Elderly Suicides: A Need for Prevention

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Citation

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Abstract

Every 18 minutes a life is lost to suicide. Approximately every hour and a half, an elderly adult age 65 and over takes his /her life by suicide. Despite a decline in the rate of suicides over the past several years, suicides by elderly white males remains high. This paper provides summary data pertaining to elderly suicides in a southern rural population and discusses implications for preventive health services that must be implemented to decrease the number of successful elderly suicides.

Suicide is the eleventh leading cause of death in the United States. Every 18 minutes a life is taken due to suicide. Approximately every hour and a half, an older adult age 65 and over takes his/her life by suicide. [1] In 1999, Dr. David Satcher, Surgeon General of the United States, launched a national prevention program to educate citizens and healthcare professionals about suicide. [2,3] Despite a decline in the rate of suicides over the past several years, suicides by elderly white males is 50% higher than our nation's youth. [4] This paper will provide summary data pertaining to elderly suicides across a sixteen year period in a southern rural population and discuss implications for preventive health services that must be implemented to decrease the number of successful elderly suicides each year.

Comprising nearly 13% of the United States population, persons age 65 and over committed 19% (5,489) of the recorded suicides during 1999 (29,199). Fifteen successful elderly suicides occurred each day, alongside four unsuccessful attempts. [1] In Mississippi, sixty-four elderly suicides occurred during 1999, representing 21% of the total recorded suicides (305) in the state. Table 1 shows the total number of elderly suicides in Mississippi by race compared to the total number of suicides by race from 1984 through 2000. [5] As the data show, more elderly whites than non-whites are choosing suicide. Graph 1 shows the number of elderly white suicides is nearly eight times the number of non-whites. Because African Americans make up nearly 37% of the population in Mississippi, the contrast in the number of elderly suicides by race requires further review.

Figure 1

Table 1: Number of Suicides in Mississippi By Race By 65 Years +: 1984-2000

Year	Total Suicides	Suicides By Caucasians	Suicides By Caucasians 65+	Suicides By African Americans	Suicides By African Americans 65+
1984	273	227	49 (22%)	46	6 (13%)
1985	271	221	57 (26%)	50	5 (19%)
1986	292	246	61 (25%)	46	10 (22%)
1987	282	244	63 (26%)	38	8 (21%)
1988	297	245	72 (29%)	52	7 (13%)
1989	316	257	69 (27%)	59	8 (13%)
1990	289	243	57 (23%)	46	6 (13%)
1991	325	263	65 (25%)	62	7 (11%)
1992	331	268	52 (19%)	63	4 (6%)
1993	327	261	59 (23%)	66	8 (12%)
1994	313	247	57 (23%)	66	4 (6%)
1995	318	258	57 (22%)	60	9 (15%)
1996	310	263	42 (16%)	47	4 (8%)
1997	338	278	62 (22%)	60	6 (10%)
1998	330	284	53 (19%)	46	4 (9%)
1999	305	246	59 (24%)	59	5 (8%)
2000	290	234	39 (17%)	56	4 (7%)

Figure 2

Graph 1: Number of Suicides in MS By Race

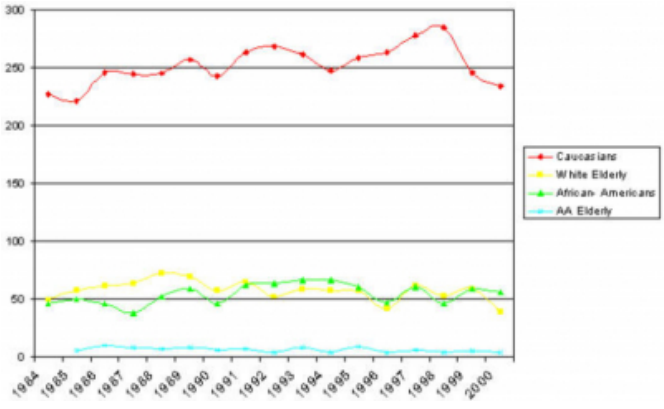


Table 2 shows the number of elderly white and non-white males who committed suicide during 1984 through 2000.

The number of elderly white male suicides is over twice the percentage of non-white males throughout the timeframe studied (25% to 10%). On a yearly basis, the number of elderly white to non-white male suicides ranges from a high of 61 white and 8 non-white males to a low of 32 whites and 2 non-white males, with a cumulative total of 819 elderly white males to 80 nonwhite males across all years.

Graph 2 shows the fluctuations in these data by elderly white and nonwhite males from 1984 through 2000.

