

The prevention of suicide in old age

E. Stengel

Zusammenfassung

Die Mehrzahl der Selbstmörder sind ältliche oder alte Leute. Die Fortschritte der medizinischen Therapie ist vor allem den jüngeren Altersgruppen zugute gekommen. Die Bevölkerung ist daher überaltert, und es gibt heute mehr alte Leute als jemals zuvor. Die Selbstmordneigung im Alter hängt von der Persönlichkeit und von früheren Erlebnisfaktoren ab. Sogar bei alten Leuten ist die Selbstmordneigung größer, wenn sie in einem «broken home» aufwuchsen. Die meisten alten Leute, die Selbstmordhandlungen begehen, sind körperlich oder geistig krank. Der Irrglaube, daß Krankheit im Alter immer unheilbar ist, ist für viele Selbstmorde verantwortlich. Es kommen mehr Selbstmordversuche als Selbstmorde im Alter vor, aber die Differenz ist kleiner als bei den jüngeren Altersgruppen. Soziale Isolierung ist der wichtigste ursächliche Faktor bei Selbstmordhandlungen im Alter. Sie kann durch Emigration der jüngeren Generation verschärft werden. Nur eine weitgehende Verbesserung der medizinischen und sozialen Hilfe für alte Leute könnte zu einer Reduktion der Selbstmordfrequenz im Alter führen, aber bisher ist die Gemeinschaft nicht bereit, angemessene Hilfsmittel für diesen Zweck zur Verfügung zu stellen.

Summary

The majority of people who kill themselves are elderly and old. The advances of medical treatment have benefited mainly the younger age groups. As the result, the population has become overaged, and there are more old people than ever to-day. The suicide proneness of the old depends on personality and early life experiences. Even old people who had a broken home in childhood are more suicide prone than others. Most of those who commit suicidal acts are physically or mentally ill. The misconception that illness in old age is always incurable is responsible for many suicides. There are more suicidal attempts than suicides in old age, but the difference between the two is much lower than in the younger age groups. Social isolation is the most important single factor in the causation of suicidal acts among the old. It can be aggravated in a population by emigration of the young. Only a vast improvement of medical and social care for the old can reduce the suicide rate, but so far society has been unwilling to allocate adequate resources to this purpose.

It is sometimes believed that the relatively high incidence of suicides among the elderly and the old is a new development in our time. This is not so. The suicide rates have always increased with advancing age, but usually declined after the age of seventy. However, the suicides of old people never received the same attention as those occurring in the younger age groups. There seemed to be nothing sensational about old people hastening their departure. Also, there never were so many old people as there are to-day. Although the suicide rates

among the old were always relatively high, their actual numbers used to be rather small. All this has changed in the last few decades. The advances of scientific medicine have so far benefited chiefly the younger age groups and more people than ever before are becoming old and sick and suicidal to-day. While the suicide rates among the younger age groups have remained stationary or have declined, both the suicide rates and the absolute number of suicides among the old have been increasing steadily. The term suicide refers to the fatal suicidal act only. If one includes suicidal attempts, that is the non-fatal suicidal acts, the absolute number of suicidal acts is higher in the age groups between 20 and 50 than later, but the ratio between the attempts and the suicides is much higher among them than among the elderly. Table 1 demonstrates the numerical relationship between suicidal attempts and suicides in various age groups. It shows that in all age groups suicidal attempts are more numerous than suicides, but that the difference between the two outcomes is becoming smaller with increasing age. The table is reproduced from a survey of suicidal acts which occurred in Sheffield, which has a population of about half a million, in a period of two years. The figures explain why the general public and even doctors have the impression that suicidal acts are more common among the young and middle aged than among the old. They simply see more of those acts in the younger age groups and, unless one is personally or professionally involved, a suicidal attempt is more impressive than a suicide. These are some of the reasons why the growing problem of suicide among the old does not seem to stir the emotions of the general public although, as the table shows, the absolute number of suicides in a population is higher after the age of fifty than before that age, at least in European and Western countries.

Preventive and prophylactic measures are based on knowledge of causation which is very complex as it is derived from a multiplicity of factors. Some of them arise from the conditions of old age while others are rooted in the individual's past. Most people, including many doctors, believe that the suicides of the old are quite easy to understand. This is a misconception usually held by the young and the middle-aged. The old do not as a rule share this attitude towards the suicides of their contemporaries.

