Care for suicidal older people: current clinical–ethical considerations

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This article opens by reviewing the state of the knowledge on the most current worldwide facts about suicide in older people. Next, a number of values that have a role in this problem are considered. Having a clear and current understanding of suicide and of the related self-held and social values forms the framework for a number of clinical–ethical recommendations for care practice. An important aspect of caring for older people with suicidal tendencies is to determine whether their primary care fosters self-esteem and affirms their dignity. In addition to providing a timely and appropriate diagnosis and treatment of suicidality, the caregiver is responsible for helping the patient to cope with stressful conditions, and for treating the patient with respect and consideration, thereby supporting the patient's dignity and giving the patient a reason to live. Paying attention to these central points will foster caring contact with suicidal older people.

only those actions that lead to immediate death, the act being carried out without help from others. Suicides occur when death is the direct and desired consequence of wounding or intoxicating oneself. A clear distinction exists between suicide and euthanasia: in suicide the person shortens his or her own life, whereas in euthanasia, a third party carries out the act.⁷ In addition, suicide is clearly different from physician-assisted suicide, in which a physician provides a person with the necessary means to end life but the person is still the one who carries out the act.⁷ With the World Health Organization definition, no physician is involved; the person deciding to commit suicide does not receive medical guidance, nor does his/her decision to commit suicide fit within the medical decision-making framework concerning the end of life.

Incidence

The global incidence of suicide increases with age¹ (fig 1). Worldwide, the number of suicides per 100 000 males aged ≥ 75 years is up to twice that of males aged < 25 years.⁸ With women, the rate in the > 75 years bracket is even higher, up to three times higher than that of females aged < 25 years.

In most European Union member states, the lowest number of suicides occurs among young adults (15–24 and 25–34 years), whereas the highest number of suicides occurs among older people (65–74 and > 75 years).² Only in the UK, Ireland and to a certain extent in Finland is the trend different: in these countries, the greatest number of suicides occurs among adults within the younger age brackets (fig 2). In countries such as Germany, Italy, Spain and Denmark, the number of suicides increases steadily with increasing age (fig 3). In countries such as Belgium, The Netherlands, France and Austria, although the highest number of suicides occurs among those in the oldest age bracket (> 75 years), a “peak” has emerged in the number of suicides among those in the younger age brackets (fig 4).

Overall, for every 12 suicide attempts, on average, one is successful. By contrast, for the > 75 age bracket, for every four suicide attempts, on average, one is successful.⁹ One interpretation of this disparity is that suicidal behaviour in older people has a more certain outcome compared with that in people of other age brackets. These findings can be explained, in part, by the physical vulnerability of those aged > 75 years; in general, their bodies have lost much strength and resistance such that their chances of surviving self-inflicted wounds are much lower than those of younger people.⁹ In addition, older people tend to be more isolated than younger people, so their attempts are less likely to be

Worldwide, people aged ≥ 75 years are more prone to commit suicide than people in any other age bracket.¹ In the European Union, suicide among older people is a particularly serious problem.^{2–3} Despite these alarming findings, very little has been written about how to care for older people with suicidal tendencies.⁴ Caregivers are either insufficiently trained to spot suicidality in older people or do not know how to deal with suicidal tendencies.⁵ Furthermore, until now, very little attention has been given to ethical considerations underlying the care of suicidal older people.

This article begins by laying out the state of current research on suicide in the older population. Next, we consider a number of values that are thought to have a role in suicidality. Current knowledge on suicide, together with an elucidation of values, comprises the framework for a number of clinical–ethical recommendations for care practice. These recommendations generally relate to older people in ambulatory settings or in nursing homes, but can also be applied to caring for suicidal older people in other settings such as hospital wards.

STATE OF CURRENT KNOWLEDGE

Definition

The World Health Organization defines suicide as “the act of killing oneself deliberately initiated and performed by the person concerned in the full knowledge or expectation of its fatal outcome”.⁶ According to this definition, suicide is related to

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Figure 1 Numbers of suicides (per 100 000 inhabitants) worldwide according to age and sex.

discovered and stopped by other people. The high number of completed suicides relative to the low number of suicide attempts among those >75 years of age indicates that these individuals are more likely not to attempt suicide on impulse, rather they ponder carefully their intent to die.¹⁰ Compared with people from other age brackets, older people are less likely to inform caregivers or relatives of their plans to commit suicide, and are more determined to proceed with their plans.

