

Warning Signs of Elderly Suicide and Factors Affecting Professional Help-Seeking: Case of Sri Lanka

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Abstract

Though the suicide rate is remarkably high among older persons in many countries, seeking external assistance in dealing with suicidality is infrequent. Against this background, the objectives of this paper are twofold: to identify possible depressive signs and suicide warnings exhibited by older people before the act of suicide, and to examine the factors affecting the help-seeking behavior of older people who die by suicide. The study revealed that angry outbursts, sleep disturbance, isolation, reduced speaking, and thoughts of the meaninglessness of life are the significant possible signs of depression. However, only a few older persons directly expressed early warnings such as 'talking about death or suicide.' Yet, it seems that family members are unaware of the early warning signs. The study found four significant factors that limit the help-seeking behavior of older people dealing with suicidality: a weak social network, poor understanding of depressive and suicidal signs by family members, negative attitudes relating to old age culture, and a crisis of personal perspectives in help-seeking. We conclude that promoting mental health services to older persons and improving their help-seeking behavior in response to various life stressors would help prevent suicide in the older population.

Keywords

Elderly suicide; help-seeking behavior; old age culture; risk of suicide

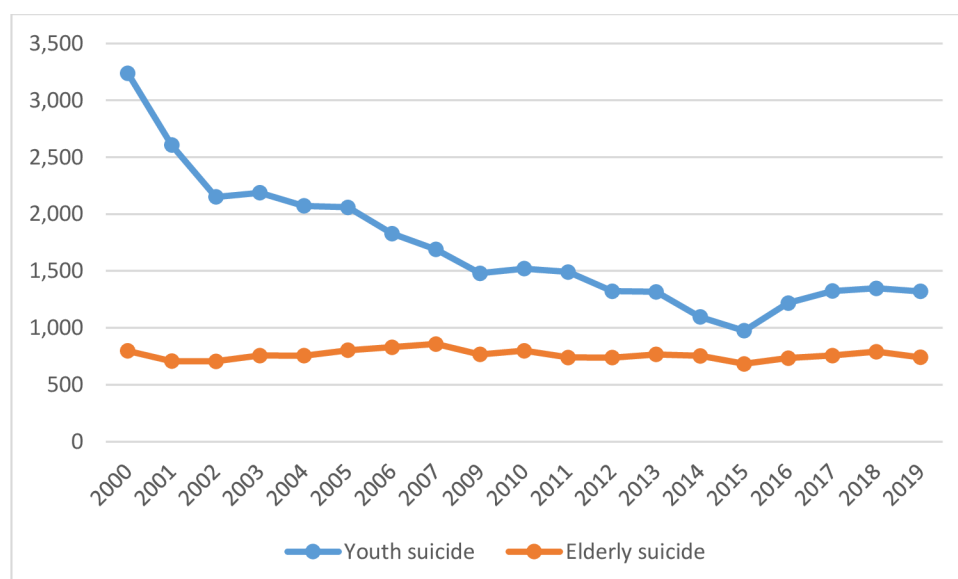
Introduction

Suicide is a global, although preventable public health issue. Worldwide, it is estimated that approximately one million people die annually due to suicide. Over the last 45 years, suicide rates have surprisingly increased by 60% (World Health Organization, 2019). In 2016, suicide was recognized as one of the three major causes of death, along with road injury and interpersonal violence, among both females and males aged 15–29 (World Health Organization, 2019). Though suicide is more frequent among adolescents and youth, the suicide rate is remarkably high in the older population in many countries (Bilsen, 2018; World Health Organization, 2021). This finding indicates the importance of preventive measures targeting this age group.

Sri Lanka is one of the countries with the highest recorded rate of suicide in the world. Since the 1970s, suicide has been significantly increasing, peaking in 1995, when the suicide rate in Sri Lanka was the highest in the world (47/100,000) (Kodituwakku, 2016). Since then, the rate has gradually dropped due to various preventive strategies resulting in a substantial decrease in the annual deaths by suicide, from a peak of 47 per 100,000 in 1995 to 19.6 in 2009 and 14.6 in 2018 (World Health Organization, 2019). However, evidence indicates that even though the number of suicide deaths in Sri Lanka has drastically reduced, the rate of deliberate suicide attempts is many times higher than the suicide rate. For example, self-poisoning has increased 300% since the 1990s (Widger, 2014). Therefore, suicidal behavior remains a leading cause of severe injury and death, particularly among the youth and aging population in Sri Lanka.

Similar to the global context, the aging population is more vulnerable to suicide in Sri Lanka. For instance, Figure 1 illustrates the change in the total number of committed suicides in the youth population and older population over the past two decades (2000–2019). As shown, suicide in the age of 15–39 group shows a declining trend while elderly suicide remains constant with some fluctuations in a few years.

