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When elderly people give warning of suicide

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ABSTRACT

Background: The study has a dual objective: (1) to investigate the extent to which, and how and to whom, elderly people gave warning (according to the definition of the term given by the American Association of Suicidology) prior to suicide; (2) to investigate how these warnings were perceived by the recipients of them, and what reactions the recipients had to the warnings.

Methods: This is a psychological autopsy study based on qualitative interviews. Sixty-three informants were interviewed about 23 suicides by individuals aged over 65 in Norway. The informants comprised relatives, general practitioners (GPs) and home-based care nurses. In general, the analysis of the interviews follows the systematic text condensation method.

Results: The interviews contained four main themes regarding reactions to the warnings: "not taken seriously," "helplessness," "exhaustion," and "acceptance." A total of 14 of the 23 elderly people gave warning before the suicides occurred. The warnings were given to relatives (11), home-based care nurses (5), and GPs (2).

Conclusions: Even though more than half of the elderly people had given warning (most frequently to relatives) before the suicide, the warnings did not initiate preventive measures. Together with passive attitudes, the lack of recognition of both the risk of suicide and the opportunities for treatment prevented possible measures being implemented. The paper discusses the grounds for the reactions as well as how suicide warnings given by elderly people can be taken seriously.

Key words: aged, psychological autopsy, suicide prevention, qualitative, suicidal behavior

Introduction

During the past 15 years, a number of case control studies have contributed considerable knowledge about factors that are associated with suicide among the elderly (Conwell *et al.*, 2000; Harwood *et al.*, 2001; Beautrais, 2002; Waern *et al.*, 2002a; 2002b). However, prevention at the individual level is difficult for several reasons. The strongest risk factors – such as depression, somatic illness, functional decline, and reduced networks – occur frequently in a normal population of elderly people and are, therefore, of limited use in clinical settings for identifying those who are susceptible to suicide.

In suicidology, *risk factors* describe factors that correlate with suicidality (Conwell *et al.*, 2002). They are population-specific and distal in relation to the act of suicide. Typical long-lasting and distal risk factors in the elderly are illness and functional decline, both of which were key elements in the understanding of the suicide issue in a Norwegian qualitative study of elderly suicide completers (Waern *et al.*, 2002a; Conwell *et al.*, 2010; Kjølseth *et al.*, 2010a). Warnings concern more dynamic and proximal factors that can indicate an acute crisis. In several articles, Rudd and his colleagues have discussed the term *warnings* – signs and symptoms that indicate a more immediate danger of suicidal behavior (Rudd *et al.*, 2006; Rudd, 2008). Although there will be some overlap between identified risk factors and suicide warnings, Rudd *et al.* make it clear that warnings are more observable and subjective. According to the AAS (American Association of Suicidology), the consensus is that there is a hierarchical system of warning signs, with the three following ranked highest: (1) someone threatening to hurt or kill themselves; (2) someone looking for ways to kill themselves: seeking access to pills, weapons, or other means; (3) someone talking or writing about death, dying, or suicide (Rudd *et al.*, 2006). The rationale behind the definition of

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warnings in a health context is that acquiring greater knowledge of these signs and paying attention to them in the population as a whole will lead to earlier detection of such situations and will make intervention possible. For elderly people who are at risk of taking their own lives, the goal will be to prevent suicide. A prerequisite for this is that the recipients of the warnings not only have the required knowledge but also react to the warnings that are given and act accordingly.

Whether the elderly warn of suicide, and if so how, will depend on what the individual is like as a person. Several writers have described typical personality traits among elderly suicide cases: lower scores on openness to experience, more rigidity, a great need for self-determination, and emotional reserve (Duberstein *et al.*, 1994; Duberstein, 2001; Harwood *et al.*, 2001; Kjølseth *et al.*, 2009). Individuals with these characteristics will be vulnerable when functional decline occurs in old age since they fear the loss of autonomy. They are dependent on being in control themselves, and they often lack closeness in their relationships. They therefore do not manage to communicate their problems to others, and they often reject help (Duberstein, 2001; Kjølseth *et al.*, 2009). These characteristics may also make it difficult for those around them to interpret any possible signals, and it may not be easy to approach the elderly person even if the problems become evident. Contact with the health service can also be difficult since elderly people tend not to trust those involved (Kjolseth *et al.*, 2010b). Studies have shown that many elderly people are in contact with the health service shortly before the suicide, but without the subject of suicidality being taken up during the consultation (Harwood *et al.*, 2000; Luoma *et al.*, 2002).