Suicide proneness of old people

Only a minority of individuals react to stressful life situations with suicidal acts. It is necessary therefore to postulate that some people are more prone to such acts than others. Considering that there are so many factors in the life situations of old people which by themselves seem to account adequately for suicidal acts, it comes rather as a surprise that even in old age childhood experiences should play a part in the aetiology of suicide proneness. This is what Batchelor and Napier (1953) found in a series of 40 patients aged 60 and

Table 1 Age and sex distribution of 639 attempted suicides.

Year	Sex	under 20	20-29	30-39	40-49	50-59	60-69	70-79	80 and over	Totals
1960	male	10	29 (1)	27 (4)	17 (4)	14 (6)	11 (7)	9 (2)	5 (3)	122(27)
	female	25	28	43 (2)	34 (3)	28 (5)	19 (1)	12	9 (1)	198(12)
1961	male	11	24	24 (4)	20 (1)	13 (6)	4 (5)	10 (4)	5 (1)	111(21)
	female	28	41	32 (1)	32 (11)	29 (6)	23 (5)	16 (3)	7	208(26)
Totals 1961/62		74	122 (1)	126(11)	103(19)	84 (23)	51 (18)	47 (9)	26 (5)	639(86)

The number in brackets refer to suicides.

over who had been admitted to hospital following suicidal attempts. In 26 (65%) of the cases there was a family history of psychiatric abnormalities. 7 (17%) gave a family history of suicidal acts. There was a history of mental illness in close relatives in 14 (35%) cases, mostly of depressive illness. One half of the old people who had attempted suicide had experienced a broken home in their childhood. This was the same proportion as that found in a large series of cases of attempted suicide of various ages. More than one half of Batchelor and Napier's series had been mentally ill before the breakdown which had led to the suicidal attempt in old age. Three quarters of them showed features of vulnerable personalities, such as morbid anxiety and sensitivity, excessive jealousy, obsessional tendencies and hypochondriasis. Their personality traits had been responsible for their difficulties and failures in social adaptation which had been defective in one half of all the cases. These are the people who in old age would need more help from society than others especially if they are single or widowed. But unfortunately these people tend to put off potential helpers by the way they respond to friendly approaches.

It seems, then, that many people enter old age with a greater than average degree of suicide proneness, irrespective of what that period of life has in store for them. There is nothing one can do about this in the way of prevention at that stage, except to note that people with those characteristics in their personalities and their history require more attention than others. If there should ever be a time when our society will have both the determination and the resources to prevent suicide in old age, or in any other age, there would be registers of people in special need of social care and they would receive more of it than others because they need more.

Stresses and deprivations of old age

Every age has its own frustrations and sufferings in addition to those which it shares with other ages. Those of old age, which usually provide the conscious motives for suicide, are more transparent than some of the motives in the

younger age groups. In the suicidal acts of the old, as in those of the young, self-destructive and self-preserving tendencies coexist side by side, and the outcome depends very much on the relative strength of those opposing tendencies. In old age the self-destructive tendencies outweigh the urge to self-preservation more often than in the younger age groups. This is why a larger proportion of suicidal acts are fatal in old age than earlier in life, as I have shown before. Or, to put it in other words, suicidal acts are becoming more dangerous with increasing age.

Physical illness appears to be more common among people who kill themselves than among comparable samples of the general population and this applies particularly to the old. The pathologist Ian Stewart reported about post mortem examinations of people of all ages who had died through suicide. He found that only one third of a large series had been physically healthy and that most of the old had had a wide variety of painful, disabling or fear-engendering diseases. For a variety of reasons it would be difficult to design a controlled study into this problem, but there is plenty of evidence that physical illness plays an important part among the factors causing suicide especially among the old. We often come across attempted suicide precipitated by physical illness which had not been diagnosed or not been adequately treated. When, subsequently to the suicidal attempt, appropriate treatment is instituted further suicidal acts hardly ever occur. The same applies, only more so, to mental illness. Every psychiatrist knows many cases where a suicidal act was the first indication of mental illness. This happens relatively more often among the old than in the other age groups. The mistaken belief that mental illness in old age is incurable dies hard. It must be responsible for a large number of suicides of patients with depressive illness occurring in old age for the first time and wrongly regarded as not amenable to treatment.

