Suicide in working elderly males, ages 75+
(last update: 1/29/2010)

The suicide rate among elderly males, age 75 or older, is one of the highest of any special population in the United States. Estimates place the suicide rate for men 75 or older at 37.4 deaths per 100,000 and at 61.0 per 100,000 for men 85 or older (CDC MMWD, 2006). By comparison, the suicide rate for the general population for the same year was 11.1 deaths per 100,000 and 22.81 deaths per 100,000 for males ages 18-64 (CDC, 2006). Within the elderly population, elderly men account for 81% of completed suicides nationwide (Szanto, Prigerson & Reynolds III, 2001), and white men age 85 and older had a rate of 49.8 suicide deaths per 100,000 or higher for the 85+ age group (NIH Older Adults: Depression and Suicide Fact Sheet, 2003). This phenomenon is not limited to the United States. Szanto, Gildengers, Mulsant, Brown, Alexopoulos, Reynolds (2002) found that men aged 75 years and older have the highest suicide rate among all age groups in almost all industrialized countries.

Men in the 75+ age group have risk factors common to other populations, such as undetected or unmanaged depression, alcohol or drug use, and ready access to effective suicide means. They also have suicide risk factors for men in general, such as poor or absent emotional reasoning skills, poor help seeking skills and fear of stigma from receiving mental health support. On top of these burdens, they also the risk factors associated with working age males including grave health conditions, traditional male role pressures, changing or declining economic status, etc.

In addition to the burdens imposed by all of the risk factors above, research has identified a number of risk factors specific to men 75 years and older. Rapidly declining health, grief over the loss of their spouse, loss of daily function, visual impairment, reduced living circumstances and social isolation have all been found to contribute to suicides by 75+ year old males. Given that a risk factor is defined as something that predisposes or increases the risk of a behavior or negative outcome, it should not be surprising that men 75 years and older have one of the highest risks for suicide. Even an elderly male with no suicidal tendencies carries a high risk for suicide. Fortunately, as described below, a suicide screening program designed specifically for the elderly is in development.

National and Idaho rates and trends of suicide in elderly males age 75 and older

In 2006, the most recent year for which comparable data are available, the national suicide rate for males age 75 and older was 35.70 deaths per 100,000 according to data obtained from the Centers for Disease Control and Prevention WISQARS online data system. From the same source, the 2006 Idaho rate for elderly males was 50.97 deaths per 100,000, approximately 43% higher than the national rate. This places Idaho as the 8th highest state for suicides in this population. Table 1 below shows the ten states with the highest elderly male suicide rates reported to the CDC. Note that this is not just an Idaho phenomenon: six of the top ten states are in the west or northwest of the United States.

2006, United States Suicide Injury Deaths and Rates per 100,000 All Races, Males, Ages 75 to 85+ ICD-10 Codes: X60-X84, Y87.0,*U03				
State	**Deaths**	**Population**	**Rank**	**Crude Rate per 100,000**
Wyoming	11*	12127	1	90.71
Montana	23	26213	2	87.74
Nevada	43	52057	3	82.6
Alaska	5*	7749	4	64.52
Oregon	55	95060	5	57.86
Arizona	93	165118	6	56.32
New Mexico	26	47326	7	54.94
Idaho	***17****	***33350***	***8***	***50.97***
Missouri	70	142824	9	49.01
Arkansas	35	71720	10	48.8
United States	**2494**	**6985922**		**35.7**
Retrieved from the Internet December 2, 2009: http://webappa.cdc.gov/cgi-bin/broker.exe * Rates based on 20 or fewer deaths may be unstable. Use with caution.				

Table 1. Idaho's ranking for completed suicides by elderly males ages 75+ for 2006.

White males comprise the majority of completed suicides by elderly males. Figure 1 shows the national suicide trends from the 1950s through 2006 for white men aged 65 and older. The figure also shows the comparatively high suicide rate of white elderly males relative to same age males of other races. Note that there was a steady rise to a peak of 46.7 deaths per 100,000 for white elderly male suicides in 1987, followed by a steady decline to the lowest recorded rate for 2006 at 30.9 deaths per 100,000. The same decline is also apparent for elderly males of other races,

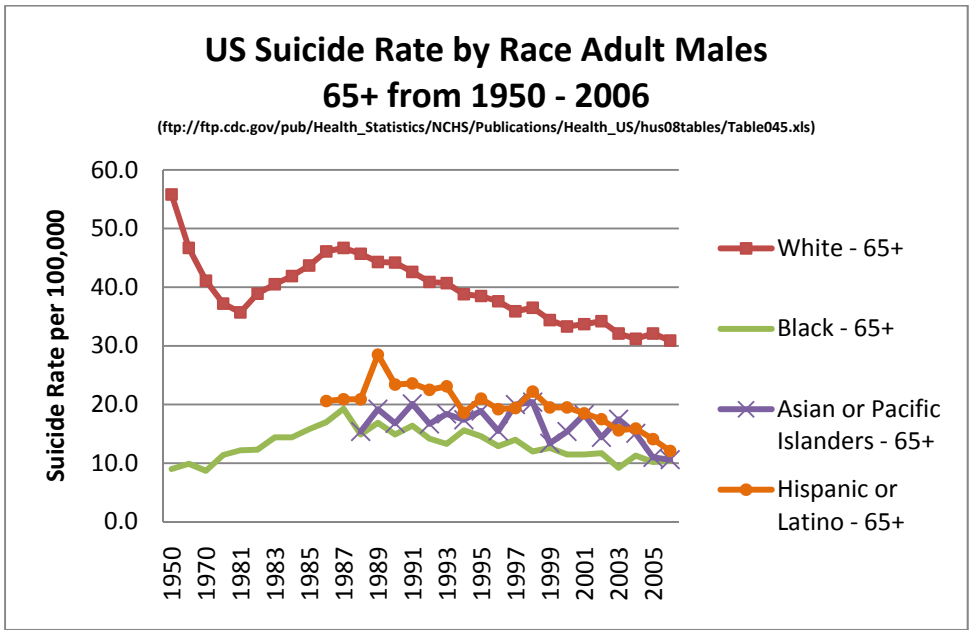

Figure 1. U.S. suicide rates by race for elderly males age 65 and older.