Figure 1: Comparison of Suicide Between Aged 15–39 Group and > 60 Group



Note: Department of Census and Statistics (2021) and Sri Lanka Police (2021)

The problem of elderly suicide will likely further escalate as the older populations grow rapidly in many countries, particularly in developing countries like Sri Lanka (Senavirathna & Sanjeevani, 2019; Sri Lanka Medical Association, 2019). Accordingly, this alarming situation warrants more scientific investigations on elderly suicide and the development of appropriate preventive mechanisms.

There is no doubt that help-seeking behavior is critical in reducing suicide and suicide attempts, irrespective of age, gender, or any other psychosocial dynamics. Despite growing research interest in and interventions focusing on help-seeking behavior, it is difficult to find a universally agreed definition or indicators to measure the concept of help-seeking behavior (Filiatreau et al., 2021; Rickwood & Thomas, 2012). The literature shows that the roots of the help-seeking behavior can be traced to the conceptualization of the 'sick role' by Parsons (1951), who influenced the later conceptualization of 'illness-behavior' used in medical sociology. Mechanic defined illness-behavior as "the way in which symptoms are perceived, evaluated, and acted upon by a person who recognizes some pain, discomfort or other signs of organic malfunction" (Mechanic & Volkart, 1961, as cited in Mechanic, 1995, p. 1208). Mechanic's definition of illness-behavior provides a micro-sociological lens through which to interpret the reactions of the individual to illness and has been modified and broadened during the last few decades to incorporate cultural, psycho-social, economic, demographic, structural, geographic, and organizational dimensions that influence the reaction of the individual to illness (Young, 2004). Thus, the contemporary concept of help-seeking widely used in social work and health science has been derived from medical sociology.

According to Umubyeyi et al. (2016), help-seeking behavior is the process of "seeking help from health care services or trusted people in the community and includes understanding, guidance, treatment and general support when feeling in trouble or encountering stressful circumstances" (p. 21). Accordingly, help-seeking has two significant aspects: (1) the formal sector consisting of the professional sector or medical professionals, and (2) the informal sector consisting of nonprofessional groups or the community, such as family, friends, neighbors, and religious leaders (Brown et al., 2014). Similarly, Scales et al. (2013) categorized help-seeking behavior into four principal subdivisions: self-care, social networks, helpers, and gatekeepers.

Unlike other issues, formal help-seeking behavior by people with mental disorders and suicide mentality is inadequate due to negative attitudes toward the stigma of mental health services. In particular, personal help-seeking behavior is weak among individuals who suffer from suicidal ideation (Han et al., 2018). Hom et al. (2015) found that only 29.5% of individuals receive assistance from mental health services in dealing with suicidal ideation, plans, or attempts. As they point out, the preference for self-management, fear of hospitalization, and structural factors (e.g., time, finances) are critical barriers to reaching out to professional mental health care. Meanwhile, family and friends are the essential gatekeepers of informal assistance (Arria et al., 2011). Studies also point out, the formal help-seeking behavior of youth and adolescent suicide attempters is relatively high since they have broad social networks and a high degree of access to preventive measures (Arria et al., 2011). If young people articulate early warnings of suicide, it will increase their help-seeking behavior in a crisis (King & Vidourek, 2012). Furthermore, parents, family members, teachers, and friends are attentive to early signs of depression, worrisome behavior, and suicidal mentality when the person at risk is young or adolescent. At the same time, older individuals receive little attention.

Previous research has extensively discussed the risk factors of suicide in older adults and they have been categorized under three major thematic areas: mental illness, physical illness, and social problems, in which a vast array of research highlights the contribution of mental disorders, depression, and other life stressors (Beautrais, 2002; Conejero et al., 2018; Conwell et al., 1996; Czyn et al., 2013; de Leo & Ormskerk, 1991; Lawrence et al., 2000; Mokhtari et al., 2019; Singh, & Misra, 2009; Waern et al., 2002). Harwood et al. (2001) showed that 77% of older people in England who committed suicide were plagued by some psychiatric disorder before completing the suicidal act. Another study in the United Kingdom by Cattell (2000) pointed out that 60% to 90% of older people suffered from depression and other mood disorders before suicide.

Quan et al. (2002) found that older persons who suffered from ischemic heart disease, chronic pulmonary disease, peptic ulcer, prostatic disorder, depression, and other psychiatric illnesses were at high risk of suicide. Further, pronounced vulnerability to serious illnesses, chronic diseases, and social isolation and loneliness increase the risk of mental health problems and suicidal ideation in old age (Heuser & Howe, 2019; World Health Organization, 2021). Thus, it is possible to conclude that receiving proper mental health care for specific psychological stressors is extremely important in suicide prevention. Yet access to mental health care depends on filling the gap in the availability of mental health care services and help-seeking behavior (Filiatreau et al., 2021; Stanhope & Henwood, 2014). Another important help-seeking determinant is mental health literacy – the beliefs and attitudes influencing how mental illness is recognized and treated (Farrer et al., 2008). Help-seeking is also associated with personal, social, and cultural characteristics, individual capacity and motivation, the severity of symptoms, and previous help-seeking experiences (Culph et al., 2015).