Elderly people select those they want to confide in. Although it is claimed that the elderly communicate less on possible suicidality (Carney *et al.*, 1994; Conwell *et al.*, 1998), Waern showed in a study that many elderly suicide cases had given warning signs of suicidal feelings to relatives during the year before they took their own lives (Waern *et al.*, 1999).

Suicidal communication from the elderly has previously been investigated by a quantitative research design (Waern *et al.*, 1999). We do not know of any studies that have investigated *warnings* given by elderly suicide cases as they are defined according to the AAS consensus, and how any such warnings were perceived by those around them. Since we wanted to study the informants' *experiences* of the warnings that the elderly people had communicated and their *reactions* to the warnings, it was appropriate to apply a qualitative research method. This method lends itself well to providing an understanding of people's experiences and feelings while it can also shed light on processes. The informants' reactions concern individual processes. A qualitative interview gives the opportunity to acquire more nuanced descriptions from the informants than those generated by a questionnaire, and follow-up questions can be asked that expand on the information.

In the study the problem was defined as follows:

1. To what extent, in what ways, and to whom had the elderly people given warnings of suicide as defined by the AAS consensus?
2. How were the warnings perceived by the recipients, and how did the recipients react to the warnings?

Methods

Design

This is a psychological autopsy study. Psychological autopsy allows the circumstances of the suicide to be reconstructed through interviews with informants and through information from other available sources such as medical journals, police reports, etc. (Beskow *et al.*, 1990). Based on the reasons given in the introduction, we chose a purely qualitative approach in this study in the form of interviews with relatives, general practioners (GPs), and care staff.

Sampling

A total of 172 municipal medical officers in ten counties in southern Norway were asked to report regularly to the project manager all definite suicides among those aged over 65 in their region. The medical officer acquired information on the deceased's closest relatives, his/her GP and the home-based care nurse, if any. Written information on the project and a request to take part in the interview were sent to potential informants. On receipt of written informed consent to participate, the project manager contacted the informants and arranged the interview.

Altogether 29 suicides were reported to the project manager over a period of approximately 18 months (2006–2007). In two cases, the relatives did not want to take part in the interview; in three cases, it was impossible to obtain information on the relatives; and in one case, the cause of death was uncertain. The study comprises 23 suicides – four women and 19 men aged between 65 and 90 years. Four of them were under 70, seven were between 70 and 80, and 12 were over 80. The average age was 78.

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Informants

The aim was to have two or three informants for each suicide: close relatives, the GP, and the home-based nurse/home help (if relevant). Eleven had not had a home-based care nurse, and six had not had any contact with their doctor. The relatives interviewed were four spouses, 19 children, three siblings, and eight daughters or sons-in-law/close friends. The prerequisite for participating in the interview was that the informants had had close contact with the elderly person as relatives, had been his/her GP for a long period (years), or had had regular contact during the last year of life as a home-based care nurse or home help. In this context, the term "close contact" implies that the person knew the deceased well. A total of 63 interviews were conducted for the 23 suicides with 34 relatives, 17 GPs, and 12 home-based care nurses.

Interviews

The goal of the interview was to acquire knowledge about all the circumstances of the elderly person's suicide from the informants' descriptions. This also included knowledge about the warnings the elderly had given prior to the suicide, if any, and how the informant had experienced and reacted to these warnings.

The interviews usually lasted approximately two hours and were tape-recorded in their entirety. They took place two to six months after the suicide, as recommended by Beskow (Beskow *et al.*, 1990). All the interviews were conducted by the first author, who is a specialist in internal medicine/geriatrics and has extensive clinical experience as well as experience of conducting qualitative interviews.

