

## Suicidal behavior in late life: reasons and reactions to it

Today, suicide in old age has the highest rates nearly everywhere, all over the world. Suicide rates in the general population have recorded important declines in the last two decades (Naghavi et al., 2019), and, globally, the greatest declines have been noted precisely among older adults (Naghavi et al., 2019). These positive figures and trends have not been attributed to any specific campaigns aiming at the prevention of suicide in old age but have been rather directed to highlight the improvements in general health care and in quality of life of people; the most fragile segment of population, older adults, seems to have particularly benefitted from these improvements. In addition, in a number of countries, poverty rates have ameliorated proportionately in older individuals more than in younger age groups (OECD, 2017).

According to the Organisation for Economic Co-operation and Development, poverty rates of people aged over 65 years were very high in Australia (34%), with Korea (50%) and Mexico (27%) among the poorest (OECD, 2017). Suicide rates have not been declining in Australia for at least the last decade, and, contrarily to what has been witnessed by most western countries, it is possible that the lack of substantial improvement in poverty rates may be correlated to the lack of improvement in suicide rates. A similar argument has been proposed by Stack on the observation of the Gini indices of a number of countries, with the USA presenting the highest income inequality (Gini Index) and being virtually the only western country with a steep rise in suicide rates (Stack, 2018).

Especially in the last 10 years, Australia has not experienced any significant change in suicide rates of older adults, with this segment of population showing overall the highest rates. These rates become even higher with advancing age, particularly so among male subjects. A study conducted by Shah and associates (2014) showed that even at a very advanced age (in centenarians), suicide rates continue to increase as well as the disproportion between the suicide rates of males and females increases, with older males expressing rates of suicide 7 – 8 times higher than older females (in all other age groups, the rate ratio is approximately 3:1). This seems to imply an aggregation of different risk factors for elderly males or an increase in severity and number at a very advanced age (this appears to be a more likely hypothesis than the possible improvement in living conditions for females) (De Leo and Kølves, 2017; Koo *et al.*, 2017a).

This particular aspect has so far received very little attention from scientific literature, still substantially divided—when it comes to suicide in old age—between rationalistic and ageistic

interpretations. Yet, the phenomena of macroscopic dimension (at least for the developed world), such as increased longevity, decreased nativity index, and increased number of mononuclear families, let prefigure a world in which loneliness can greatly and progressively affect the quality of life of people. Some governments, starting from that of Theresa May in the UK, are setting programs to combat the problem of loneliness in old age and its possible influence on mortality rates in general and suicide in particular. In an opinion piece for the *New York Times*, Arthur Brooks (2018), the president of the American Enterprise Institute, states that “loneliness is killing us,” quoting “skyrocketing rates of suicide in the country, with 45,000 deaths in 2017.” Even the Australian government has undertaken initiatives aimed at tackling the phenomenon of loneliness. And, anyway, it is an Australian group of scholars, the one headed by Anne Wand, that has very commendably dealt with the neglected topic of suicidal behavior in very old-age subjects (Wand *et al.*, 2019). The study they present in this issue of *International Psychogeriatrics* represents a rather original effort: to observe and record the motivations for suicidal behavior of a group of people aged 80 years and over and to analyze the modifications occurred 1 year after the index event in association with the reactions of their principal carers (generally the children), triangulating these observations with those relating to the considerations expressed by the treating physicians, the subjects’ General Practitioners (GPs).

Their qualitative analysis of the experiences of subjects with direct and indirect suicidal behaviors (e.g. refusing to eat) highlights many of the themes already reported in the literature, such as loneliness, being a burden to others, feeling rejected and hopeless, feeling in despair, and affected by endless suffering (De Leo and Arnautovska, 2016; Koo *et al.*, 2017b). For some subjects, the outcomes of their suicidal behavior may also involve positive aspects, such as the solution of problems that afflicted them. For others, becoming subject to increased vigilance, which in some circumstances means being admitted to a psychiatric ward, represents the outcome. Several individuals feel that their carers do not understand them and their requests are not validated; in essence, they feel unheard.

Therapeutic nihilism represents the real protagonist of the interesting work carried out by Wand and collaborators (Wand *et al.*, 2019). One year after the first survey, only about a third of the doctors would respond to the follow-up questionnaire. The reasons for such a modest participation to the second wave of the survey are not clear, but the authors of the research rightly suggest the existence of a certain embarrassment on the part of the treating physicians. Possibly, ageistic views, rationalistic interpretations, and therapeutic nihilism do nothing but emphasize the lack of concrete perspectives in giving relief and dignity to people who have

become dependent and fragile (De Leo, 2018). One of the main messages from the study of Wand *et al.* (2019) is represented by the need for greater incisiveness in mental health care, as for the best possible treatment of depressive symptoms, not only characterized by therapeutic means of pharmacological nature but also by specific psychosocial treatments. The latter represents a traditionally difficult area for physicians (usually, it is not part of their professional training), and for this reason, it is generally delegated to psychologists and social workers. The need for better training in the area of prevention and treatment of suicidal behavior remains evident, and certainly, much more could be achieved in this area with appropriate preparation. Suicide prevention should be a shared commitment, where multidisciplinary teamwork appears as the most logical approach. The task of restoring dignity in people and combating ageistic views is also a problematic area, and the same holds true for fighting the stigma associated with suicidal behavior. Research of Wand *et al.* (2019) ends up, emphasizing once again, on how increased vigilance and admission to a psychiatric ward can often represent temporary solutions that are more aimed at doctors' defensive concerns than at the well-being of patients. Not infrequently, the result of hospitalization means triggering in a patient's feelings of imprisonment, misery, and defeat: in other words, lacking in the care and attention that would actually have been desired. It seems to me particularly important that the authors have underlined the relevance of this problem. For those who deal with suicide prevention issues, this problem is important because it often leads subjects carrying suicidal ideation to mask their real intentions, in order to prevent their need for human attention from being simply turned into an increase in vigilance and eventually psychiatric "incarceration." It is precisely the conviction of not being able to be heard and understood that in the end determines fatal suicidal behavior.

Carers often perceive these dynamics well but are led to hope that their fatigue and impotence can be solved by some technically wise interventions of treating physicians. When they realize that instead, ageism and therapeutic nihilism prevail, they feel abandoned and defeated. It is difficult to hypothesize that their frustration and resentment cannot but negatively influence the health of the individuals they take care of, ending up by increasing their sense of discouragement and abandonment. I therefore fully agree with Wand and associates when they support the importance of family relationship dynamics and listening to the emotional needs of caregivers in preventing the suicidal behavior of their assisted person.

Suicide prevention is a difficult and complex art; it may seem even more so when the life to be preserved is characterized by endless suffering and lack of prospects for improvement, in

particular when the individual in question feels that he or she is only a burden to carers. In these difficult circumstances, attention to dynamics and communications is essential to every preventive initiative. I believe the work of Wand and associates represents a strong call in this direction.

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