Causes

Suicidal behaviour is a complex phenomenon, which usually has various contributing factors.¹¹ Current theory takes a biological/psychosocial and multicausal approach.¹² In general, a contrast is drawn between immediate, circumstance-driven factors (state) or stressors on the one hand and underlying, permanently present factors (traits) on the other. Suicidal behaviour is thought to emerge when both types of factors are present and protecting factors are absent.

Circumstance-driven factors

In older people, the most frequently observed circumstance-driven factors (state) include depression, illness and disabilities, and various experiences of loss. A significant number of those

aged >75 years who commit suicide have depression.^{11 13 14} Depression significantly increases the risk of suicide.¹¹ The experience of hopelessness, which is characterised by an overwhelming feeling of being trapped in an intolerable situation with no foreseeable way out (“no escape” and “no rescue”) causes many older people to transit from depression to suicide.¹⁵⁻¹⁷ Older people are particularly at great risk for suicidal behaviour when their hopelessness is accompanied by other symptoms of serious depression, such as low self-value.¹⁸

The hypothesis that depression, illness and disability are directly linked has been advanced.¹⁹ More research is needed to determine the exact influence of illness and disability on suicide in older people.²⁰ What is certain, however, is that males aged >75 years having a physical disability are at greater risk of committing suicide than their female counterparts.^{11 14} Controlled studies show that the effects of illness and disability are almost always influenced by depression.¹¹ This means that the presence of physical disabilities and illness in older people who die as a result of suicide is clearly linked to the presence of a depressive disorder.¹³

In the period prior to committing suicide, people aged >75 years often experience various kinds of losses that heavily burden them.¹¹ The loss of a partner leads to an increased risk of suicide, particularly in men.¹⁴ The loss of social support and

Figure 2 Rate of suicides (per 100 000) by age in the UK (1999), Ireland (2000) and Finland (2002).

Figure 3 Rate of suicides (per 100 000) by age in Germany (2001), Italy (2000), Spain (2000) and Denmark (1999).

increased social isolation are often linked to more frequent suicidal thoughts and feelings.¹¹

Participation in formal, social networks is a protecting factor against suicide and is often a buffer to ward off depression. Moving into a nursing home can also be a protecting factor against suicide. On the other hand, anticipation of moving into a nursing home can also be a major reason why some older people may display suicidal behaviour.¹⁴ The fear of becoming dependent on other people, and the expected loss of personal possessions (and with them, their identity), privacy and control over their own lives, all have a role.

Permanently present factors

Among the permanently present factors (traits) that may influence the development of suicidal behaviour is a poorly functioning serotonergic system.²¹ Interestingly in this context, genetic background and prior traumatic life experiences can

influence the serotonergic system, regardless of one's age, and can lead to an increased propensity towards suicide.²² This propensity may also be the result of cognitive impairment, as a positive relationship exists between cognitive impairment (as is the case of dementia syndrome) and depressive symptomatology.²³ A direct link with suicide, however, is yet to be fully established.

The influence of personality traits is also a factor. The following personality traits are linked to an increased risk of suicide: strong need to be active and independent, reduced tolerance of new experiences, reduced adaptability to change, inability to express or describe psychological pain (alexithymia), inability to form and maintain close relationships, loss of control, and having difficulties in depending on other people.^{24 25}

CLARIFICATION OF VALUES

In the previous section, we advanced the idea that engrained behavioural patterns in the personality of older people, together

Figure 4 Rate of suicides (per 100 000) by age in Belgium (1997), The Netherlands (2000), France (1999) and Austria (2002).

with their way of thinking and feeling, can contribute to their developing suicidal behaviour. These behavioural patterns are also influenced by the specific values people hold. Values—ideals that matter most to people in life—determine one's actions, even before one's actions can be subjected to critical thought. The suicidal behaviour of older people is also often influenced by pre-reflexive patterns expressing certain values. This section discusses the influence of three of these values—autonomy, dignity and responsibility—thereby allowing us to gain the best possible understanding of how these affect the actions of older people, which is necessary to formulate clinical–ethical recommendations for providing care for suicidal older people.