A limited amount of scholarship has investigated help-seeking behavior in older persons' mental disorders and suicidality. Ono et al. (2001) studied the existence of suicidal ideation and help-seeking behaviors among older people in a town in Japan using a sample of 358 respondents. They found that 'thoughts of death' or 'thoughts of suicide' prevailed among 44 participants, and 12 had continued suicidal ideation over two weeks. However, only 15 of the 44 suicidal older persons had consulted someone about their problems. Further, this study revealed that although many older people articulated subclinical depressive symptoms with recurring thoughts of death or thoughts of suicide, only a few had consulted family members, professionals, or others.

In a psychological autopsy study using qualitative interviews with 23 suicide decedents who knew the deceased well, Kjølseth et al. (2010) investigated the contact older people who committed suicide had with a health service. They found that many older people with functional decline distrusted health services and were reluctant to get help because they feared losing their autonomy by becoming dependent on such support. Regarding their previous service experiences, many did not receive the desired help in crises, further increasing their distrust. Also, there was no good communication with helpers. At the same time, although depression is identified as a significant mental illness among older people (Polacsek et al., 2019) and a root cause of suicide in this age category (Conwell et al., 1996), help-seeking in a needy situation is frequently delayed (Polacsek et al., 2019). The factors that inhibit and enable formal help-seeking in older people with clinical depression include the stigma of seeking support, self-motivation, access to formal support, the strangeness of informal support, ageism, mental health literacy, and difficulty obtaining an initial diagnosis (Polacsek et al., 2019). The findings of these studies commonly acknowledge that comprehensive mental healthcare services are vital in preventing mental disorders and suicidality in older people.

Indeed, factors affecting mental problems and receiving help to deal with stressors in old age would depend on psychosocial, power, cultural, religious, and diverse contextual factors. Also, these factors may vary from culture to culture, but a better understanding of help-seeking behavior related to elderly suicidality is essential in preventing suicide in this population. Against this background, this paper is the result of a study carried out in Sri Lanka. It aims to identify possible depressive signs and suicide warnings exhibited by the older people before their act of suicide and to examine the factors affecting the help-seeking behavior of the older people who died by suicide.

Materials and methods

This research is primarily a qualitative study. Thirty interviews with family members of older people who committed suicide between 2015 and 2020, identified through the researcher's social network in various parts of the country, were analyzed. Therefore, we did not necessarily attempt to generalize the findings to the entire Sri Lankan society since the study uses a conveniently selected small sample. Convenient sampling was used due to the sensitivity of the topic. The relationship to the person who committed suicide and the ability to describe the history of the particular suicide incident was used as the criteria to select participants.

Additionally, video discussions were conducted with five elderly rights promotion officers (ERPO) and three counselors directly involved in elderly care and suicide prevention at the regional level. The purpose of interviews with ERPOs and counselors was to verify data gathered through the 30 interviews with family decedents of suicides. Since the ERPOs are well aware of the welfare and health problems older persons face, interviews with them were used to understand the general issues among the older people that can influence elderly suicidality. Further, we received the assistance of counselors to verify the data related to possible depressive symptoms derived from the interviews with the suicide decedents. Likewise, interviews with counselors were essential to learning about the available mental health care services for older persons and their effectiveness. In the analysis, recorded interviews were transcribed, translated to English, and analyzed using thematic analysis.

Before data collection, we obtained ethics approval from the Research Ethics Committee of the Department of Sociology of the University of Peradeniya (No: Pdn/soc/CRE/00254). Further, we obtained consent from the participants before beginning the interviews. Moreover, when referring to particular suicide cases in this paper, alternative personal names and locations are used to ensure the ethical conduct of the research.

Findings and discussion

Of the 30 suicide cases, 24 (80%) were male, and 6 (20%) were female. In terms of age at suicide, three (10%) were 60–70 years, 16 (53.3%) were 71–80 years, and 11 (36.6%) were > 80 years. The median age was 77.9 years. When religious affiliation was considered, 28 (93.3%) were Buddhists, while two (6.6%) were non-Buddhists. The majority (17, or 54%) consumed insecticide as the method of suicide, and seven (23%) utilized hanging, while the others used other methods like drug overdose, drinking acid, jumping into deep water, or using a sharp

object. Meanwhile, before the suicide incident occurred, the spouses of 12 (40%) older persons had already died, while 18 (60%) spouses were still living. The spouses of all the females who committed suicide had died before their act of suicide. Regarding the type of residence, 18 (60%) of the older persons lived in their child's house when they decided to commit suicide, while 12 (40%) lived with their spouses in a self-owned house. Interestingly, five older persons (16.6%) lived alone in their own house when they committed suicide. Economically, 17 (56.6%) older persons were inactive and dependent on their children, relatives, and/or state welfare and social security programs. Only three (10%) were beneficiaries of pension schemes or a provident fund balance, while ten (33.3%) engaged in income-earning activities like farming, self-employment, and daily work. Table 1 shows the demographic and socio-economic characteristics of the suicide cases.