Data analysis

All the interviews were transcribed almost verbatim by the first author (only non-verbal communication was excluded). In general, the analysis follows *the systematic text condensation method,* a method based on elements from both phenomenological analysis and grounded theory and modified by Malterud (2001; 2002). Malterud states that the method is suitable for descriptive transverse analysis of material from many different informants for developing new descriptions and concepts.

The analysis has four stages: first, all the interviews are read through several times to acquire an overall picture and to capture the *essence* of what is recounted in each suicide case on the subject in question. The first author had already gained a good insight into the material during the process of interviewing and transcribing. In the next stage, the *meaning units* in the text are identified – extracts that give information about the topics defined in the approach to the problem. These text elements are systematized and coded so that they can then be read in connection with other related text elements across informants. In the third phase, the content is abstracted and condensed into main topics and sub-topics, and finally the results are re-contextualized, i.e. the descriptions of the contents are validated against the original material.

Ethics

The study was approved by the regional ethical research committee. The informants were guaranteed anonymity in the published results. The informants had a positive attitude to being interviewed (only two suicides had to be excluded because the relatives did not want to take part). Many said that participating had been a positive experience. The interview gave them the opportunity to express thoughts and feelings about the suicide that they would not otherwise have been able to impart.

Results

To what extent, in what ways and to whom were warnings given?

Fourteen of the 23 elderly people in the study had given warnings in one or more ways in accordance with the AAS consensus description. Most of them had talked a lot about death, and had repeated over a period of time that they did not wish to live any more. Many of them had said that it was better to die than to live the life they then had. Several had said that they wanted to end their lives, and some had been open with the care staff about suicide plans. These individuals had discussed with their helpers their motives for their wish to take their own lives, and some of them had in a way tried out their argument with the care provider. In some examples the elderly person had shown relatives a weapon/ammunition and had asked the relative to take care of it for them.

Some of them had been concerned about putting their affairs in order since, as one person had said, *"I'm going to die soon."* An elderly man had told his carer, who was going away for some weeks: *"I won't be here any more when you get back."*

Warnings were most frequently given to relatives (11), home-based care nurses (5), and more seldom to the GP (2).

How were the warnings perceived?

The informants' reactions had four main themes: not taken seriously — helplessness — exhaustion — acceptance.

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Not taken seriously

For many it had appeared unlikely that the elderly person really was suicidal, even though in retrospect they realized that they had been given clear signs. They had not understood the gravity of the signs. The thought that the elderly person could commit suicide almost did not occur to them – nor to the healthcare staff. A daughter put it this way: *"To believe such a thing – you just don't do it. In a way you understand it but you don't want to hear. You don't really take it seriously."* Or, as a home-based care nurse told us about an elderly man who had made a direct statement a short time before: *"It just never occurred to us. If we had thought along those lines we would have seen there was a change!"* Another home-based care nurse told us about her elderly patient: *"In retrospect I can see that she gave me plenty of hints. But I didn't understand them."* Some informants had nonetheless been worried that something was going to happen. An elderly man with considerable functional decline had talked a lot about death and about the fact that he did not want to live much longer. His daughter said: *"I was afraid he would think something up!"*

Helplessness

Many of the informants – particularly the relatives – said they had felt uncertain and powerless when faced with the warnings from the elderly person. Not only did they not know how they should deal with the warnings, they also felt that there was no place where they could seek help. One elderly man told us how his wife had come with clear warnings: *"She told me – I just couldn't do anything about it – what could I have done?"* Another old man had given clear warning signs to his brother. The brother had been fully aware of the risk of possessing a weapon but told us: *"Those whose job it is to help them could say something about it, but I was just so very uncertain – thought about it often – should I take the gun away from him?"* The uncertainty also caused fear or unwillingness to get involved. It transpired afterwards that one of the elderly people had talked to a friend about it, but the following had been said: *"It wasn't something one should get involved in!"*

The health personnel also experienced uncertainty. They found it difficult to meet the existential problems of the elderly in a direct manner, and one of the nurses expressed it as follows: *"It's not that I didn't notice it. I didn't want to notice it! You feel so alone. It's a subject that doesn't exist – but it's there every single day."* It was also difficult to get support from colleagues in such situations: *"It's not something we talk about. It's too problematic."*