Autonomy

Autonomy is an important value in the ethos of Western societies. This becomes apparent when we examine how people take for granted the consequences of their autonomy: people should be able to lead their lives according to their own desires and needs, with minimal intervention from others.²⁶ Suicidal behaviour in older people is influenced by a number of pre-reflexive patterns that strongly focus on individual autonomy.

In the context of suicide, consider the social consequences of losing one's autonomy. People who lose the ability to lead an autonomous life tend to see themselves as “burdens”, rather than complete human beings, and also sometimes see themselves as “lesser persons”, those who “have lost all value”.²⁶ Thus, an older person may view his situation as “problematic”, rather than ideal, if he involuntarily becomes dependent on others. This dependency is labelled as a disability that hinders one's ability to be a complete person. As such, some older people may view this stage of life as a stage that is far removed from the ideal situation (ie, complete autonomy).²⁷ Losing the ability to lead a life that meets individual preferences may contribute to a feeling of worthlessness and inferiority in older people. Thus, autonomy has a pre-reflexive role in the suicidal ideation of older people: their frustration at feeling the need to be autonomous contributes to their feelings of hopelessness and lack of self-esteem.²⁸

Dignity

The value of autonomy is closely related to that of dignity. Older people often associate autonomy and independence with the dignified retention of their mental capacities.²⁹ According to some authors, for certain people the risk of becoming incompetent and being subjected to the arbitrary acts of others is considered a major motivator for committing suicide before it is too late.^{30–31} It is particularly the fear of losing one's mental capacities that is thought to be a major cause of suicide. These authors contend that older people take their own lives to prevent mental deterioration from taking away that which other people love about them and that which they love about other people: the ability to enter into a loving relationship.

Responsibility

The value of responsibility can also be an important motive for committing suicide: older people often do not wish to become a burden on their relatives. They do not want to be reduced to people who are merely the object of other people's responsibility.³⁰ For many older people, the fear of becoming a burden—in some cases a financial one—on their relatives is greater than their fear of death.³²

Financial matters are not the only aspect of being a burden, as it is mainly the fear that relatives will have to pay a high emotional price when caring for an older person.³³ Through suicide, older people reassert themselves as moral agents who accept their responsibility towards their relatives and/or society.

We conclude this section by stating that intolerability—the main reason underlying suicide—is closely linked to the values a person holds. The reason why one person feels the need to die whereas another person does not depend on the availability of a social network, and is also linked to the fact that different people with different personalities experience the same situation differently. Whether an older person views living in a nursing home as intolerable is determined by things like fear of losing one's independence and dignity. It is also probably related to the fear of being a burden to others. These fears are all linked to values such as autonomy, dignity and responsibility.

CLINICAL–ETHICAL CONSIDERATIONS

A care perspective of suicide

The previous section showed that older people are strongly influenced by the social ideal of individual autonomy, even to such an extent that some feel it is a “duty to die”.³⁰ This is seen in their self-image and suicidal behaviour. Should autonomy be understood as the possibility to question whether societal values correspond to what one thinks is important? In fact, our behaviour becomes autonomous only when it is consistent with our identity and when it allows us to develop our identity.²⁶ Experiencing oneself as a “self” and maintaining this self-awareness throughout the various stages of our lives and all our experiences is necessary for carrying out our autonomy. In depressed and hopeless older people, this self-awareness is seriously threatened. Through an accumulation of factors, some older people experience a gap between the person they used to be and the person they are now. Confronted with the loss of relatives and social relationships, and subjection to functional limitations as a result of illness or old age, they are no longer capable of leading a life in which they can identify themselves. As is typical in situations of hopelessness, older people experience this situation as unchanging and permanent.

Showing respect for the autonomy of older people entails offering them the care they need to maintain themselves as individuals. This care involves helping them to continue to develop in a positive way, despite negative stressors and events.³⁴ This could be done by empowering them, a kind of support aimed at controlling the burden these older people have to carry. We will illustrate this using a couple of examples.