Table 1: Socio-Demographic Characteristics of the Studied Cases

Case	Gender	Age	Religion	Method used	Status of spouse	Residence	Economic status
1	Male	78	Buddhism	insecticide	living	owned house	dependent
2	Male	76	Buddhism	hanging	living	owned house	provident fund
3	Male	82	Buddhism	insecticide	living	son's house	dependent
4	Male	81	Hinduism	insecticide	dead	son's house	dependent
5	Female	84	Buddhism	insecticide	dead	owned house	dependent
6	Male	78	Buddhism	drinking acid	living	daughter's house	pension
7	Male	69	Buddhism	hanging	living	owned house	small business
8	Female	78	Buddhism	insecticide	dead	daughter's house	dependent
9	Male	80	Buddhism	drug overdose	dead	son's house	dependent
10	Male	78	Buddhism	insecticide	living	son's house	dependent
11	Male	72	Buddhism	jumping into deep water	living	daughter's house	agriculture
12	Male	81	Buddhism	insecticide	living	owned house	dependent
13	Male	79	Buddhism	insecticide	living	son's house	pension
14	Female	78	Buddhism	insecticide	living	son's house	agriculture
15	Male	83	Buddhism	insecticide	dead	daughter's house	dependent
16	Male	78	Buddhism	insecticide	living	daughter's house	agriculture
17	Male	84	Buddhism	insecticide	dead	son's house	dependent
18	Male	65	Buddhism	hanging	dead	son's house	cleaner
19	Male	75	Buddhism	sharp object	living	son's house	agriculture
20	Female	86	Buddhism	drug overdose	dead	owned house	dependent
21	Female	80	Buddhism	insecticide	living	owned house	dependent
22	Male	76	Buddhism	hanging	dead	owned house	brush making
23	Male	80	Buddhism	insecticide	living	son's house	dependent
24	Male	78	Buddhism	hanging	living	daughter's house	agriculture
25	Female	79	Buddhism	insecticide	dead	son's house	dependent
26	Male	83	Buddhism	insecticide	dead	owned house	dependent
27	Male	77	Christianity	drug overdose	living	owned house	dependent
28	Male	74	Buddhism	hanging	living	own house	daily wage
29	Male	67	Buddhism	hanging	living	son's house	daily wage
30	Male	78	Buddhism	insecticide	dead	owned house	dependent

Possible depression symptoms

"People who commit suicide don't want to die but to end their pain," says Rainey (2020). Therefore, early detection of signs of pain and early intervention can reduce the suicidal vulnerability of any age group. One of the objectives of this study was to identify possible depression symptoms and suicide warnings in older people who have had suicidal ideation.

We use the term ‘possible’ because it is difficult to judge the symptoms articulated before suicide as exact depression symptoms without a proper clinical investigation. However, we could not find such clinical records and had to depend on data from a secondary person who knew the deceased well. Thus, we believe this proposed term ‘possible’ is appropriate to proceed with our argument.

This study found that almost all of the older persons had shown some possible symptoms of severe or moderate depression over a considerable period, ranging from two weeks to one year before the suicidal act. Table 2 shows the possible depression symptoms experienced by older persons who committed suicide. These symptoms were identified from answers to the following question: *Did you observe any behavioral and/or mood changes with the person who committed suicide? If yes, what were they?*

Table 2: Possible Depression Symptoms Experienced by Older Persons Before Committing Suicide

Symptom	Interviewee’s comment		
	Expressed (n = 30)	Did not express (n = 30)	Did not notice (n = 30)
Feelings of sadness, emptiness, or hopelessness	19 (62%)	5 (18%)	6 (20%)
Angry outbursts even over small matters	25 (83%)	2 (7%)	3 (10%)
Sleep disturbance	22 (73%)	2 (7%)	6 (20%)
Reduced appetite or rejection of food	15 (50%)	7 (23%)	8 (27%)
Isolation, reduced speaking	24 (80%)	4 (13%)	2 (7%)
Thoughts of the meaninglessness of life	22 (73%)	2 (7%)	6 (20%)
Unexplained physical pains	13 (43%)	8 (27%)	9 (30%)