Exhaustion

Some of the elderly had talked about their wishes/plans about death/suicide over a longer period of time and to such an extent that it had exhausted those around them. The informants gradually came to see the warnings as empty threats and they found it wearying, even irritating. Some adult children put it in this way: *"We'd heard it for such a long time that I think it just went in one ear and out of the other."*

A daughter told us: *"He said it nearly every day. He'd made his decision, but nobody believed it."* Another commented on the elderly person's warnings as follows: *"He said it so often – and then you don't notice it so much. When you cry wolf . . ."* A son had become somewhat tired of his father's threats of suicide as the old man's functional capacity gradually diminished more and more: *"In a way he's got little left when he has to come with such a threat!"*

Some relatives who had wearied of repeated and frequent warnings also told us that they felt a certain aggression. This could be directed toward the health service because they had not given them help, but also against the elderly person – even though it was seldom directly expressed. Some of them did take the subject up, like one son who said: *"We felt that she didn't mean it. It was just melodrama and we weren't very sympathetic. It was only me that heard about it! And it's left me with aggression inside me."*

Acceptance

Several informants also told us that they had experienced a sort of understanding, partly described as respect, for what they perceived as the elderly person's wish to end life. Some of them also said that bearing in mind the personality of the elderly person and the total health situation they could well understand the desire to die. A nurse told us about an elderly man who was becoming increasingly frail and who had constantly expressed a wish to die: *"I think he had lost interest in life. It happens the day you just can't stand any more, so . . ."* Other informants were direct in their opinion, as this quote shows: *"In a way I thought he had no life left."*

One spouse said the following: *"If an old person is so frail and sick and can't see any future . . . isn't it right then to respect them? If they choose to end life this way then I have to respect the choice."* And as a son said: *"That was the way he was."* Several children expressed the same, also the son who put it this way: *"He wanted to choose himself. And he was completely entitled to!"* The health personnel could also express such opinions: *"Actually I have full respect for what he did. I understand him."* There were also examples of close relatives who had expected this type of end

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to life: *"We knew Dad so well that we knew it would happen. It must be a year ago that one of my siblings said that one fine day we'd find Dad dead – and that he would have taken an overdose of tablets."*

Discussion

More than half of the elderly people in this study had given warnings to those around them, and almost all of them had warned their relatives (family/friends). Several had also given warnings to nursing/care staff, without these warnings being passed on to the elderly person's GP. Only in two cases had the warnings reached the GP directly.

The informants' descriptions of reactions to the warnings contained four main themes. First, they could not see/believe that the warnings were genuine; second, they felt helpless because they did not know what they could/should do to help the elderly person; third, repeated warnings over a period of time sometimes resulted in exhaustion in those around the elderly people, a feeling that could be mixed with aggression – both toward the health service and/or the elderly person; finally, many expressed a form of acceptance of the elderly person's wish to die. Those in contact with the elderly people could understand that the situation these people found themselves in could justify the wish/choice to be allowed to die.

The results from this study show that suicidal communication from elderly people may be difficult to both interpret and deal with for those around them. It must also be emphasized that in a not inconsiderable minority of cases (9 out of 24) the informants had not perceived any warning signs. Knowledge of the typical traits that characterize many elderly suicide cases may help to elucidate the results. Self-determination and control have been necessities of life that must be maintained – even when their functioning declines in old age. When the person behaves in this way, it may be difficult for those around them to realize when there is a risk of suicide, and it is not surprising that they cannot imagine that these elderly people could lose their grasp on existence. For the same reason it can be difficult for those around them to approach them with help, which creates uncertainty for both parties. Even the acceptance that many informants told us about must be seen in the light of the personality traits of the elderly. There may be a form of respect for the elderly individual in comments such as: *"That was the way he was!"*

Other age-specific aspects can also make it difficult to interpret the warnings given by an elderly person: it is more natural for elderly people to talk about and face death as an approaching reality than it is for those in younger age groups. It can therefore be difficult for those around the elderly to recognize that statements on this subject involve more than reflections on age. Our clinical experience has shown us that it is not unusual for elderly patients to communicate in various ways a wish to die, without this being an expression of the intention to take their own lives. A more detailed conversation may reveal that such wishes express pain or suffering, or also often a weariness of life.

