy
  – Depression/psychological problems
  – Somatic problems/physical pain
  – Thwarted belongingness/family conflict-more likely to use lethal means/re-attempt within a year-active monitoring necessary
  – Perceived burden to others- not the case as with belongingness
  – Lack of meaning in life/not wanting to live
  – Some gave no reason/could not remember or understand their attempt
Risk factors in later life suicide

- **History of suicide attempts** negatively predict suicide in later life
  - Method of lethality key- very important for older men
  - Lack of knowledge of/contact with crisis intervention services
  - **Stigma** attached to suicide- creates moral crisis
    - Relevance to grief of survivors, insurance benefits
    - Coverage by media implies that suicide is acceptable
    - Exposure to suicide can lead to complicated grief/PTSD for survivors
  - **Hopelessness** associated with previous visit to health care professional
    - Chronicity of illness- loss of hope for the future
    - How much is my life worth, really? Am I better off dead? Who cares about me?
      - Lack of knowledge/directness by physician
- **Resilience** (self acceptance, positive meaning in life, positive relations w/other) is related to less suicidal ideation
Warning Signs

- Thinking about life and death in absolute terms (illness or retirement take everything away from me- my life was over after my wife died)
- Talking/reading about suicide and depression
- Giving valued possessions away
- Hopelessness/helplessness
- Sleep difficulties
- Lack of self care
- Stockpiling medications
- Sudden interest in firearms/availability of firearms
- Social withdrawal
- Change in everyday behaviors
- Rush to complete/revise a will
- Overt suicidal threats
- Suicidal ideation that is active, presence of gun at home
When is a suicide a suicide?

- **Intention is key**-thinking about suicide may have been present awhile
  - Suicides in later life are **Egoistic**—alienation from others and life, lack of societal/group integration, **purposeful** in nature (Durkheim)
  - **All** attempts in later life must be considered as serious and purposeful
  - Special attention to men, those who are isolated, institutionalized, or chronically ill

- **Indirect self destructive behavior** (Schneidman)
  - Failing to take care of one’s health—weight loss, general appearance
  - Drinking, taking drugs, mixing drugs and alcohol
  - Failing to take medications
  - Provoking a staff member via one’s behavior
Suicide Intervention in later life (Lapierre et al, 2011)

- **Focus upon decreasing risk factors** (e.g. depression, illness, institutionalization, social isolation) and enhancing protective factors
- **Preventative/resilience strengthening programs**
  - Focus on protective factors
  - Improve quality of life for older persons, shift focus to what older persons can do, older persons as a resource, hopefulness vs. emphasis on late life decline, invisibility, problem orientation, helplessness
  - Change our views about growing older!
- **Telephone counseling, Clinical (pharmacological, interpersonal) therapy**
- **Health promotion, support groups/social support**
- **Greater reliance on friends and family, community gatekeepers as sources of info**
- **Create peer counseling/peer support a la Hope Squad (community-based peer support)**
- **Community-based outreach**
  - Mental health workshops, screening for depression, assessment of suicidal risk
  - Assessment of depression, hopelessness and suicidal ideation
  - Facilitating group activities
  - Proactive in nature (home health care, primary care physicians, psychologists, social workers, nurses)
  - Only 38% of those elders who attempted suicide were Dx with a mood disorder
  - **1-800-273-TALK national suicide prevention hotline (988)**
Intervention - available evidence

- Existing programs are more successful with older women (Lapierre et al, 2011)
- Key dimensions of intervention
  - Treating depression and enhancing one’s skills in managing it
  - Increasing everyday functionality
  - Develop a therapeutic alliance, personalized treatment plan
  - Proactive follow-up
  - Problem- High rates of refusal/dropout in some studies
  - In treating an older person who is suicidal:
    - Is suicide morally defensible?
    - Have I erred in trying to prevent someone who is older from killing himself? Immediate hospitalization? What is the risk in not doing so?
    - “Have you walked in my shoes?”
  - Listening and talking, listening and talking, listening and talking
  - Proactive, proactive, proactive
  - Enhance protective factors
  - Assess degree of risk- be cautious about assuming low risk for suicide
CDC webinar 2020-intervention