It follows that the availability of adequate medical services for the early diagnosis and treatment of physical and mental illness will reduce the incidence of suicide substantially, especially in old age.

Let us now turn to social conditions which can contribute to an increase in the incidence of suicide, especially in the older age groups. I should like to illustrate this by a brief report of a study carried out in the North of England some years ago. The suicide rates of two cities, A and B, showed a striking discrepancy. A had a population of half a million, B of eighty five thousand. A was therefore expected to have a higher suicide rate than B. In fact, the difference was in the opposite direction, B having three times the suicide rate of A. What could be the reasons for this difference? The hypothesis to be tested first was that the two cities differed in the composition of their population by sex, age and social class. No significant differences of the sex ratio and in the class distribution in the two populations were found. Among the suicides, however, the percentage of females in B was 43, but only 36 in A in the five

year period under review. In one of the five years it was 51% in B, which was at variance with the rule that male suicides always outnumber females. As to age, in B the proportion of people who had committed suicide aged 65 and over, was 43%, in A only 35%. There was then an excess of females and of old people among the suicides in B compared with A. Table 2 shows the percentage of people aged 60 and over in the general population of the two cities. The proportion of old people was markedly higher in B than in A. There was a similar difference in their death rates (Table 2). The hypothesis that the age composition of the two cities was such that the suicide rate could be expected to be higher in B than in A was thus confirmed. The fact that B was overaged in comparison with A might account for the difference in the death rate of the two cities. It is of course possible that other factors apart from the age composition played a part, but there is no reason to doubt that age was important.

This study is relevant for the problem of prevention of suicide in old age. The causes for the abnormal age composition of the city with the excessive suicide rate have application for prevention and prophylaxis. B was one of the English cotton towns. Over the last few decades the cotton industry has undergone a steady decline which became rapidly worse more recently. This led to a decline of the population due to emigration from the younger age group and resulting in an overaged and therefore more suicide prone community. Within twenty years the city had lost 15% of its population. No similar changes had taken place in the other city. However, the difference in the suicide rates was far in excess of the discrepancy in the age composition of the two cities. The change in the age composition in B was psychologically of such a nature that it may have increased the suicide proneness over and above the rate to be expected for these age groups in the general population. The social isolation of the elderly in B was due not only to the gradual loss of social contacts inherent in old age, but to the departure of relatives which might have been felt to be avoidable. The old people of B were not only socially isolated but also what Peter Townsend called socially desolate, i. e. deprived of and deserted by loved ones. This distinction will be discussed later. There is reason to believe that the causes for the excessive suicide rates in other communities are similar to those observed in B. West Berlin is a case in point. Its population is excessi-

Table 2 (from the *Journal of Mental Science* 107, 1013, [1961])

Percentage of persons aged 60 and over			Average annual death rate per million		
	<i>Male</i>	<i>Female</i>		<i>Male</i>	<i>Female</i>
A	13.4	16.7	A	13.312	10.670
B	21.6	20.0	B	16.405	14.087

vely overaged due to emigration from the younger age groups. There are indications that similar factors play a part in the excessive suicide rate in Hong Kong.

Observations such as these are relevant for suicide prevention and they have a lesson for those responsible for population policy. In a well ordered industrial society the consequences of the decline of a particular industry should be foreseen and neutralised by the development of other industries. This is in fact being done, belatedly, in B in the hope that the loss of young people through emigration will be halted. This policy is showing the first signs of succeeding.

The older age groups have contributed more than their share to the narrowing of the gap between male and female suicide rates which have been observed in most industrial societies over the last few decades. There has been a change in the peak age of female suicides. Female suicide rates in England and Wales used to reach their peak in the age groups 45–65; male rates on the other hand increased steadily with age, reaching their peak at 65 and over. During the last decades (1951–1960), however, female rates have been highest between 65 and 74 years. The same has been observed in most nations for which figures by age and sex are available (Sainsbury). A variety of factors have been blamed for the steady increase in the female suicide rate since the beginning of this century. Hartelius listed three: urbanisation, emancipation and secularisation, i.e. the decline of the influence of religion. The greater longevity of females whose expectation of life is at least five years longer than it is in males, must be an important factor. It means that there are always more widows than widowers. More women are living in social isolation than men. Wherever the suicide rate has increased it has done so at the expense of the female sex, especially of elderly women. This trend was obvious in the contrasting suicide rates of the two English cities referred to.