Figure 2 shows the US suicide rate for elderly white males 65-74, 75-84 and 85 years and older. The higher suicide rate of the two older groups is apparent in the figure, reaching 74.8 per 100,000 for the 85 year and older white male in 1991. The figure also shows the contributions of each age group to the peak in elderly male suicides that occurred during the late 1980s.

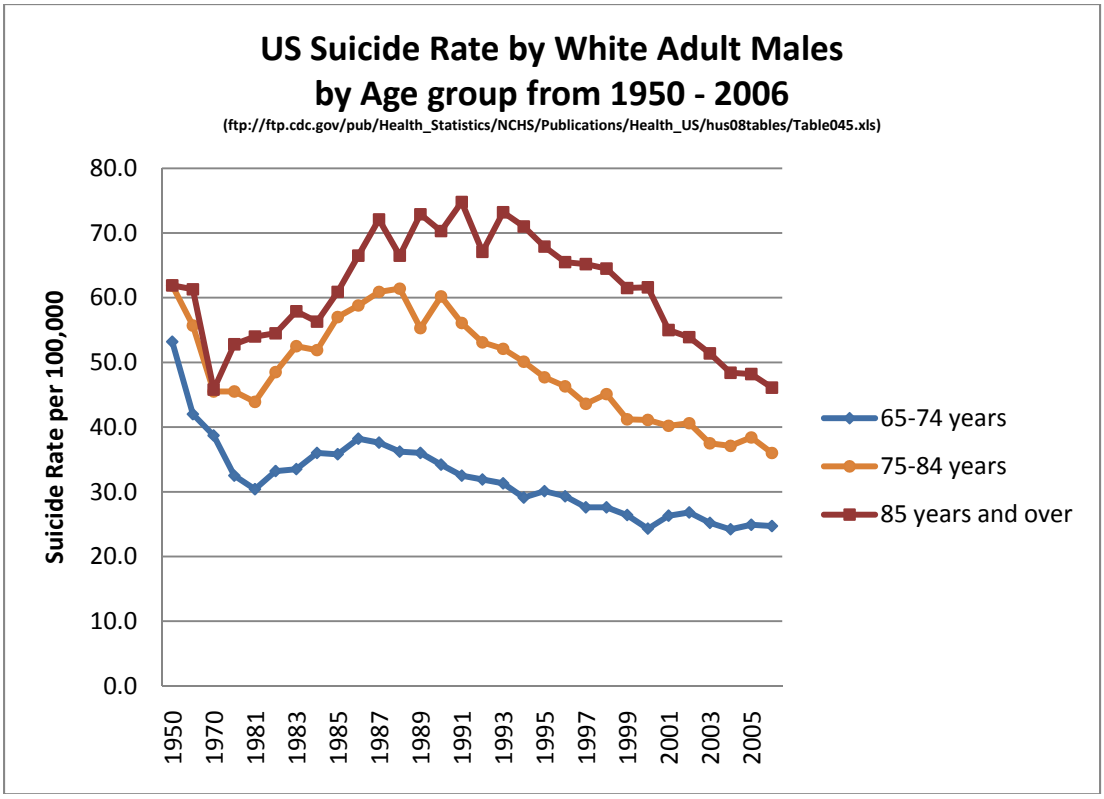

Figure 2. U.S. suicide rates by age group for elderly white males age 65 and older.

In general, Idaho has higher suicide rates than the U.S. average for all subpopulations and this holds true for elderly males as well. Table 2 and Figure 3 compare Idaho and the US suicide rates per 100,000 for elderly male ages 65 and older from 1999 - 2006. Note that while the Idaho *rates* appear much higher than the national rates, the actual *incidence* of elderly male suicides is comparatively low (see Table 3). The low number of Idaho elderly male suicides makes it difficult to have confidence in the national CDC rates when expressed as a rate based on a hundred thousand.

Idaho & US Suicide Deaths, 1999-2006
Males, All Races, ages 75 to 85+

Year	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
US Rate	42.43	42.4	40.43	40.93	37.85	37.13	38.02	35.7
Idaho	98.72	68.02	69.24	67.3	52.32	50.97	85.9	50.97

Retrieved from the Internet January 28,2010: http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html

Table 2. U.S. and Idaho suicide rates per 100,000 for elderly males from 1999 – 2006.