According to Table 2, angry outbursts even over small matters, sleeping disturbance, isolation, reduced speaking, and thoughts of the meaninglessness of life are highlighted as the significant possible depression symptoms displayed by older persons over a considerable period before the suicidal act. Furthermore, each victim suffered from at least two symptoms. Nevertheless, as our interviews revealed, none ever received professional mental health care services or coping strategies from family members, friends, or relatives to deal with the depressive experience. Two older persons were referred to an outpatient department (OPD) due to a reduced appetite for food and unexplained physical pains, but not to a mental health care provider. Medical practitioners advised the patients to get rest and continue the treatments received from the OPD. Though the number is not significant, these two cases, on the one hand, indicate that even healthcare providers may miss depression symptoms in older people since they pay more attention to physical frailty related to aging in making a diagnosis. On the other hand, it can be asserted that healthcare providers’ careful attention to the psychological causes of physical symptoms in older people and referral to mental health care services are essential in improving their wellbeing. One interviewee explained her mother’s suicide experience as follows:

Four months before the incident, my mother told me that she had some sleep disturbance and continued pain in her backbone and shoulders, and always felt fatigued. We went to the hospital and got some treatments. The doctor said the issues were normal and continued with the treatments. My mother followed the treatments but was unhappy with

*them and said she continued to suffer from the same pain and sleep difficulties. For several days, she spent the whole night without sleep. But we were not much worried about it, so I told my mother to relax and practice some religious rituals. But now, I feel we **did not understand my mother's situation correctly**. We could have brought her to a psychiatric doctor. (interview data, emphasis added)*

This excerpt demonstrates that although the needy person was searching for external assistance to overcome a challenging situation, the family, although proactive in seeking external help for its members in a health crisis, did not proceed with an appropriate solution. Family members could not seek proper mental health care due to the lack of education about symptoms of anxiety, depression, and other stressors in old age. Many interviews indicated that family members interpreted such symptoms as usual and familiar to older persons. Furthermore, as noted in the short extract above, the emphasis is that the 'doctor said the issues were normal.' This statement symbolizes how professional medical practitioners miss possible depressive symptoms in older people due to being more concerned about physical frailty than psychological symptoms of physical pain. This dismissal may be associated with society's lack of geriatric mental health literacy. In Sri Lanka, it is possible to state that older people's mental disorders are excluded from the dominant mental health discourse, which is highly attentive to adolescent and youth mental problems.

Another factor explaining why family members paid little attention to early signs of possible mental disorders is the generational gap, where children have little control or power over their parents or grandparents. Some interviews showed that children and their older parents maintained very distant relationships. The older parents did not like to talk much with their children, and they lived independently and autonomously. This avoidance is more evident among older males than females due to patriarchal hierarchies. In general, unlike mothers, fathers speak very little with their children in traditional Sri Lankan society, which indicates the authoritative role of the father in the family. Though this has changed much with societal modernization, it can still be used to conceptualize the generational gap in Sri Lankan society, particularly in rural society. Children are hesitant to discuss behavioral or mood changes with their parents in a structured family environment. Therefore, this generational gap reduces proactive social contacts and the sociability of older people, which negatively influences their help-seeking behavior under challenging situations. This realization confirms the finding of Kjøseth et al. (2010) that older people who suffer from suicidal ideation have poor communication with helpers.

Poor understanding of early warning signs

Understanding early suicide warning signs and intervening at the earliest possible moment is vital in suicide prevention. The World Health Organization (2014) emphasized that "early identification and effective management are key to ensuring that people receive the care they need" (p. 9). Research suggests that a majority of people with suicide ideation express warning signs. Kim et al. (2022) found that 93% of suicide victims showed warning signs. These signs were observed more often in those diagnosed with psychiatric disorders, especially those with a depressive disorder. 'Talking about dying or suicide' and 'apathetic behavior' were the most common warning signs. Applying the findings from Kim et al. (2022) to our study may have some limitations because the older persons in our analysis had no records or history of diagnosed psychiatric disorders. Our study found that eight older persons (8/30) directly expressed warnings, such as talking about death or suicide. Many

others exhibited some behavioral changes related to possible depression. Sometimes, those close to the victims were unaware of the early warnings, even though the older people indicated such.

Regarding the older people who displayed early warnings, family members failed to recognize the signs correctly. They missed the opportunity to seek the help the older persons needed to deal with the crisis. The narratives below, taken from our sample, are illustrative. They answered the question: *How did you respond to the behavioral and mood changes shown by the older person before their death?*

*We did not expect that he would make this type of decision. Usually, he is a very aggressive person. **Since aggressiveness is natural in old age**, we did not worry about such behaviors. A few days before his death, he quarreled with my elder son and me. At that time, he aggressively told us that **he no longer wanted to live**. But now we understand that perhaps we could have saved his life if we had referred him to a doctor. (interview data, emphasis added)*

*We noticed that my mother's behavior had changed from earlier. But we never thought that she would commit suicide. Religiously, she was a devotee. Usually, she likes to stay alone and speaks very little. Two to three months before the incident, she often worried about her physical difficulties and dependence on someone else. She thought she had become a burden to everyone and said that **further living was meaningless**. But we thought **she was just saying these types of things**. (interview data, emphasis added).*