The AAS consensus does not provide precise answers to the question of which utterances must be viewed as warnings and which may be the expression of an old person's thoughts about death. However, the statements in our study, which were regarded as warnings, fulfilled one or more of the three main criteria – and were also in the form of clear and repeated utterances.

When old people give such warnings, they may be expressing a cry for help. As one informant described it, it may also be that the elderly person is still undecided and is trying out his/her arguments on a partner in a dialogue. It can also be an expression of the painful existential situation of choice that elderly people find themselves in (Pompili, 2010). Regardless of what the elderly person wants to communicate, the response he/she receives to the warnings will be of great importance.

Conwell found that elderly suicide victims of both genders communicated their intentions to others more seldom than younger people, or *"they were less likely to be heard"* (Conwell *et al.*, 1998). Nonetheless, in this study the proportion in the age group 75–92 who had given warning signs during the last month of their lives was as high as 35%. There is, therefore, a not inconsiderable proportion of elderly people who are at risk of suicide and who – on the basis of the signs they give – could have the chance of being identified if the warnings were recognized. Our results confirm earlier studies that show that it is most often relatives who receive the warnings (Waern *et al.*, 1999). Care staff (home-based care nurses) who had had good contact with the elderly people over a longer period of time were also sometimes given warnings in confidence. Only two GPs had recognized the warnings. It is possible that the elderly person does not wish to communicate these thoughts except to those he/she is closest to. Nonetheless, the fact that so few GPs had realized that their elderly patient was threatened by suicide is thought-provoking. Presumably this reflects a form of consultation that rarely allows discussions about existential issues with patients in this phase of their lives. This can be due to several reasons.

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GPs have a very tight schedule in their working day and must give priority to somatic health problems among their elderly patients. A strong – and perhaps too unilateral – focus on depression as a causal factor of suicidal behavior among the elderly can have a limiting effect on GPs' assessments of elderly people with suicide problems. It easily becomes a question of confirming or disproving a diagnosis of depression, and possibly solving the patient's problem with medication rather than adopting a holistic approach to his/her life situation. Vannoy *et al.* found that even though GPs recognized the risk of suicide among their elderly patients, they often had no strategy for the further treatment of these individuals (Vannoy *et al.*, 2011). Professional uncertainty can make a GP reluctant to approach the suicide issue, which in addition will be time-consuming. It is also possible that many GPs regard suicidality among the elderly as an existential problem area that they cannot or should not be responsible for.

If GPs are to play a central role in the work of preventing suicides among elderly patients, it is important to study the framework of the consultation. The GP must have time and interest (and the ability) to find out about the elderly person's life situation in a holistic manner. This also entails discussions on existential issues.

The results show that relatives will be key persons in preventive strategies geared toward suicide among elderly people. However, when the elderly person's warnings are not understood or taken seriously, when they result in uncertainty or when they exhaust those around them, the consequences will nonetheless be that they do not lead to constructive measures. In addition, a lack of response or a negative response may reinforce the elderly person's feeling of having no value, which, in turn, can be a major element in his/her suicidality (Kjølseth, 2010c). Uncertainty and frustration among the relatives can also intensify any level of conflict around the elderly person, which has also been revealed as a risk factor for suicide among the elderly (Rubenowitz *et al.*, 2001).

It has been shown that close relatives are often able to identify the risk of suicide among elderly people – particularly if these individuals also have symptoms of depression (Heisel *et al.*, 2011). Relatives and friends also play a vital role when suicidal individuals seek help (Owens *et al.*, 2005). It is, therefore, critical that relatives are aware that elderly people can in fact be under the threat of suicide and that family members know what characterizes elderly people with a high suicide risk. They must also realize that warnings can indicate an immediate danger.

Even though the risk may be recognized, aspects of the relationship may nonetheless make it difficult to take further measures. Owens *et al.* describe the complexities of the relatives' situation: loyalty to the elderly person can make it problematic for them to notify external parties, even health care professionals. It can also be emotionally demanding to take the subject up with the person at risk (Owens *et al.*, 2011).