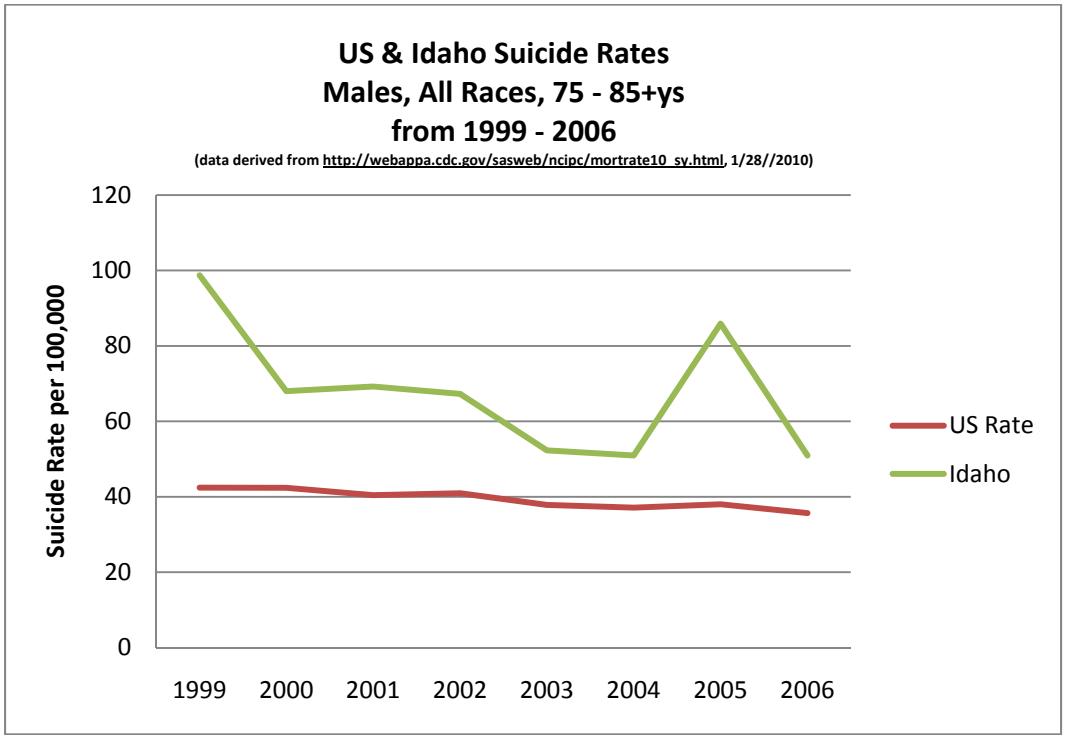

Figure 3. Graphic representation of the data presented in Table 2: U.S. and Idaho suicide rates per 100,000 for elderly males from 1999–2006.

Table 3 and Figure 4 show the number of suicides by elderly males in Idaho from 2003 – 2006. Both the table and the figure show that the actual number of elderly male suicides that occur in Idaho each year appears dramatically lower than the 100,000-based rates reported by the CDC.

Idaho Resident Suicide Deaths - Males Aged 75+
Age Group by Year of Death
2003-2007

	Year of Death				
Age Group	**2003**	**2004**	**2005**	**2006**	**2007**
75-84	11	11	20	11	11
85+	5	5	8	6	3

Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (11/2009)

Table 3. Idaho elderly male suicides by age group and year of death from 2003 – 2007.

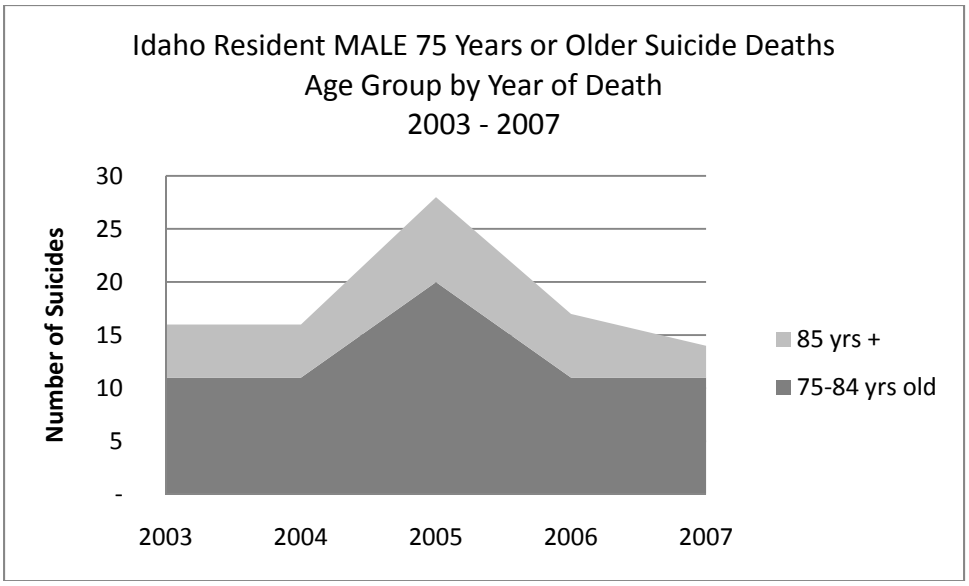

Figure 4. Idaho elderly male suicides by age group and year of death from 2003 – 2007. The figure shows the contribution of each age category to the overall number of suicides

Racial distribution of elderly male suicides in Idaho

Table 4 shows the lack of distribution of elderly male suicides across the races in Idaho. 98.9% of the elderly male suicides were by white men. The rate essentially parallels the general racial population distribution of men in Idaho.

Idaho Resident Suicide Deaths - Males Aged 75+ ICD-10 Codes for Suicide: X60.0-X84.9 and Y87.0 by Race and Ethnicity Five-Year Aggregate, 2003-2007								
		Race						
	Total	White	Black	American Indian	Asian Pacific Islander	Other race	Not stated	Hispanic
TOTAL, 2003-2007	91	90	1	-	-	-	-	1
Source: Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (10/2009)								

Table 4. Racial distribution of suicides by Idaho elderly males from 2003- 2007.

Suicide methods used by US & Idaho elderly males

Figure 5 shows the proportions of methods used in completed suicides for elderly males from 2003–2006 for the United States as a whole. Figure 6 shows the same information for Idaho elderly males for the same period. Table 6 presents the numerical data for both figures.

