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# Issues

Information and ideas for those  
serving seniors.

on Aging

## Hopelessness and Despair: Deadly in Old Age

**Dateline:** Winona, Minnesota, February 7, 1994. The Associated Press reported that a 76 year old woman shot her 79 year old husband in their home before turning the gun on herself. A note at the home indicated that the man was in failing health and the couple did not wish to spend the rest of their lives in a nursing home.

**Dateline:** Fort Lauderdale, Florida, December 7, 1994. The Associated Press reported that a 79 year old man and his 76 year old wife died a double suicide in their garage. They had sat in their car with the engine running until they died of carbon monoxide poisoning. He was confined to a wheelchair with arthritis and asthma, and his wife suffered from Alzheimer's Disease.

**Dateline:** Duluth, Minnesota, September 12, 1995. The Associated Press reported that the strain of health problems apparently drove an elderly Duluth man to kill his wife and then himself. Their daughter reported that both were in poor health and said that health problems may have played a part in their murder/suicide.

**Dateline:** Ventura, California, September 17, 1995. The Associated Press reported that a 90 year old man strangled his wife of 60 years because he feared no one would care for her if he died.

Stories like these can be read in the newspapers every day. It is difficult to understand the depth of hopelessness and despair that drives some people to take their lives and the lives of their spouses. The phenomenon of senior "mercy killings" compounded by the killer's own suicide is not uncommon, and is usually triggered by the health problems of one or both partners. Alzheimer's Disease and related dementias are frequently contributing factors. The healthier or more competent partner often fears leaving a disabled spouse behind should he or she die first.

While the rate of homicides committed by seniors is low, the incidence of suicide in the United States is highest in men over age 65, particularly among widowers. Males over 65 commit suicide three times more often than males ages 20-24, and the rate increases among men 85 years and older. White females over 65 commit suicide twice as often as younger women. While only 12% of the U.S. population is classified as elderly, 25% of all suicides occur in this group.

Several studies have been conducted to determine the reasons why seniors kill themselves and their spouses. Miller conducted a systematic examination of 301 white elderly male suicides in Arizona. He found the reasons for committing suicide most often included:

- Severe physical illness
- Mental illness, such as Major Depression
- The threat of extreme dependency or institutionalization
- The death of one's spouse

- Retirement
- Pathological personal relationships
- Alcoholism and drug abuse
- Multiple factors

Other factors which have been found to contribute to elderly suicide and homicide include:

- Losses causing depression, hopelessness, despair and low self-esteem
- Prolonged, demanding needs for care
- The inability of an individual to form and sustain meaningful relationships
- A pattern of solving problems by action rather than adaptation
- Cultural indifference or hostility to seniors

The tragedy of these suicides and homicides is compounded by the fact that they may be preventable when triggering problems are identified and addressed before they reach overwhelming magnitude. Survivors, already experiencing grief, are often plagued with guilt for failing to resolve the crisis which caused the suicide. Grief and guilt are multiplied by the double loss in instances of suicide/homicide or joint suicides.

The most effective methods for preventing suicides and "mercy killings" in the elderly involve educating seniors, their family members and health professionals about senior suicide issues, and providing psychological and supportive services to address the issues which prompt these drastic measures. In addition, altering cultural attitudes about aging in general and addressing the perceptions of aging among primary health providers will facilitate more positive perceptions of life in the senior population.

Seniors rarely contact suicide prevention centers, notify their family members or physicians of their intent, or take advantage of social services available to them. For example, Miller noted that most of the aged males in his study had visited their physicians in the month prior to their suicide, but that the doctors did not inquire or otherwise discuss the suicidal intent of these patients. This demonstrates that individuals who experience sufficient physical, mental and emotional distress to consider "mercy killing" or suicide generally need active, intense, and professional intervention to identify the death risk and implement strategies to reduce it.

Prompt, thorough and assertive intervention can be lifesaving measures for seniors with depression, hopelessness and despair. Empathetic, skilled care managers can assess clients' physical, mental and emotional states and observe for clues that clients are at risk for suicide or homicide. The ability to conduct the assessment in the clients' home environments reduces anxiety and increases clients' comfort in sharing concerns. Care managers often elicit symptoms of hopelessness and depression in their interviews with clients. They also

identify client's unresolved issues and unmet needs. Care managers then take steps to resolve the identified problems and concerns. This involves consulting with medical specialists for diagnosis and treatment of medical problems and depression, and implementation of appropriate supportive services to resolve psychosocial concerns.

1. Yurick, A.G., et al. *The Aged Parson and the Nursing Process*. CT: Appleton and Lange, 1989, page 320.
2. Esberger, K.K. & Hughes, Jr., S.T. *Nursing Care of the Aged*. CT: Appleton & Lange, 1989, pages 293-4.
3. Carnevali, D. L. and Patrick M. *Nursing Management for the Elderly*. Philadelphia: Lippincott, 1993, page 252.
4. Mill, M. (1978) Geriatric suicide: The Arizona study. *The Gerontologist*, 18, 488-495.
5. Esberger, K.K. & Hughes, Jr., S.T. *Nursing Care of the Aged*. CT: Appleton & Lange, 1989, page 331.
6. Miller, M. (1979) *Suicide after sixty: The final alternative*. New York: Springer.

**Q** How can I tell if my client is at risk of suicide or "mercy killing," and what should I do about it?

**A** These clues may alert you that a client is experiencing overwhelming feelings of hopelessness depression or despair which can lead to suicide or homicide:

- Verbal statements such as:
  - "I can't get along without him/her."
  - "I/we would be better off dead."
  - "This pain is too much to bear."
  - "He/she doesn't know me anymore."
  - "I can't afford the health care he/she needs."
- Self-neglect such as:
  - Refusing needed medical care
  - Refusing to take medications or taking them incorrectly
  - Starvation
  - Exposing oneself to hazards
  - Inadequate grooming and dressing
- Depressive symptoms such as:
  - Isolation
  - Weeping
  - Sleep disturbance
  - Difficulty making decisions

When you encounter clients who have experienced losses or who exhibit one or more of these symptoms, it is important to take positive action immediately. You may be the only person in the client's life who can or will intervene. You can discuss your concerns with the client directly. Scientific studies have shown that you will not trigger or cause a suicide by discussing it with the depressed person – in fact, talking about concerns decreases isolation and provides opportunities to solve problems. You can also notify a family member or the client's physician, or you can contact the designated adult protective service agency. What's important is to intervene promptly!