Exhaustion, which was a main topic in many informants' descriptions, can also contribute to passivity among close relatives. Living with a partner who is depressed and at risk of suicide is a considerable strain and can cause depressive symptoms in the other party as well (Benazon and Coyne, 2000). Passivity among relatives of elderly people who give warning of suicide is not a new issue. The phenomenon was described as early as 1978 in the Arizona Study (Miller, 1978). Miller gives inadequate knowledge, fear, lack of ability, and sometimes deliberate omission as causes for such passivity.

A greater challenge lies in the attitudes that offer acceptance and understanding of the choice of suicide as an end to life in old age. An American study showed that health personnel were less active in the treatment/examination of elderly suicidal patients than they were for younger patients (Uncapher and Arean, 2000). Elderly people themselves also appear to have an attitude of acceptance to suicide in their own age group (Segal *et al.*, 2004). Such attitudes can spring from a societal development in which the rights of the individual are central to the extent of demanding the right to self-determined death due to old age – as is the case in The Netherlands (Jensma, 2010). It is also a paradox that people who have now been given the opportunity to live a longer and healthier life in their "third" age are perhaps less capable of accepting the losses that inevitably come with the "fourth" age. Findings from the Berlin Aging Study illustrate the differences and the transition between the "ages" in old age (Baltes and Smith, 2003). In contrast to the optimistic results that concern the "younger" aging years, the conclusion is that the final years of life are more dysfunctional for old people – particularly with regard to mental functions. The authors comment on the results as follows:

> "Data provide grounds for reflection. Increasingly, philosophers, social scientists and citizens alike ask the question of whether survival into the oldest ages is desirable to begin with, especially given evidence that many of the oldest old live their lives in a condition where a strong expression of human rights and human dignity – as expressed in a sense of psychological control

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and personal identity – is increasingly infringed." (Baltes and Smith, 2003).

For the elderly person who is obliged to accept a life situation in which suicide is viewed as a solution, such existential questions could play a central and insistent role. Insecurity about the help society can offer them when their ability to take care of themselves fails was a key subject among elderly Norwegian suicide cases (Kjolseth *et al.*, 2010b).

Clinical implications

Preventive strategies for suicidal behavior among elderly people can be approached in different ways. For each one of them help begins when that person is *seen* as the individual he/she really is. Warnings of suicide, which can have a general character and can be difficult to interpret, must be seen in connection with the personality of the elderly individual. An understanding of the individual's character traits will also provide implications for how help can be given. When approaching these elderly people it is important for help to be provided without it being perceived as an offence against their autonomy. To be able to assist, the helpers must understand that the previous strength of the elderly person now may represent vulnerability. They must take this into account in a manner that ensures that the elderly person still feels their inherent worth (Kjølseth *et al.*, 2009; 2010b).

Our results show that knowledge about the topic must reach all those who have close contact with elderly people, i.e. society at large, to ensure that they understand when professional help should be sought. Relatives must be viewed as a valuable resource for the treatment network around the elderly patient. It is important that the relatives are also given support so that they can act as helpers. They must have information on and access to help organizations, and must know who to contact if they are worried. Attitudes in society that may lead to passiveness about treatment measures for this age group must also be faced through the subject being aired in open debate so that this complex and ethically challenging problem area can be elucidated.

Suicidal behavior among the elderly must be recognized as a health problem by health care staff. The contact between the elderly and health personnel must then be organized in such a way that it encourages discussion on the problems of life that are specific to old age. GPs in particular must view this as an important part of the work they do for their elderly patients. Health personnel's knowledge of the field must be strengthened: each individual employee who encounters the problem in his/her practice must be able to feel professionally secure in the situation while at the same time receiving support from colleagues.