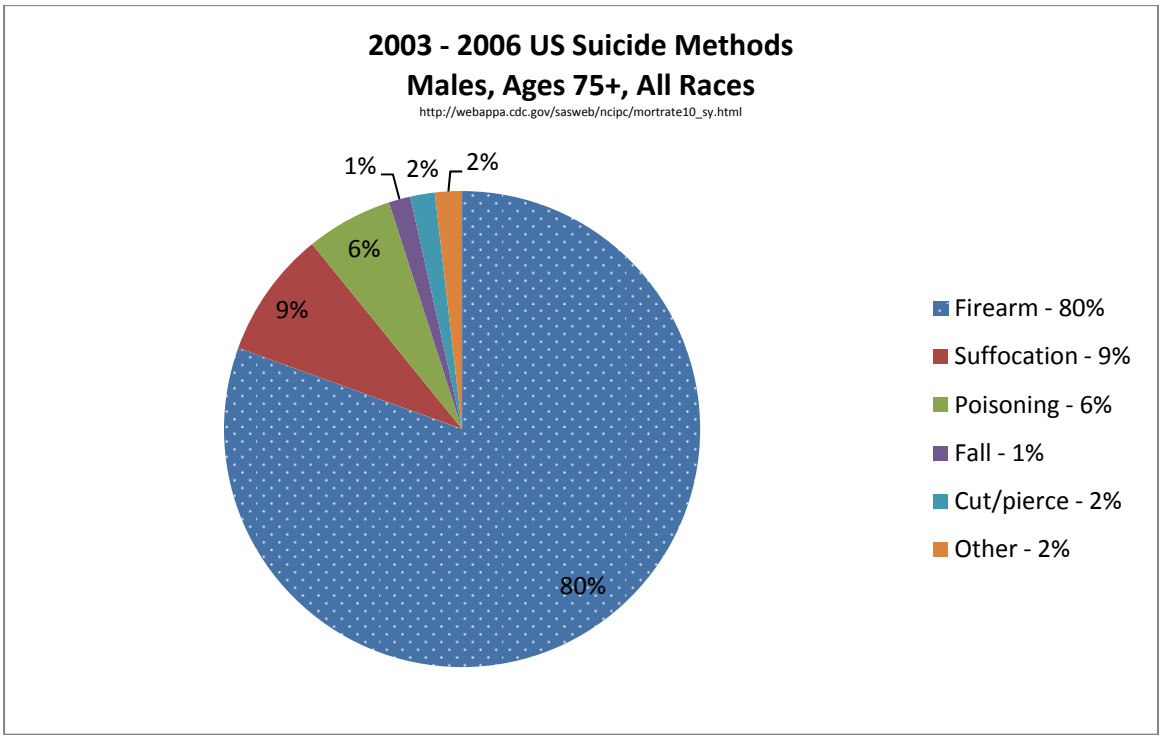

Figure 5. Methods used in completed suicides by elderly males 75 years and older in the United States from 2003 – 2006.

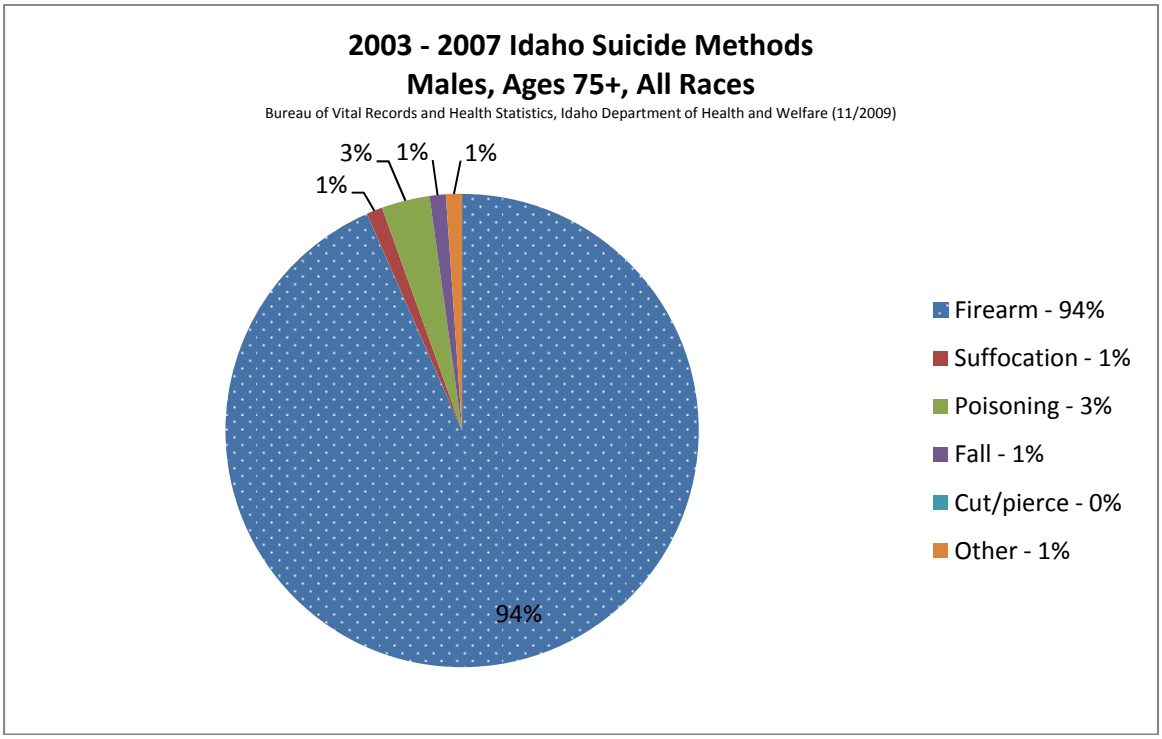

Figure 6. Methods used in completed suicides by elderly males 75 years and older in Idaho from 2003 – 2006.

Suicide Method	2003-2006 US Percent	2003-2007 Idaho Percent	Idaho N
Firearm	80.38%	93.41%	85
Suffocation	8.60%	1.10%	1
Poisoning	5.86%	3.30%	3
Fall	1.47%	1.10%	1
Cut/pierce	1.65%	0.00%	0
Other	1.83%	1.10%	1

US data: http://webappa.cdc.gov/cgi-bin/broker.exe?_service=v8prod&_server=app-v-ehipwisq.cdc.gov&_port=5082&_sessionid=3iSCw3CML52&_program=wisqars.details10.sas&_service=&type=S&prtfmt=STANDARD&age1=1
Idaho data: Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (11/2009

Table 5. Methods used in completed suicides by elderly males 75 years and older in the Idaho from 2003 – 2006.

Location of suicidal action leading to completed suicides for Idaho elderly males

Table 6 shows where the suicidal action occurred for Idaho elderly males that completed suicide between 2003 – 2007. Note that this is often different than where the person actually died, such as at the hospital.