Figure 3

Table 2: Number of Elderly White and Non-White Male Suicides: 1984-2000

Year	Number of Suicides By Elderly White Males	Number of Suicides By White Males	Number of Suicides By Elderly Non-White Males	Number of Suicides By Non-White Males
1984	47	177	5	37
1985	49	176	3	41
1986	49	185	7	34
1987	54	189	8	35
1988	61	190	6	42
1989	57	190	6	49
1990	47	198	4	38
1991	51	202	5	52
1992	43	211	4	49
1993	48	214	7	58
1994	50	205	2	55
1995	49	210	5	52
1996	32	204	3	39
1997	55	228	5	50
1998	44	232	4	38
1999	49	200	3	52
2000	34	191	3	49
Total	819 (25%)	3302	80 (10%)	770

Figure 4

Graph 2: Male Suicides in 65+ Age Group by Race

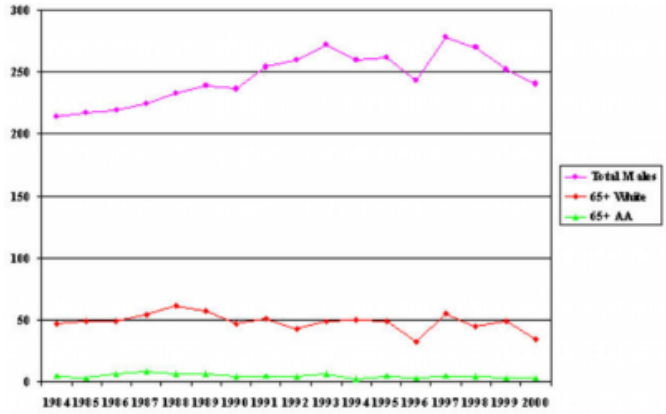


Table 3 depicts the number of elderly females by race who committed suicide over the timeframe studied. Again, more elderly white females are committing suicide than non-white females. Although the cumulative percentage of suicides by both groups appear similar across all years (17.4% whites to 16% nonwhites), the actual number of suicides per year by white females is as much as eleven times that of nonwhite females. A total of 154 elderly white females committed suicide over the timeframe compared to 25 nonwhite females.

Graph 3 shows this variability across groups and confirms national statistics indicating a lower rate of suicide completions for females. Statistically, females attempt suicide three times more often than males; however, males are four times more likely to successfully complete suicide. [1, 6]

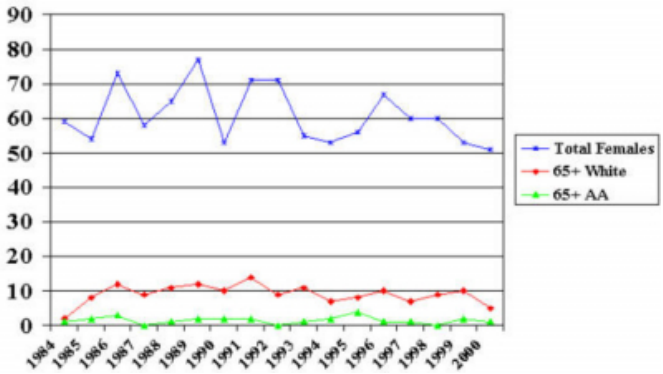
Figure 5

Table 3: Number of Elderly White and Non-White Female Suicides: 1984-2000

Year	Number of Suicides By Elderly White Females	Number of Suicides By White Females	Number of Suicides By Elderly Non-White Females	Number of Suicides By Non-White Females
1984	2 (4%)	50	1 (11%)	9
1985	8 (18%)	45	2 (22%)	9
1986	12 (20%)	61	3 (25%)	12
1987	9 (16%)	55	0 (0%)	3
1988	11 (20%)	55	1 (10%)	10
1989	12 (18%)	67	2 (20%)	10
1990	10 (22%)	45	2 (25%)	8
1991	14 (23%)	61	2 (20%)	10
1992	9 (16%)	57	0 (0%)	14
1993	11 (23%)	47	1 (13%)	8
1994	7 (17%)	42	2 (18%)	11
1995	8 (17%)	48	4 (50%)	8
1996	10 (17%)	59	1 (13%)	8
1997	7 (14%)	50	1 (10%)	10
1998	9 (17%)	52	0 (0%)	8
1999	10 (22%)	46	2 (29%)	7
2000	5 (12%)	43	1 (13%)	8
Total	154 (17.4%)	883	25 (16%0	153

Figure 6

Graph 3: Female Suicides in 65+ Age Group by Race



The use of firearms continues to be the highest ranking

method for successful suicide among both races, young and old. In 1999, 3,921 elderly persons (71.4%) used firearms to complete suicide. Hanging and/or suffocation ranked second with nearly 11% of the 5,489 elderly suicides and poisoning ranked third with 6.5%. [1]

Although not provided by age through the Mississippi Vital Statistics records, firearms were the highest ranking method for 245 (80%) of the 305 Mississippians who chose suicide in 1999. In line with national statistics, hanging and/or suffocation ranked second (N=30), and poisoning was third (N=23). [5] These rankings were true across the timeframe studied.