Validity

A psychological autopsy study is essentially retrospective. The suicide that has occurred may well affect the informants' perceptions in hindsight – both how they remember the warnings and their own reactions to them. With regard to warnings, what happened may mean that afterwards the informants place more emphasis on any signs and statements from the elderly in the time ahead. The opposite can also be the case: in retrospect, they do not want to see that clear warnings were given. Health care personnel (in particular doctors) may feel it as a professional defeat to lose a patient to suicide. This may have affected recollections of warnings among this group of informants. Suicide will also lead to reactions of different kinds among those in the surroundings, and this can influence the information that is given. Feelings of grief, guilt, anger, and shame may well color what is related in an interview. At the same time, a qualitative interview will provide the opportunity to reflect during the process, to allow follow-up questions to be asked, and to elicit more nuanced answers than those generated by a questionnaire. In addition, our impression was that the interviewer's experience and competence instilled confidence among the informants, which contributed to producing rich interview material.

Transferability

The study consists of interviews with informants who had perceived warnings from 14 out of a total of 23 elderly suicide cases. Most of these informants were relatives. There were a few nurses and only two GPs. This indicates that the study particularly provides information about the experiences of the surviving family. For a qualitative study, the number of informants who are family members is relatively high, and the results were clear and consistent in the interviews with this group. With the reservations that have been indicated, we are therefore of the view that these are reactions that elderly people who are at risk of suicide can encounter from those around them. The results provide knowledge that should be taken into consideration when planning preventive strategies for this age group.

Conflict of interest

None.

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Description of authors' roles

Ildri Kjølseth designed the study, conducted the interviews, analyzed the interviews and wrote the paper. Øivind Ekeberg was the main supervisor throughout the project. He took part in designing the study, the analysis, and the writing process.

References

Baltes, P. B. and Smith, J. (2003). New frontiers in the future of aging: from successful aging of the young old to the dilemmas of the fourth age. *Gerontology*, 49, 123–135.

Beautrais, A. L. (2002). A case control study of suicide and attempted suicide in older adults. *Suicide and Life-Threatening Behavior*, 32, 1–9.

Benazon, N. R. and Coyne, J. C. (2000). Living with a depressed spouse. *Journal of Family Psychology*, 14, 71–79.

Beskow, J., Runeson, B. and Asgard, U. (1990). Psychological autopsies: methods and ethics. *Suicide and Life-Threatening Behavior*, 20, 307–323.

Carney, S. S., Rich, C. L., Burke, P. A. and Fowler, R. C. (1994). Suicide over 60: the San Diego study. *Journal of the American Geriatrics Society*, 42, 174–180.

Conwell, Y., Duberstein, P. R., Cox, C., Herrmann, J., Forbes, N. and Caine, E. D. (1998). Age differences in behaviors leading to completed suicide. *American Journal of Geriatric Psychiatry*, 6, 122–126.

Conwell, Y. *et al.* (2000). Completed suicide among older patients in primary care practices: a controlled study. *Journal of the American Geriatrics Society*, 48, 23–29.

Conwell, Y., Duberstein, P. R. and Caine, E. D. (2002). Risk factors for suicide in later life. *Biological Psychiatry*, 52, 193–204.

Conwell, Y., Duberstein, P. R., Hirsch, J. K., Conner, K. R., Eberly, S. and Caine, E. D. (2010). Health status and suicide in the second half of life. *International Journal of Geriatric Psychiatry*, 25, 371–379.

Duberstein, P. R., Conwell, Y. and Caine, E. D. (1994). Age differences in the personality characteristics of suicide completers: preliminary findings from a psychological autopsy study. *Psychiatry*, 57, 213–224.

Duberstein, P. R. (2001). Are closed-minded people more open to the idea of killing themselves? *Suicide and Life-Threatening Behavior*, 31, 9–14.

Harwood, D. M., Hawton, K., Hope, T. and Jacoby, R. (2000). Suicide in older people: mode of death, demographic factors, and medical contact before death. *International Journal of Geriatric Psychiatry*, 15, 736–743.

Harwood, D., Hawton, K., Hope, T. and Jacoby, R. (2001). Psychiatric disorder and personality factors associated with suicide in older people: a descriptive and case-control study. *International Journal of Geriatric Psychiatry*, 16, 155–165.