Idaho Resident Suicide Deaths - Males Aged 75+
Place of injury by Year of Death
2003-2007

		Year of death				
	Total	2003	2004	2005	2006	2007
TOTAL	91	16	16	28	17	14
Home	82	15	15	26	15	11
Street, highway	3	-	-	1	1	1
Residential institution, Nursing home	-	-	-	-	-	-
Trade and service area	1	-	1	-	-	-
School, Hospital, other Public institution	-	-	-	-	-	-
Other place	4	1	-	-	1	2
Unspecified area	1	-	-	1	-	-

Bureau of Vital Records and Health Statistics, Idaho Dept. Health and Welfare (11/2009) ICD-10 Codes for Suicide: X60.0-X84.9 and Y87.0

Table 6. Location of suicidal action leading to completed suicides for Idaho elderly males from 2003–2007.

Institutionalized indirect self-destructive behaviors and the elderly

For elderly populations, recent research suggests that many deaths that occur in institutions such as nursing homes maybe iatrogenic (self-caused). Termed 'indirect self-destructive behaviors', they occur when a person exhibits minor behaviors that could lead to their own death (Szanto, Gildengers, Mulsant, Brown, Alexopoulos, Reynolds, 2002; Draper, Brodaty, Low, Richards, Paton & Lie, 2002). Such behaviors, whether conscious or otherwise, include refusal of food or necessary medications, self-

neglect, etc. These small behaviors often go unnoticed and can unbalance the health of a frail person, leading to premature death. It is possible that geriatric institutional indirect suicides occur in Idaho more often than Table 6 indicates, but go undetected and undocumented.

Former occupation of Idaho elderly male suicides

Figure 7 shows the former occupations of Idaho elderly males that completed suicide from 2003 – 2007. Note that although some occupations have a much higher incidence of suicide, these data have not been weighted by the total number of people that work in each industry. That is, an occupation with 100,000 employees will have a larger actual number of suicides than an occupation with 1,000 employees even though the relative rates might be the same.

An interesting observation is that compared to working age Idaho males, a much higher proportion of elderly men who once worked in agriculture, forestry and fisheries completed suicides after age 75. Without further knowledge, however, it's not possible to say whether working in those fields increased the risk of suicide in later years, or that more of the men who worked in those industries survived into the 75+ year range in the first place, and then completed suicides.

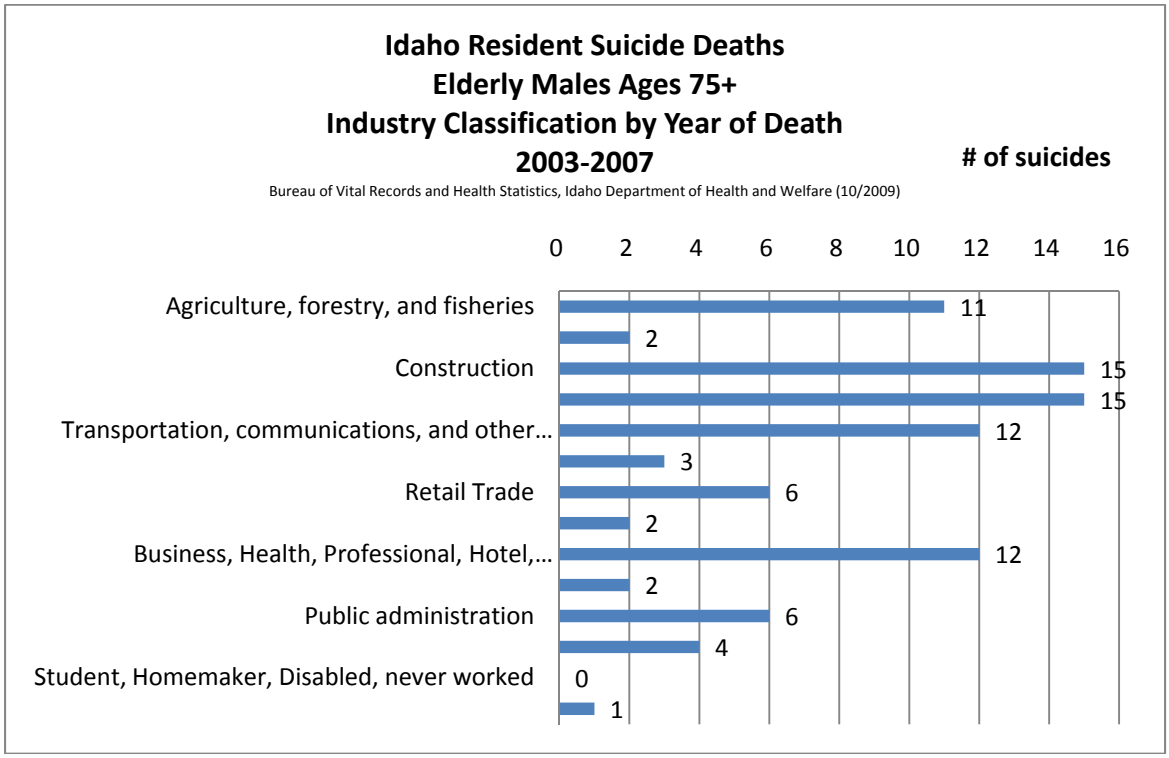

Figure 7. Occupations of Idaho elderly males that completed suicides between 2003–2007.

Marital status of Idaho elderly male suicides

The marital status of Idaho elderly males who completed suicide between 2003–2007 is shown in Table 8. While there is likely a selection bias in effect, in that there are many more married elderly males than widowed, Idaho's data are consistent with recent research: widowed elderly males appear to be at a much greater risk for suicide. Research has found that there is a critical 13-month period of heightened suicide risk that follows the death or an elderly man's wife. Byrne and Raphael (1998) found that widowers experience greater levels anxiety and psychological distress, but not necessarily more

depression or loneliness over the first 13 months post-bereavement. Other research has found that bereavement-related depression does significantly contribute to elderly suicide (Prigerson, Miller & Reynolds, 1997). One implication for suicide prevention with the recently widowed elderly male could be enhanced monitoring or even case management during the year and a month following the death of the man's wife. Enhanced contact over the 13 month critical period could reduce elderly male suicide by seeing the widower past the anniversary of his wife's death, as well as a year of depression and diminished social contact.