The high suicide rates of old men after the age of retirement used to be attributed to the loss of useful occupation. This does not apply in the same sense to females, although widowhood combines the effects of bereavement with certain aspects of forced retirement.

Economic factors are usually regarded as important among the causes of suicide in old age. However, their role is far from clear. Sainsbury has pointed out that social class ceased to play a part in suicide in old age. In the younger age groups suicide is more common in the upper than in the lower classes, but this difference is not found among the old. Suicide tends to decrease after 65 in the higher and to increase in the lower social classes. Sainsbury attributed this to the greater economic security which retirement brought to the well-to-do, and possibly also to their greater opportunities for enjoying life compared with those available to the lower classes. These observations were made in Britain and I do not know whether they apply to other countries. Sainsbury, in comparing the suicide rates in old age in twenty nations found that the

rates were neither related to the increase in the proportion of the aged in their population nor to the economic assistance provided by old age pension schemes. The introduction of such pension schemes in ten countries was not followed by a decrease in the suicide rates among the old. They rose both in countries with very comprehensive schemes and in countries with very limited provisions for the old. It would be premature to conclude from these findings that old age pension schemes are irrelevant for suicide prevention. They may be interpreted as showing that financial help is not enough. Also, the beneficial effects of those schemes may have been outweighed by other factors making for an increase of the suicide rate.

Social isolation and social desolation

Social isolation is generally regarded as the most important factor in the causation of suicide especially in old age. It is assumed to be almost inevitable in our society where the wider family group is split up into its component parts each of which tends towards an independent social existence. Social isolation may be due to bereavement and dispersion of the family. Geographical mobility among the younger age groups is greater to-day than it has ever been. The old are usually left behind.

The concept of social isolation has recently been reviewed by the British sociologist Peter Townsend. He distinguishes between social isolation, loneliness and social desolation. To be socially isolated is to have few contacts with family and community. To be lonely is to have an unwelcome feeling of lack or loss of companionship. The one is objective, the other subjective and the two need not coincide. Social isolation can be measured by reference to objective criteria, i. e. by the number of social contacts especially with relatives. Many who are living alone have a rich social life. They are not lonely. Townsend confirmed Sheldon's observations (1948) that those experiencing loneliness tended to be widowed or single people, to be living alone, to be in their eighties rather than their sixties, to be men rather than women (this may no longer be true to-day) and to be rather infirm. Townsend proposes the term "social desolation" for those recently deprived of the companionship of someone they loved. Some of those deprived in this way were not short of company. Desolation is, according to Townsend, more important than social isolation as a cause of loneliness of old people. The distinction between isolation and desolation is valuable because it introduces a psychodynamic approach into an area where there is a strong temptation especially for sociologists to rely too much on non-psychological criteria.

It is sometimes thought that the increase in suicide among the old is due to their loss of prestige in our society. This view is based on the low suicide rates among the old in the East and in Africa where the old are said to be held

in reverence. There is no doubt that being old carries by itself little prestige in our society. But the proportion of people who are getting old in Western civilisation is much higher to-day than it has ever been. Perhaps the reverence in which the old are said to be held in under-developed countries with a low expectation of life is partly due to their relatively small number and can be expected to decline when their numbers will increase. You need no longer be lucky or blessed to reach the biblical age of three score years and ten.

Prevention

All the observations to which I have referred have preventive implications. Improvement of medical services for the old is bound to reduce the incidence of suicide among them. Health authorities are only just beginning to take note of the needs of the growing numbers of old people in our society. Every measure against physical and mental disease in old age also serves to reduce the suicide rate. The same is true for measures against social isolation and the segregation of the old. Our society has given much too little thought to the use of the working capacity and the skills of the old. These are tremendous tasks which require considerable resources. In the final event it is a question of priorities. There is no country in the Western world which does not spend much more on alcohol, tobacco and gambling than on its health and social services, and too small a proportion of the resources allocated to those services benefit the old. Unless much more thought and resources are given to the problems of the old, the suicide rate will go up and the old will continue to be a burden and a reproach to our society rather than an asset.

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Address of the author: Professor *E. Stengel*, M.D., University Department of Psychiatry, Whiteley Wood Clinic, Sheffield 10, England.