Heisel, M. J., Conwell, Y., Pisani, A. R. and Duberstein, P. R. (2011). Concordance of self- and proxy-reported suicide ideation in depressed adults 50 years of age or older. *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie*, 56, 219–226.

Jensma, F. (2010). *Citizens Group Argues Right to Die*. Available at: http://vorige.nrc.nl/international/Features/article2478619.ece/Citizens_group_argues_right_to_die; last accessed 8 February 2010.

Kjølseth, I., Ekeberg, Ø. and Steihaug, S. (2009). Why do they become vulnerable when faced with the challenges of old age? Elderly people who committed suicide, described by those who knew them. *International Psychogeriatrics*, 21, 903–912.

Kjølseth, I., Ekeberg, Ø. and Steihaug, S. (2010a). Why suicide? Elderly people who committed suicide and their experience of life in the period before their death. *International Psychogeriatrics*, 22, 209–218.

Kjolseth, I., Ekeberg, Ø. and Steihaug, S. (2010b). Elderly people who committed suicide:their contact with the health service. What did they expect, and what did they get? *Aging and Mental Health*, 14, 938–946.

Kjølseth, I. (2010c). *Control in Life-And in Death. An Understanding of Suicide Among the Elderly*. Oslo: Faculty of medicine, University of Oslo.

Luoma, J. B., Martin, C. E. and Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. *American Journal of Psychiatry*, 159, 909–916.

Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *Lancet*, 358, 483–488.

Malterud, K. (2002). Reflexivity and metapositions: strategies for appraisal of clinical evidence. *Journal of Evaluation in Clinical Practice*, 8, 121–126.

Miller, M. (1978). Geriatric suicide: the Arizona study. *Gerontologist*, 18, 488–495.

Owens, C., Lambert, H., Donovan, J. and Lloyd, K. R. (2005). A qualitative study of help seeking and primary care consultation prior to suicide. *British Journal of General Practice*, 55, 503–509.

Owens, C. *et al.* (2011). Recognising and responding to suicidal crisis within family and social networks: qualitative study. *BMJ*, Epublished ahead of print, doi: 10.1136/bmj.d5801.

Pompili, M. (2010). Exploring the phenomenology of suicide. *Suicide and Life-Threatening Behavior*, 40, 234–244.

Rubenowitz, E., Waern, M., Wilhelmson, K. and Allebeck, P. (2001). Life events and psychosocial factors in elderly suicides: a case-control study. *Psychological Medicine*, 31, 1193–1202.

Rudd, M. D. (2008). Suicide warning signs in clinical practice. *Current Psychiatry Reports*, 10, 87–90.

Rudd, M. D. *et al.* (2006). Warning signs for suicide: theory, research, and clinical applications. *Suicide and Life-Threatening Behavior*, 36, 255–262.

Segal, D. L., Mincic, M. S., Coolidge, F. L. and O'Riley, A. (2004). Attitudes toward suicide and suicidal risk among younger and older persons. *Death Studies*, 28, 671–678.

Uncapher, H. and Arean, P. A. (2000). Physicians are less willing to treat suicidal ideation in older patients. *Journal of the American Geriatrics Society*, 48, 188–192.

Vannoy, S. D., Tai-Seale, M., Duberstein, P., Eaton, L. J. and Cook, M. A. (2011). Now what should I do? Primary care physicians` responses to older adults expressing thoughts of suicide. *Journal of General Internal Medicine*, 26, 1005–1011.

https://doi.org/10.1017/S1041610212000312 Published online by Cambridge University Press

Waern, M., Beskow, J., Runeson, B. and Skoog, I. (1999). Suicidal feelings in the last year of life in elderly people who commit suicide. *Lancet*, 354, 917–918.

Waern, M., Rubenowitz, E., Runeson, B., Skoog, I., Wilhelmson, K. and Allebeck, P. (2002a). Burden of illness and suicide in elderly people: case-control study. *BMJ*, 324, 1355–1357.

Waern, M. *et al.* (2002b). Mental disorder in elderly suicides: a case-control study. *American Journal of Psychiatry*, 159, 450–455.

https://doi.org/10.1017/S1041610212000312 Published online by Cambridge University Press