Idaho Resident Suicide Deaths - Males Aged 75+ by Marital Status Five-Year Aggregate, 2003-2007	
Marital Status	**Total # of suicides**
Married	46
Married, but separated	1
Never married	3
Divorced	5
Widowed	36
Unknown	0
TOTAL	91
Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (10/2009).	

Table 8. Marital status for Idaho elderly males that completed suicide between 2003 – 2007.

Suicide, seasonality and the day of the week for working age male suicides

Research has identified a strong seasonal trend in suicides that peaks in the spring following a low point over the winter, although there is considerable variation depending on country, gender, etc. (Kim, et al., 2004). This trend is not readily apparent in the data for Idaho elderly males (see Figure 9). However, the relatively low number of elderly male suicides in Idaho makes it difficult to draw strong conclusions. In Figure 9, only 10 suicides over a five year period separate the low in February from the high in July.

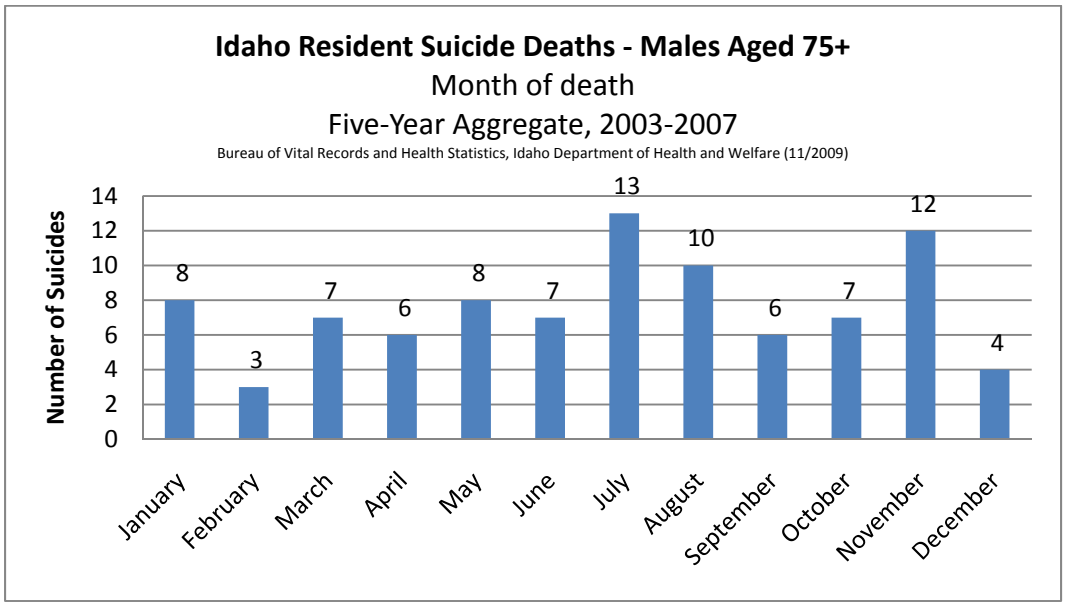

Figure 9. Seasonality of Idaho elderly male suicides from 2003 – 2007.

Research has also examined the relationship between the days of the week and suicide rates. Similar to the seasonality research, there is research support for different peak days with some consensus on Mondays and Wednesdays. Recent work appears to be settling on Wednesday as the primary day of the week that suicides are most likely to occur (Kposowa and D'Auria, 2009). Figure 10 shows the number of Idaho elderly male suicides completed on each day of the week from 2003 – 2007. In the figure, it appears that Sunday is the peak day for suicide for elderly males in population in Idaho. However, strong interpretation of the data is hampered by the low number of cases. Similar to the month of year data, only 11 deaths over a five year period separate the lowest from the highest day of the week.

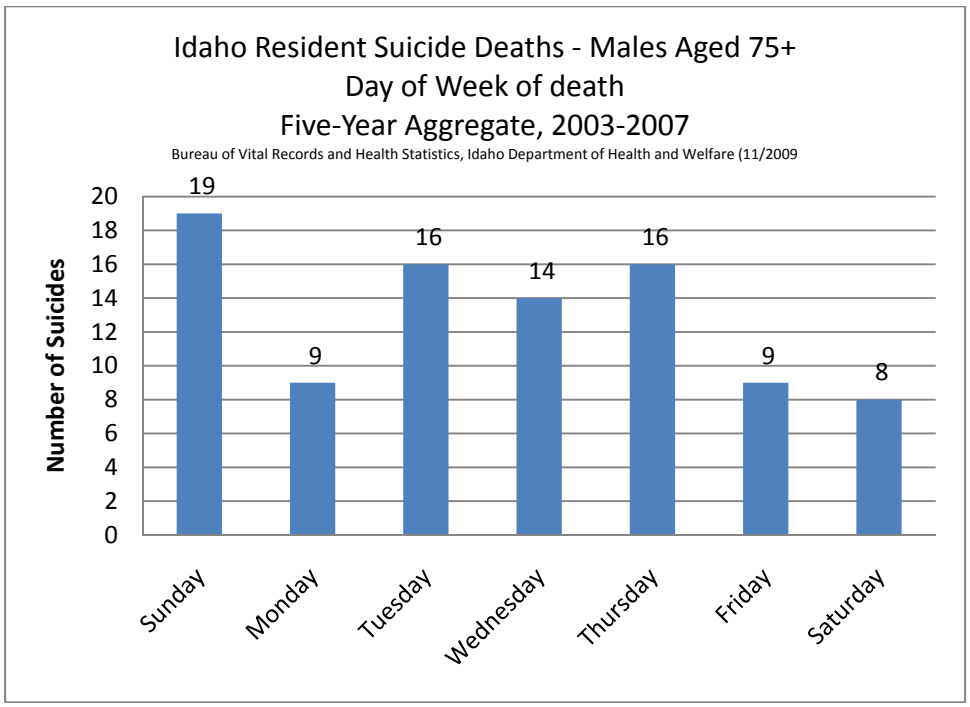

Figure 10. Completed suicides for each day of the week by Idaho elderly males from 2003 – 2007.