*Two days before the incident, Siyya (grandfather) called me and asked me to bring a pesticide bottle from town if I went there. Since Siyya grows vegetables, I thought it was for the garden, so I got one, and he returned the amount I paid. I made a joke even saying don't drink this. He said **half was for the vegetables, and the rest was for him**. After the incident, I learned that Siyya had quarreled with Achchi (grandmother) and committed suicide to hurt her. (interview data, emphasis added).*

These excerpts demonstrate that victims made some statements about their future decision to commit suicide, but relatives could not accurately interpret such expressions and behavioral changes. As we noted earlier, this failure was due to the lack of knowledge about suicide warnings and understanding such warnings as a generalized feature of old age. For instance, quotes like 'aggressiveness is natural in old age' and 'she was just saying these types of things' are symbolic expressions that indicate how mental health problems in old age are normalized or minimized in the sociocultural context. Further, the study found early warning expressions used by the older persons to indicate their suicidal ideation, such as the feeling that 'further living is meaningless,' 'I no longer wanted to live,' 'my life has become miserable,' 'I will teach you who I am,' and 'I want to die.'

These utterances are not strange in Sri Lankan society because many older persons use or repeat these phrases to express their old age suffering, physical difficulties, chronic diseases, and dependency. Furthermore, in the Buddhist tradition, such self-expressions (except 'I will teach you who I am') are symbolic representations of the Buddhist teachings of *karma* and *dukkha* (suffering) principles, which means further living with more suffering and pain is bad

karma or *karumaya*. Thus, such statements have become culturally approved symbolic expressions of suffering in old age that does not draw helpers' particular attention, even though the older person may be suffering from suicidal ideation.

The above extracts suggest the relevance of conceptualizing elderly suicide according to Joiner et al.'s (2009) interpersonal-psychological theory of suicide. This theory argues that a significant risk of suicide arises from the interaction of three factors: (a) the individual's experience of loneliness/isolation (thwarted belongingness), (b) the individual's perception of being a burden on others (perceived burdensomeness), and (c) the individual's habituation to self-harm by prior non-suicidal self-injury, suicidal behavior, or other risk behaviors (acquired capability) (Barzilay et al., 2015). The first two factors are very closely associated with elderly suicide. According to these core constructs, loneliness and the absence of reciprocal care are the major dimensions of thwarted belongingness that result in self-reported loneliness, fewer friends, living alone, non-intact family, social withdrawal, and family conflict.

Perceived burdensomeness is also a dimension of social disconnection. This factor results from an incorrect mental calculation, by which a person thinks they are a burden to others and that their death is worth more than their life. The theory posits that thwarted belongingness and perceived burdensomeness together produce hopelessness. People who make this erroneous mental judgment convert such feelings of self-hatred into suicidal behavior. It is possible to state that the experience of loneliness or isolation and perceived burdensomeness in old age is increased by economic dependency and physical vulnerabilities. Under such conditions, persons with suicidal ideation could likely think that receiving help from others is a failure or weakness, seeing as that they should be able to address their problems without external assistance. Their position is that death by suicide is the best solution to the crisis they suffer from. This attitude drastically reduces the realization of the need for external assistance to manage the crisis (Curtis, 2010; Gair & Camilleri, 2003).

Weaker social network

Social support and personal social networks are essential in maintaining physical and mental health. Studies suggest that people with close relationships within their social network manage various life stresses and traumatic situations better (Amati et al., 2018) and have better psychological and physical health status (Institute of Medicine, 2001). Tsai et al. (2014) documented that suicide intention was approximately three times higher among individuals with lower social network density than those with higher social network density. They also proposed that increasing social integration would help reduce suicide risk.

Sri Lanka has a fundamental secondary older person caring mechanism, consisting mainly of institutional caring, social security programs, and a universal healthcare system. However, the family still plays a crucial role in the care of older people owing to the cultural and spiritual bonds between children and parents that ensure that caring for older people is an obligatory function of children. Regarding institutional care, the Parliament of the Democratic Socialist Republic of Sri Lanka establishing the National Secretariat for Elders in 2000 was a landmark in the protection and welfare of older people. The National Secretariat for Elders carries out various programs to ensure enabling and supportive environments for older persons. Within the Secretariat, the elderly rights promotion officers (ERPO) were established to manage the duty of promoting productive old age.

With the onset of aging societies, elderly care homes and various welfare programs are some of the responsibilities of the ERPOs that undoubtedly increase the well-being of older Sri Lankans. Our study used the effective and inclusive participation of older persons in such programs as an indicator of understanding the social networks of older persons who committed suicide. Interviews with ERPOs indicated that although those in the 60–75 age group actively participate in social connectedness and promotion activities, those aged 75+ participated little in such activities due to physical difficulties. However, this subcategory of old age is the most vulnerable to specific mental and physical problems later in life.