Diagnosing and treating suicidality

Although treating depression and hopelessness in suicidal older people is a primary form of empowerment, caregivers often fail to detect suicidal behaviours in older people.⁴ Some 70% of older people who commit suicide are thought to have had contact with a caregiver in the month prior to their death (20% on the day itself and 40% in the week prior to their death). This would seem to indicate that even when suicidal older people display certain signals, these signals often go unnoticed. Often, caregivers consider remarks from older people like “I've had enough” or “Why should I go on living?” as part of the ageing process and therefore as being “normal, something not to be taken very seriously”. Very often, caregivers miss the signs linking depression and suicidality.⁴ Many older people—particularly older males—also have difficulty in expressing or communicating complaints of an emotional and psychological nature. The physical complaints uttered by older people are sometimes an expression of an underlying psychosocial problem. In this respect, social desirability probably plays a part. Physical complaints are often accepted more easily than psychosocial complaints, as older people fear being looked upon as weak, frail, faint or mental. That is why it is critical that primary caregivers learn to recognise signals suggesting suicidal thoughts and depression.⁵

Once caregivers diagnose a person with suicidality, it is extremely important that they explicitly and promptly address this suicidality; they should bluntly ask the person whether he is thinking about suicide or is planning to commit suicide.³⁵ Next, caregivers must thoroughly evaluate the diagnosis, determining possible underlying and associated problems (substance abuse, personality disorders, etc), identifying potential physical causes, and assessing whether the risk of suicide is acute.

The caregiver as a “resilience mentor”

When intervening during a suicidal crisis, it is important for caregivers to talk to the older person, but it is more important for caregivers to listen to them. Often, listening as such is already therapeutic. As caregivers (eg, nurses) in geriatric care settings often have regular contact with older people, they are ideally suited for taking on a listening role.³⁶

Certain care tasks—particularly those tasks relating to physical fragility—can evoke powerful emotions in older people.³⁷ In this respect, the way caregivers deal with this fragility, the way they react, talk and listen, is extremely important.³⁸ By being receptive and attentive to the emotions of older patients—whether expressed by words or actions—caregivers can help them cultivate openness and trust,³⁹ which is a first step towards helping them to liberate themselves from isolation. By showing they are willing to listen—as an expression of their genuine care—caregivers also meet a need many suicidal people experience: a need to know that there is someone who cares about them.⁴⁰ Showing genuine concern through attentiveness and listening is often more powerful than the power of persuasion and therapeutic know-how in combating suicidal tendencies in older people.⁴¹

Effective listening and care requires a type of presence from the caregiver that goes beyond a mere physical proximity to that person. To be there for that person, caregivers need to be trained in being passive. This passiveness relates to paying attention to what the other person has to say. It involves an attitude of moral humility, in which the caregivers do not immediately act upon what they perceive to be an older person's needs, but first spend a great deal of time just listening, allowing the patient to express his or her pain.⁴² Caring for suicidal older people, therefore, consists of the imperative “do something” and also of the imperative “be there”, which implies “being with the other person”.

As the suicidal older person opens up—a reaction to the involving presence of the caregiver—the chance increases that a trusting relationship will grow, which leads to therapeutic possibilities.⁴³ This trust-based relationship offers caregivers the chance to become “resilience mentors” for the patient. Through their actions, caregivers not only extend to the suicidal older person the opportunity to express his/her aggression, anger or sadness—which usually reduces suicidality—but also create a situation in which the older person is given back a form of self-respect. Contact with caregivers who talk with them causes people to feel respected, affirming their dignity.³⁶ The caregiver's involvement conveys a particular message: “You are unique and you matter, and you are certainly worthy of my time and attention at this moment.” This is exactly the kind of behaviour that lets people who cry out in despair feel that they can exist and that they have value.

When caregivers and their older patients communicate meaningfully, a level of reciprocity is achieved that is crucial for bolstering the self-awareness of older people.⁴⁴ Through their interaction with a caregiver who is really listening, these older people experience for the first time that they are not characterised by their problems and that their reality does not necessarily match their self-image. Through humble reluctance

on the part of the caregiver, the older person is respected as a person of intrinsic and irreducible value.