• Take a public health approach - awareness of the problem, changing attitudes (keep well, seeking help is a strength) - cancer/heart disease parallel - proactive effort/commitment

• ID older adults who are at risk - loss, pain, insult, depression, drinking, older men
  – Isolation, having access to physical means for self harm (fearlessness about pain, injury, death)
  – Changed thinking about ending one’s life - 2 year gap between thought and action
  – Rarely impulsive - no evidence for efficacy of a safety contract
  – More attention to those seeking health care - 80% of older men who killed themselves had a healthcare visit 1 month prior to their deaths, those recently released from psychiatric care - routine question re: self harm as part of healthcare screening - be direct
  – Safety planning - what were you doing when you thought about suicide? (call hotline, be with others)
  – Remove access to means for self harm - stress reasons for living, follow-up is important
  – Personal contact - phone call, home visits, handwritten letters - lessens isolation / gives hope
NCOA webinar- 2021

• Screening for risk-overcoming stigma

• **Barriers to getting help**-personal contact, community education, community-based services, outreach (800-273-8255) (988)

• **Physicians are key**-proactivity, not normal in later life

• Project ASSIST-connect with elder, understand choices/alternatives to suicide, develop a safety plan

• **Empathy, not judgment**
Barriers to Communication about Suicide

- My parent (spouse/partner) will get angry with me
- I will insult him/her
- I might put suicidal thoughts in his/her head
- I won’t know what to say
- I wouldn’t know what to do
- Lack of knowledge about resources

**ASK** - Ask the question, **Seek** more info, **Know** where to refer
Suicide among Veterans

• **17-22/day** (an underestimate- rests on accurate data- may/may not be on death certificate, excludes behavior that is not overtly suicidal- drinking, lack of self care) 12/100,000 vs 21/100,000
• % has decreased, overall number has increased over last decade
• Family concerns, insurance benefits influence labeling a death as a suicide
• Veterans (many of whom are older, aged 55+) are at risk
• History of depression/major depression exacerbated by combat-related stress (guilt, anger, grief, flashbacks)
• Symbolic suicidal behavior- drug, alcohol use, smoking
• PTSD (flashbacks, anxiety, guilt, anger, adjustment difficulties), traumatic brain injury (pain, frustration, loss of hope for improvement- applies to Vietnam, Iraq & Afghanistan veterans)
• PTSD correlates with suicidal ideation, even for those who do not meet clinical criteria for PTSD
• Male, older age (not true for female veterans) are risk factors
Suicide among Veterans

- **Risk goes up after age 55 for veterans vs. non-veterans for men**, not for women
- Any trauma may put one at risk for suicide
- Among veterans, non-fatal attempts favor women
- Attemptors either in primary care or outpatient mental health care
- Non-fatal suicide attempts - intentional overdose, poisoning
- VA Crisis hotlines, inpatient, residential MH centers are key/targets for help
- **First 4 weeks after service discharge are critical** - require close monitoring/case management
- **More accurate and timely assessment of risk, more comprehensive MH care are key**
- 50% of those with PTSD do not seek treatment; only half of those who get treatment that is “minimally adequate” (RAND study)
- Options for those with PTSD: **prolonged exposure therapy** (education, breathing, real world practice in confronting situations formally avoided- you gain control, talking about the trauma), **cognitive therapy**
- These options may not be viable for those who are actively thinking about suicide
Suicide among Veterans

- STARRS (Study to assess risk and resilience in servicemembers- 2015 NIMH funded)-no single indicator predictive-like reflect many factors
  - Male sex, Hearing loss, nonviolent weapons offense
  - # of inpatient days with somatoform/dissociative Dx
  - Score above 50 on USAF qualifications test
  - Suicide attempt prior to enlistment
  - Previous Dx of psychosis, suicidal ideation, depression
  - **Focus on transitions /coordinate with MH professionals** (change in assignment, returning from deployment, active duty to reserve duty, leaving the military)
  - **Go beyond VA to provide care**-community-based-Operation Deep Dive-examines community factors in veteran suicide
  - **REACH A VET screening, Safety Planning intervention** –follow-up of hospital emergency care- Univ. of S. Alabama