According to our research, 26 (86.6%) suicides out of the 30 cases were by those in the 75+ age group. Because individuals in the 75+ age group are likely to be largely excluded from social events, they are at more risk of social isolation and mental disorders. According to the ERPOs, older people who attend social connectedness promotion activities are happy about such activities. They feel that their old age is meaningful when participating in meetings, religious activities, community events, and various voluntary activities. Furthermore, such participation is an opportunity to share experiences and grievances and obtain health information and assistance for specific illnesses or difficult situations. Thus, the programs help create a sense of inclusiveness and belonging in the older people and weave a strong support network around them.

Our study used social engagements by the older people who committed suicide as another indicator of their social network. We found that the persons who committed suicide had no effective social engagements or only rare engagements.

Table 4: Social Engagements of the Elderly Who Died by Suicide

Activity	Degree of participation		
	Very often (n = 30)	Rarely (n = 30)	No participation (n = 30)
Caring for grandchildren	4 (13.4%)	10 (33.3%)	16 (53.3%)
Domestic activities	19 (63.4%)	9 (30%)	2 (6.6 %)
Religious activities	4 (13.4%)	10 (33.3%)	16 (53.3%)
Community activities	2 (6.6%)	9 (30%)	19 (63.4%)
Visiting neighbors or friends	6 (20%)	9 (30%)	15 (50%)
Engaging in any productive activity	5 (16.6%)	7 (23.4%)	18 (60%)

According to Table 4, it is clear that the participation in each social engagement activity of the older people who died by suicide is significantly low. Except for their participation in domestic activities, the vast majority did not participate in other activities very often; nearly 23% to 33% rarely participated in such activities, while no participation in each activity was significantly high. Again, for each activity, rare or no participation highlights the poor social connectedness of the older persons who committed suicide. It should also be noted that, as we discussed earlier, participation in such social engagements is low in the 75+ age group due to their physical difficulties and other vulnerabilities.

Moreover, as evidenced from the interviews, older women reported higher levels of participation in most social engagement activities than men, except for engaging in economically productive activities like farming and gardening. In sum, it can be argued that the older people who committed suicide had weak social networks, resulting in inadequate

help-seeking in dealing with various stressors, including thoughts of suicide. To illustrate this, we refer to the case of Perera as an example.

Perera was 76 when he committed suicide in 2018. Perera and his wife lived in a house that belonged to his wife in a countryside village called Marassana, Kandy, in Sri Lanka. He had two married sons, and they lived in Colombo. Perera was a silent person but very attached to his wife. They lived happily since they had no economic difficulties or other problems. He had minimal contact with his relatives and community. However, his wife died of cancer in 2017. Then, Perera's sons requested that he stay with them in Colombo. However, Perera was reluctant to stay with his sons in Colombo and said he would stay at his house since some relatives lived nearby. Meanwhile, Perera's sons often visited their father and contacted him over the phone.

However, he was saddened about the passing of his wife, even after one year following her death. Perera often went to the temple with his wife when she was alive, but he stopped that behavior after his wife's death. Meanwhile, his sons noticed specific behavioral changes in their father, like quick anger outbursts. They thought their father was still mourning the death of his wife, and he would return to normal after some time.

Further, from time to time, Perera's sons asked him to come and stay with them, but Perera vehemently refused his sons' proposal, saying that it would be an additional burden to them if he stayed with them. Sometimes, Perera did not answer calls from his sons. As Perera's elder son said, a few days before Perera's death by hanging, Perera told one of his neighbors that it would be better if he could have died before his wife because his wife's death had become a painful experience for him.

Considering this story, it is possible to assume that Perera was suffering from depression and trauma after the passing of his wife. The unexpected death of a loved one can be traumatic and cause depression, and the bereavement period is mainly associated with an elevated risk of multiple psychiatric disorders (Keyes, 1998). Perera's case reveals that he experienced severe trauma in the bereavement period after the death of his wife. Furthermore, Perera had very few social contacts, mostly limited to his family, particularly with his wife. Therefore, Perera's lack of social connectedness escalated his painful, traumatic experience into suicidal ideation. Perera had a very narrow social network, and once he lost proactive connectivity, it led to a traumatic situation resulting in the decision to commit suicide. Perera engaged in no help-seeking behavior during the bereavement period to deal with the traumatic experience due to his lack of proactive social connections and the poor understanding of his sons of the early signs of depression during the bereavement period.