Attention to responsibility

People derive their deepest sense of dignity and identity from their ability to be affected by something that they experience as being different from themselves.⁴⁵ They want to stay connected to other people and to the world, they want others to view them as being significant and, they want to leave a meaningful mark on another person. Suicidal older people often lack this positive outlook on life, instead they feel useless and burdensome. Suicide is, then, the ultimate protest against their perceived meaninglessness. Caregivers who have an involving presence with older people also often have a crucial role in this respect. Together with the older person, they search for purpose. The starting point is an expression of Viktor Frankl's⁴⁶ view that, for each individual, life has meaning, a meaning that should be discovered. To Frankl, the meaning of one's life lies in one's responsibility for others and depends on how one copes with real-life events and carries out tangible tasks and projects that occur over time.

The well-being of older people in nursing homes significantly increases when caregivers appeal to their personal responsibility and treat them as moral subjects.⁴⁷ Older people feel they can make a difference, that they are useful, and that they still mean something to someone. Activities in which older people and youngsters interact also have a positive effect on older people.^{48–49} For example, they can work together on specific projects (eg, constructing a vegetable garden, practising an ancient craft in which older people have an important role as mentors) or teach each other things (eg, older people who teach youngsters about local history, youngsters who help older people to work with computers). Intergenerational activities are mutually beneficial. Firstly, intergenerational activities help to remove any preconceptions (so-called “ageism”) youngsters may have about older people. Secondly, intergenerational activities also help older people to transform from having a negative self-image due to depression and thoughts of suicide—“I'm old and needy and therefore I'm worthless”—to having a more positive self-image.⁵⁰

Attention to meaning

Throughout their lives, older people have expressed care in various forms: caring for their children, their parents, their friends and acquaintances. Encouraging older people to recount episodes in their life story is a good way to help them connect with their own (care) narrative and, at the same time, to re-acquire meaning.^{51–53} In telling their life story (reminiscence or life review), older people are reminded of projects and real tasks that give meaning to their lives. They learn that they are not just “old”, but that they have *grown* old, and that this stage of their life has meaning in the general framework of their entire life.⁵⁴ By exchanging stories with others, older people meet other individuals and learn that other people are also struggling with the same questions and problems. By paying attention to older patients as they recount their life stories, caregivers can inspire them: these stories offer strategies for survival and show good qualities in people.

When approaching suicidal older people, it is important for caregivers to cultivate in them a sense of meaning. To help these older people discover new types of hope, it is important that caregivers are trained to detect the spiritual needs of older people and also to deal with these needs.⁵⁵ Engaging in conversations on the role of faith and religion, encouraging reconciliations with estranged family members or friends, arranging contact with a pastoral or moral counsellor to initiate reconciliation and comfort through religious rituals, are all examples of concrete interventions that caregivers can carry

out. Religion and spirituality help older people to deal with existential emptiness, hopelessness, sadness, anger or guilt. That is why these issues should have an essential role in a care approach directed towards suicidal older people.

CONCLUSIONS

An important aspect of caring for suicidal older people is to determine whether their care fosters self-esteem, self-value and dignity. As with adults of all ages, older people want to go through life as autonomous, dignified and responsible people. Caregivers should therefore be made aware of the way in which older people create their own world and maintain their self-awareness. In this respect, the relationship between caregiver and older person plays an important part.

The resilience model shows how care can be put into practice by supporting the autonomy, dignity and responsibility of suicidal older people. As discussed here, resilience is related to the question: "How can older people continue to grow—as a person—despite the setbacks related to growing older?" Crisis situations require caregivers to allow older people to take on a certain degree of control over their situation, enabling them to take responsibility for themselves, no matter how small that responsibility appears to be. This first requires a timely and appropriate diagnosis and treatment of suicidality. Later in the care process, caregivers also focus on getting older people involved in relationships as responsible people. With the attention the resilience concept pays to responsibility and giving meaning, older people are helped to view their dependency on others in a more positive way.

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