

Challenges to preventing suicide in later life

Suicide is a major public health concern worldwide at all ages, accounting for over a million deaths each year. It is of especially grave concern, however, in later adulthood. In countries that report such statistics to the World Health Organization suicide rates to rise steadily throughout the life course for both men and women to clear peaks among the oldest old. Currently the world's population over age 80 years is approximately 105 million. The United Nations estimates that by the year 2050 there will be almost 400 million people in this age group. Even as the number of older people grows, the number of younger and middle-aged people will decrease. In Latin America, for example, there are now 10 working aged adults for each person over age 65, a ratio that will drop to 3:1 by 2050. The challenge, therefore, is a sobering one: far greater numbers of people entering that stage of the life cycle in which suicide risk is highest while resources available to help manage their needs are becoming more limited.

There are other challenges to effective prevention of suicide in later life. Studies indicate that with increasing age people tend to use more immediately lethal means for self-harm, and implement them with more extensive planning and greater intent to die. Therefore, death is a more common result than at younger ages. The ratio of attempted to completed suicides in the general population is approximately 40:1, and as high as 200:1 in younger adults. Among older people, however, that ratio is between 1:1 and 4:1. These characteristics underscore the need for development of primary prevention strategies that reduce the likelihood of an older person becoming suicidal. They also require aggressive development and implementation of secondary intervention strategies that result in early detection and intervention for seniors with suicidal ideation or a history of attempts.

Although rates of attempted suicide in older adults derived from standard surveillance methods appear markedly lower than at younger ages, there are other common behaviors in later life that, while not typically classified as suicidal, may result in death. Examples abound in long term care facilities, such as refusal to eat food or to take one's medications. Are such "indirect self destructive behaviors" truly suicidal, or rather are they expressions of autonomy in settings where the older person may have few other options for controlling his or her environment? How do we make such distinctions? The stakes are high, as they balance the chance of a preventable death against respect for the older person's right to autonomy and self-expression. The phenomenology, correlates and risk factors of self-destructive behaviors in later life, and how they differ among subgroups of the older adult population, require rigorous study.

Similar challenges pertain to the understanding of suicidal ideation in older adults. It is critically important, for example, that we gain greater understanding of nuanced distinctions between suicidal ideation and thoughts of one's death (or even wishes for an early demise) that may be normative in later life. Terms such as "death ideation," "active" and "passive" suicidal ideation abound in the clinical and research literatures, yet the differences between them, if any, remain largely unexplored.

Given the rapid growth of the older adult population and the vulnerability of seniors to death by suicide, gaining greater understanding of suicide attempts, suicidal ideation, and related thoughts and behaviors is a high priority for research. The papers included in this special issue are helpful contributions to our gaining a more complete picture of antecedents to suicide, pointing the direction towards more effective and efficient detection and prevention of unnecessary deaths.

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