ELDERLY SUICIDE IN SINGAPORE

E H Kua

ABSTRACT

The suicide rate in Singapore has remained at 9-11 per 100,000 over the past decade. Comparing the age specific suicide rate, elderly people (60 years and above) have a much higher rate (21.3 per 1000,000) than the young (5 per 100,000). The data also indicate that elderly men are more prone to kill themselves than elderly women.

Risk factors in elderly suicide and preventive measures are discussed.

Key words: Suicide, Elderly, Singapore.

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INTRODUCTION

Since the early monograph on suicide by Durkheim (1) there has been an interest in suicidology. An alarming finding in many studies in western countries is the high rate of suicide in the elderly (2, 3, 4, 5, 6). Reports from Singapore also indicate a similar trend (7, 8). Although suicide as a cause of death in the elderly is insignificant compared with coronary heart disease or cancer, a significant fact is that suicide is a preventable cause of death. Another alarming fact is the underestimation of the number of suicides because of the strict legal definition of the term suicide. A verdict of suicide is recorded by the Coroner if there is clear evidence that the injury was self-inflicted and the deceased intended to kill himself. If there is any doubt about intent, then an accidental or open verdict is recorded. Because suicidal intent is not always apparent, the statistics of suicide are usually underestimated. In Britain it has been suggested that the majority of open verdicts are probably suicide (9).

This study reports on the recent pattern of suicide by elderly people (above 60 years) in Singapore.

METHODS

The data on suicide were obtained from the Coroner's Court and the Reports on Registration of Births and Deaths in Singapore. The suicide trend of elderly people from 1981 to 1986 was examined. Comparison was made between the young (10-59) and elderly (60+), and between elderly men and women.

RESULTS

The mean suicide rate in Singapore from 1981 to 1986 is estimated at 10.5 per 100,000 population. The range is between 7.8 in 1981 and 12.8 in 1986. As shown in figure 1, the suicide rate rises gradually from 2 in the age group 10-19 to 6 in the age group 50-59. After that the rate increases steeply to 13 in the 60-69 years group to 31 in those over 70 years.

Department of Psychological Medicine
National University of Singapore
National University Hospital
5 Lower Kent Ridge Road
Singapore 0511

E H Kua, MBBS, MRCPsych
Senior Lecturer and Consultant Psychiatrist

The young (10-59) has a mean suicide rate of about 5 per 100,000 population. The rate remains constant from 1981 to 1986 (figure 2). The mean rate of the elderly (60 and above) during this period is 21.3 — 4 times higher than the young. The suicide rate of the elderly fluctuates during the 6 years — it rises from 17 in 1981 to 23 but falls to 16 in 1984. It remains high at 25 in 1985 and 1986.

The pattern of suicide of elderly men and women is indicated in figure 3. In 1981 the rates for men and women are almost similar but in subsequent years the suicide rate of men is always higher than women. The difference is large especially in 1982 and 1985. In both sexes the rate fell in 1984.

DISCUSSION

The mean suicide rate in Singapore has not varied much from 1969-1980. It fluctuates between 9-11 per 100,000 population (7, 8). The age specific suicide rate in Singapore seems to follow the trend in the United Kingdom (2, 3, 6). The rate increases proportionately with age —

Figure 1. Suicide Rates (per 100,000) by Age Groups in Singapore 1981-86

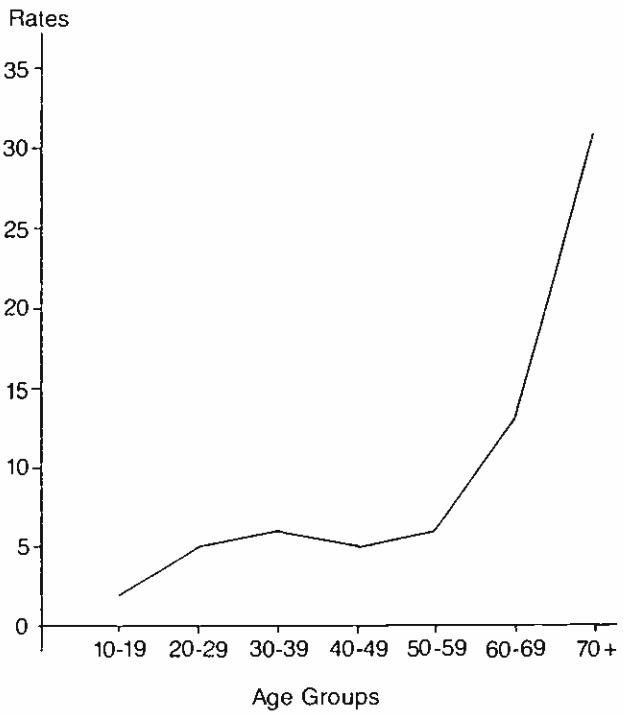
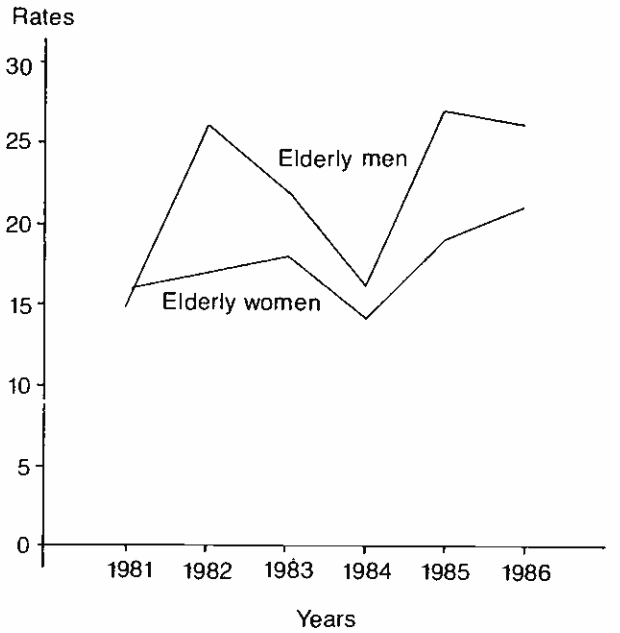