Gender issues in elderly male suicide

Research has identified a number of male-specific issues and circumstances that play a disproportionate role in elderly male suicides.

- Chronic illness and grave medical conditions increase the risk of suicide for elderly males. Heart or lung disease, cerebral vascular accidents (stroke), musculoskeletal disorders and cancer are all correlated with elderly male suicide (Waern, Rubenowitz, Runeson, Skoog, Wilhelmson, & Allebeck, 2002; Conwell, Lyness, Duberstein, Cox, Seidlitz, DiGiorgio, Caine, 2000; Grabbe, Demi, Camann, and Potter, 1997).

  Waern, Rubenowitz, Runeson, Skoog, Wilhelmson, & Allebeck (2002) documented the gender difference in elderly suicides using matched treatment-control groups. They noted that serious physical illness was present in 56% of the elderly who completed suicide compared with 16% of a control group matched on age and other factors who did not have a serious physical illness. In addition, serious physical illness and high 'overall burden of illness' scores were stronger risk factors for men than women. In men, the presence of a physical illness was associated with a

fourfold increase in suicide, whereas there was significant increase in women. Table 9 shows the disparity in suicide by elderly men and women under physical and mental health burdens.

Serious illness and disability in elderly people who committed suicide and living control participants by sex.						
	Men			**Women**		
	Suicides (n=46)	Controls (n=84)	Odds ratio (95% CI)	Suicides (n=39)	Controls (n=69)	Odds ratio (95% CI)
Any serious physical condition	30 (65)	32 (38)	4.2	17 (44)	28 (41)	2.1
Overall physical burden score	19 (41)	23 (27)	2.8	4 (10)	21 (30)	0.4
Any serious mental condition	41 (89)	6 (7)	99.8	35 (90)	9 (13)	61.6
Waern, Rubenowitz, Runeson, Skoog, Wilhelmson, & Allebeck, 2002, http://www.bmj.com/cgi/content/full/324/7350/1355/T2						

Table 9. Serious illness and disability in elderly people who committed suicide and living control participants by sex.

- Recent contact with a primary care physician (Harwood, Hawton, Hope & Jacoby, 2000), chronic physical illness, prior experience of self or someone else suffering from a debilitating disease, high overall burden of physical illness and an independent and inflexible personality have all been associated with elderly male suicide (Horton-Deutsch, Clark & Farran, 1992).

- A large number of lesser physical issues have also been linked to elderly male suicide. Dyspnea (continual sense of breathlessness and other chronic breathing problems), visual impairment and neurological disorders such as Parkinson's are independently associated with increased risk of suicide in elderly males (Waern, Rubenowitz, Runeson, Skoog, Wilhelmson, & Allebeck, 2002).

- Bereavement and recent widowhood is also a significant contributing factor to the high suicide rate in elderly men. Guohua (1995) found that the risk of suicide for widowed men was 3.3 times that of married men, but that the risk of suicide for widowed women did not increase compared to that of married women. Szanto, Prigerson, Ehrenpreis and Reynolds (1997) found that 57% of elderly male patients with high grief scores also had higher levels of suicide ideation. Heightened suicidal ideation in bereavement has also been found to be associated with severe loneliness and depressive symptoms (Stroebe, Stroebe and Abakoumin, 2005), especially during a 13-month critical period .

- Social isolation has been identified as a special risk factor for elderly men (Arakia & Murata, 1986), especially for men in rural areas. For the recently widowed, informal observation of social involvement of family and friends reveals intense social activity during and shortly after the funeral. However, despite the best intentions and encouragement to "call us if there's anything we can do," social contact drops to a new low after the first month, leaving the grieving widower alone in an empty house.

- Functional limitations due to elderly infirmaries have also been identified as a significant contributing factor to elderly male suicide. Indeed, Kaplan, McFarland, Huguet and Newsom (2007) found that when functional limitations were parsed out of the equation, chronic conditions alone were not predictive of suicidality in the elderly. Their work suggests that it is not simply the presence of the physical problems associated with old age. Instead, it is the burden that the physical problems impose on the quality of life that underlies the association between illness and geriatric suicide. In support of this notion is the observation that the level of depression in the elderly increases with other illnesses, but that it is when their ability to function becomes limited that suicide risk increases (NIH Older Adults: Depression and Suicide Fact Sheet 2003).

  This may also explain some of the increase in suicide risk for men following the death of their wives. The surviving male may suffer a sudden and major decrease in functional daily living abilities due to the loss of the roles and contributions to functional daily living previously performed by his wife.

Risk & causal factors

Men in the 75+ age group have risk factors common to other populations, such as undetected or unmanaged depression, alcohol or drug use, and ready access to effective suicide means. Men in the 75+ age group have the risk factors that elevate suicide risk for men in general, such as poor or absent emotional reasoning skills, poor help seeking skills and fear of stigma for receiving mental health services, etc. Men in the 75+ age group also have the risk factors associated with working age males including grave health conditions, traditional male role pressures, changing or declining economic status, etc.

A number of risk factors have also been identified that are specific to men 75 years and older. Given that a risk factor is defined as something that predisposes or increases the risk of a behavior or negative outcome, it should not be surprising that men 75 years and older have a very high risk of suicide. Even an elderly male with no suicidal tendencies carries a high risk for suicide. The following lists summarize the research identified risk factors specific to elderly men (Catell, 2000; Turvey, Conwell, Jones, Phillips, Simonsick, Pearson & Wallace, 2002).