DISCUSSION

According to the National Mental Health Association, as many as 8.4 million people have considered suicide. [3] The elderly constitute a large proportion of these contemplators. Inadequate recognition of depression in the elderly is an important factor in the high rate of suicides among this age group. According to the National Institutes of Mental Health, the major predictor of suicide in the elderly is depression. [7,8] Additional life events also make the elderly at risk for suicide: loss of a loved one, prolonged or disabling illness, prolonged pain, fear of dying, financial problems, sleep disorders, family problems, loneliness and social isolation. [4, 9,10,11] Because studies have shown that a large percentage of elderly adults (70%) visited their primary care clinician at least one month prior to committing suicide, [12] programs that improve physician recognition and treatment of depression are needed. Depression often co-exists with other physical illnesses and life stressors; therefore, the tendency to accept depression as a natural consequence of these events is a mistake made by patients and physicians alike. [13]

Factors that have been shown to place the elderly at a decreased risk for suicide include having a hobby and an active lifestyle associated with participation in organizations. [11] Developing accessible programs for the elderly at neighborhood community centers and area churches is an important ingredient in decreasing the number of suicide contemplators and successful completers among our elderly population.

Concomitant with developing programs that facilitate an active and positive lifestyle are programs that address education and awareness of risk factors or predictors of suicidal behaviors. These factors include loss of interest in friends, hobbies, or job, giving away possessions, reading, drawing or writing about death, changes in sleep or eating habits, a sense of hopelessness, behavior changes (sexual promiscuity, destructiveness), marital problems, increased use of alcohol or drugs, unexplained crying, moodiness, or irritability. [4, 14,15,16,17,18]

Moreover, awareness programs must incorporate intervention strategies for use with elderly individuals exhibiting such risk factors or predictors of suicide. A "BALANCED" Approach for the recognition and interruption treatment of suicidal behavior has been proposed: [14]

"Believe the warning signs: Don't attempt to provide explanations for the individuals behavior that delay your attempts to intervene. Don't try to do everything yourself. Seek help from colleagues, other professionals, or the victim's family members.

Accessible:Be accessible to the person.

Listen: Listen carefully and talk directly about suicide. Ask the individual if he or she is thinking about suicide and inquire about their plans. "Have you thought about killing yourself?" "Have you developed a plan for suicide?" If so, "How do you intend to kill yourself?" Discuss consequences with the person. "What will happen as a consequence of killing yourself?" Often patients will think of their family and friends reaction and this can be a strong deterrent to action.

Action Plan:Help the individual develop an action plan for assistance. Identify steps that

the person can take when intrusive suicidal thoughts occur – these thoughts are re-current, non-stoppable, and uninterruptable. Have them repeat the steps of the plan to insure follow through when distressed.

Non-judgmental: Be non-judgmental by sharing unconditional positive regard. Don't try to argue with the individual. Remind him or her that their depression can be treated; that there are other alternatives. Talking about their feelings is an important step.

Consistent involvement: Show continued support for the individual's treatment. Monitor their compliance with prescribed medications and therapy sessions. Find out about the side effects of the medications. Remain available to talk and listen.

Extract: firearms, drugs, medications, obvious instruments

that the individual could use to harm themselves. Obviously, you can't remove everything. Think along a continuum of expediency - what does the person like to do? Is he/she a hunter? Are there firearms in the home?

Dial 911: Decide to take immediate action if warning signs are present, a plan has been developed, means are available, and the suicidal thoughts are intrusive. Do not leave the person alone to wait for a resource to "open". Dial 911 and ask the dispatcher for assistance." Source: Hart-Hester, S. & Smith, P. Suicide in Mississippi- A growing concern. JMSMA; 1998; 39(8): 277-281.

CONCLUSION

Suicide among our elderly population is cause for concern. Elderly white suicides in Mississippi are nearly eight times the number of non-white suicides. In particular, elderly white males have shown a consistently high rate of suicide across the last sixteen years. The percentage of elderly white male suicides is over twice the percentage of non-white males throughout the timeframe studied. According to 2000 census data, nearly 37% of the population is African American; therefore, further investigation is needed into the cultural and/or social factors affecting the number of suicides among this population.

Depression is a significant predictor of suicide among our elderly population; therefore, additional training in the recognition and treatment of depression in the medical setting is warranted. Currently, NIMH funded researchers are studying the efficacy of a primary care based depression education program for increasing practitioners' recognition and treatment of depression in the elderly. [8]

Community programs that encourage active lifestyles remain important mechanisms for decreasing suicidal behaviors. Educational awareness programs identifying behaviors predictive of suicide as well as intervention strategies for interrupting suicidal behaviors are needed within these community programs.

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