Figure 2. Suicide Rates (per 100,000) of Young (10-59) and Elderly (60+) Singapore 1981-86

Figure 3. Suicide Rates (per 100,000) of Elderly Men and Women, Singapore 1981-86



suicide is predominantly a problem of late life. The increase in rate with age is not linear. The rise is steep only after 60 years. From 1981 to 1986 the suicide rate for elderly people increases steadily from 17 in 1981 to 25 in 1986 but there was a drop in 1984 to 16. As in the United Kingdom, the suicide rate in Singapore is higher for elderly men than women.

What are the risk factors in elderly people?

The studies by Sainsbury (10) and Barraclough (11) have underlined the association between depression and suicide. Depression in the elderly may be triggered by life events such as bereavement or onset of a physical illness like cancer. The symptomatology of depression in the elderly has been examined to provide clues to predict suicidal tendency. It has been found that the intensity of hopelessness is a more accurate indicator of suicide risk (12). Other grave symptoms include persistent insomnia, guilt feelings, agitation and hypochondriacal delusion. However, not all persons subjected to the same stressful event will develop depression. Personality factors and available social support are crucial factors which determine the vulnerability of the person. The types of personality more susceptible are those who are rigid, dependent and less able to adjust to change in old age (13).

The reports by Barraclough (11) and Whitlock (14) show the high incidence of physical illness in elderly suicide. Carcinoma of the lungs and pancreas may present with symptoms of depression before the advent of physical symptoms.

The sociological theory of suicide in the elderly supports Durkheim's concept of anomie. Suicide may result from social isolation due to a breakdown of social bond. This may emanate from death of a spouse, separation or children leaving home. Elderly people who live alone or isolate themselves are especially susceptible to depression because of the absence of a confiding relationship (15). In Singapore it had been noted that many of the elderly suicides were male Chinese immigrants who were unmarried and unskilled labourers, who were poor and lived alone or with friends (7).

The link between retirement and suicide is less clear. Probably the consequences of retirement — lack of finance, role in society and social isolation — precipitate the onset of depression. Those who fail to plan for retirement are more likely to have difficulty in adjustment. It has been observed that the suicide rate after 65 decreases in the higher social class but increases in the lower social class (16). The explanation being that the former tends to have better financial security at old age and are also more able to seek out recreational activities compared to the latter.

Having identified the high risk group, can suicide be prevented. Lindesay (2) argues that factors like depression, physical illness or bereavement are merely statistical predictors which are too general to be of practical use in assessing the elderly's potential for suicide. Many people who committed suicide had previously visited a doctor. Therefore the doctor can play a crucial role in suicide prevention. They must be vigilant especially if the elderly patient lives alone and suffers from a painful illness. The seriousness of the suicidal intent can also be assessed from the circumstances of the act. For example, the elderly person may have made preparation in anticipation of death, such as arranging an insurance and drawing up a will. Sometimes he leaves a suicide note and takes precautions to avoid discovery or intervention in the suicide attempt.

Many depressed elderly present to the general practitioner with somatic complaints like headache or chest discomfort, which may mislead the doctor. If depression is diagnosed, it is mandatory for the doctor to elicit any suicidal thought. Some doctors are reluctant to raise the subject for fear of putting the idea into the patient. There is no evidence to indicate that discussing it with the patient will encourage the act. The doctor should also be alerted if the patient requests for a higher dose of hypnotics or comes more regularly for these drugs. If the depressed patient is suicidal it may be necessary to admit him immediately to a hospital for further treatment.

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