- Suicide risk factors for elderly males
  - Morbid physical illnesses
  - Chronic illness
  - Chronic pain
  - Psychiatric illness
  - Recent widowhood
  - Living alone
  - Social isolation
  - Alcohol or medication misuse
  - A tightly controlled personality

- General signs and symptoms that may also be seen in elderly males
  - Previous suicide attempts
  - Depression and anxiety
  - Talking about suicide, or making a plan
  - Statements of not being missed if dead

- Expressions of hopelessness, helplessness and anger at oneself or the world
- Themes of death or depression in conversation, writing, reading or art
- Strong personality changes, withdrawal, aggressiveness or moodiness
- Giving away possessions

Prevention & Intervention

Suicide prevention for the elderly male has the same elements as for other populations: awareness/signs and symptoms trainings, depression and suicidality screenings, help seeking destigmatization, and where actual intent is known, means reduction. But there are some situations and preventive methods unique to the elderly male. For example, close monitoring and regular social contact over the critical 13 month period following the death of an elderly man's spouse may prevent many elderly male suicides (Byrne and Raphael, 1998).

One suicide prevention approach empirically demonstrated as effective with elderly men and women is to make suicide and depression screening a routine part of visits to the primary care physician's office. Raue, Alexopoulos, Bruce, Klimstra, Mulsant, and Gallo (2001) observed that most elderly in the United States have a high rate of contact with their primary care physician and that many geriatric suicides occurred within a month of a primary care visit. Investigating how an imminent suicide had not been detected during the recent office visit, they found that primary care physicians and their staff did not consider depression and suicide screening as the purview of the medical office setting. Others indicated being uncomfortable asking questions about depression or suicide.

To address this, they developed PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial). PROSPECT is designed to detect depression and suicidality in the elderly by the routine use of a few short screening questions and to treat the depression and through short-term use of a mild antidepressant (e.g., citalopram). Essentially a simple training protocol, PROSPECT's effectiveness is due in part to enabling and empowering the primary care physician and office staff to include depression and suicidality as part of their role as medical care providers and to intervene when necessary. A summary of the PROSPECT protocol may be found at: http://www.idahosuicide.info/_uploads/PROSPEC%20-PreventionOfSuicideInPrimaryCareElderlyCollaborativeTrial_final.pdf.

Screening tools for elder depression and suicide risk

A number of depression and suicide risk screening tools designed for the elderly have been developed. While there are many well developed mental assessment instruments, they tend to be comprehensive and quite lengthy. In contrast, the ideal suicide screening tool can be quickly administered by non-professionals in a variety of settings beyond a clinical context. Those who do indicate an elevated suicide risk are referred on to in-depth clinical assessment and intervention as indicated.

A depression and suicidality screening tool can be as simple as two questions, such as that used by PROSPECT: Are you depressed? Have you had thoughts or feelings about suicide lately? Three others, in increasing complexity, are describe below.

- 3-item screener developed by Szanto, Gildengers, Mulsant, Brown, Alexopoulos & Reynold (2002)
    - Have you been feeling so sad lately that you were thinking about death or dying?
    - Have you had thoughts that life is not worth living?
    - Have you been thinking about harming yourself?

Scoring – A positive answer to any item indicates risk and a need for more intensive assessment.

- 4-item version of the *Geriatric Depression Scale* (Almeida and Almeida, 1999).
  - Are you basically satisfied with your life? (NO)
  - Do you feel that your life is empty? (YES)
  - Are you afraid that something bad is going to happen to you? (YES)
  - Do you feel happy most of the time? (NO)

  Scoring – Two or more answers corresponding to the answers in parentheses indicates depression. One answer that corresponds indicates uncertainty. No corresponding answers indicate that there depression is not a concern.

- *15 item Geriatric Depression Scale* (Brink, Yesavage, Lum, Heersema, Adey, and Rose (1982).

  - Are you basically satisfied with your life? YES / **NO**
  - Have you dropped many of your activities and interests? **YES** / NO
  - Do you feel that your life is empty? **YES** / NO
  - Do you often get bored? **YES** / NO
  - Are you in good spirits most of the time? YES / **NO**
  - Are you afraid that something bad is going to happen to you? **YES** / NO
  - Do you feel happy most of the time? YES / **NO**
  - Do you often feel helpless? **YES** / NO
  - Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO
  - Do you feel you have more problems with memory than most? **YES** / NO
  - Do you think it is wonderful to be alive now? YES / **NO**
  - Do you feel pretty worthless the way you are now? **YES** / NO
  - Do you feel full of energy? YES / **NO**
  - Do you feel that your situation is hopeless? **YES** / NO
  - Do you think that most people are better off than you are? **YES** / NO

  Scoring - Answers in **bold** indicate depression. For clinical purposes, a score > 5 points is suggestive of depression and should receive a follow-up interview. Scores > 10 almost always indicate depression. An online, computer scored version of the GDS-15 is available at http://www.stanford.edu/~yesavage/Testing.htm

- *Harmful Behaviors Scale* (Draper, Brodaty, Low & Richards, 2003) is an observer-rated self-harm behavioral rating tool for institutionalized people. The items with a statistically significant relationship to suicide risk are in **bold**.

  - Refuses participation in social activities
  - Resists ADL assistance
  - Refuses to follow staff requests
  - Verbal abuse
  - **Refuses to eat or drink**
  - Tries to walk unassisted against advice

- **Refuses to take medication**
- Alienates staff, provokes rejection
- Not eating/drinking on own when capable
- Physical abuse of staff and residents
- Exposes self to hazards
- Scratching excessively
- Falls
- Tries to abscond from nursing home
- Removing catheters, tubes, dressings
- **Verbal suicide expression**
- Hitting walls, doors, etc.
- **Burning or scalding**
- **Eating foreign objects or drinking toxic liquids**
- **Cutting self with sharp object**
- Taking unauthorized medication
- Overdosing on medication

Intervention

Beyond intervention successful for other populations, such as the combination of a short-term antidepressant regimen combined with psychotherapy, means reduction, etc., intervention can work by addressing the underlying stressors. For the elderly male, grief counseling, management of chronic pain and illness, and renewed involvement in social and community activities to counteract loneliness and lack of social contact could all play a role in suicide prevention and intervention for the elderly.

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