Old age culture and help-seeking

Some values associated with an aging culture negatively affect the help-seeking behavior of older persons who suffer from traumatic and various stress experiences, which they need external assistance to deal with. There is no doubt that, depending on the cultural context, individuals internalize cultural values more with age. Then these internalized values shape individual behavior (Fung, 2013). In relation to the old age culture, since older people are much more mature, they hesitate to listen to and obey guidance from others when they think

that others should follow their advice instead. Ultimately, this ego conflict escalates into a conflict between the person in need of the support network. Particularly in a patriarchal and seniority-based and stratified society like Sri Lanka, dilution of power and authority in the family in old age can lead to personality conflicts and mental disorders. To illustrate this, we refer to Silva's case.

Silva was 78 old when he committed suicide in 2017. He was an authoritative character to his family members and relatives. Silva was a farmer and had to depend on his children's income after stopping farming due to his physical inability. He was addicted to alcohol and time to time, got sick. Silva's matured children and wife advised him to stop it, change his behavior, and follow a religious life. However, he firmly rejected such demands and blamed his wife and children, saying, 'you don't want to teach me how I should behave. Everyone tries to control me.' Nearly one year before committing suicide, Silva had a very isolated behavior and did not talk much with his wife and children. Sometimes he refused meals and preferred to sleep or leave home very often. Gradually, Silva's behavior created an uncomfortable environment for everyone in the family, resulting in weaker interaction between Silva and his family members. Meanwhile, Silva told one of the relatives that he was expecting his death since he had become an unimportant person to his family.

Importantly, this case suggests that losing power, autonomy, and dignity in the family in old age creates personality troubles, gradually leading to mental disorders. Pavkov (1982) described this state of mind as reducing self-identity and self-esteem in old age, which increases unhappiness and self-hatred. According to Seligman (1976), the inability to control important life events in the latter part of life is the root cause of all depression. Especially economic dependency and physical vulnerability escalate the risk of mental vulnerability. All these conceptualizations help us to explain Silva's suicide. At the same time, it is important to ask why family members did not refer Silva to a professional mental health care provider.

On the one hand, this failure could happen due to the lack of family members' knowledge about mental problems in old age. On the other hand, Silva's authoritative and obstinate nature had created a conflictive environment in the family where family members hesitated to refer him to a professional service provider. Another critical fact emerging from this example is the generational gap between the old and young in which the actions, beliefs, and values of the older people are questioned or rejected by young children or inversely. Ultimately this gap escalated into a conflictive environment in the family, absent professional help-seeking.

Hopelessness or meaninglessness is another negative factor associated with the old age culture, limiting help-seeking behavior in needy situations. Making meaning and maintaining it is a basic human need. Starting from birth, individuals try to figure out what is important and what is not important through socio-cultural artifacts such as going to school, doing a job, or having a family. There is no doubt that these engagements make peoples' lives active and meaningful throughout their life course. Pavkov (1982) identified three major psychological and physiological factors contributing to depression and suicide in old age: haplessness, helplessness, and hopelessness. This conceptualization applies to the relationship between suicide and meaninglessness in old age.

Our study found that some older people, particularly those over 75, had negative attitudes. For example, comments such as they were a burden to themselves and their family, they are

tired of living, and therefore life is a tragedy. This 'existential emptiness' (Punová et al., 2020) or, as Frankl (2020) termed it, 'neurosis' is further exacerbated when one has physical difficulties and chronic diseases. According to our study, 11 individuals constantly claimed that their life should end since further living is suffering, and death is the solution to prevent further suffering. So, existential emptiness or neurosis could be considered a major contributing factor to suicide in the study sample. This form of negative thinking and valuing the continuation of life can reduce help-seeking behavior in some risk situations, like a suicidal mentality developing from such stressors.

The Buddhist understanding of suicide is essential here to explain elderly suicide since most individuals (28) adhered to Buddhism. Fundamentally, deciding to commit suicide is against the Buddhist doctrine of life. Buddhism teaches that taking life is an action of demerit and that suffering will not end with death. This understanding is nicely described by Wolfson (2009), in quoting David Rosen, who said that "Something needs to die, but maybe it is not you." Wolfson continued, "that is a very Buddhist way of thinking; there is some suffering here that needs to go away, but it is not 'I' who needs to go away" (p. 2).

Furthermore, from the Buddhist spiritual point of view, one's reincarnation will be badly affected if one takes their own life. Thus, Buddhism proposes mindfulness meditation as the preventive mechanism against all forms of stressors and sufferings. Therefore, it seems that notions of meaninglessness and suffering embodied in the old age culture fundamentally go against Buddhism's noble teaching about life and suffering. In our study, it was observed that meaninglessness prevailed in people who had little (32%) or no religious engagement (54%) in old age than in those who practiced a spiritual life.

Crisis of personal perspective in help-seeking

Sociologists and anthropologists believe that culture plays a vital role in all aspects of health and illness, including the perceptions, interpretations, beliefs, and behaviors associated with health and illness. Anthropologists have documented that people seek help for their suffering based on the meaning that culture assigns to suffering (Arnault, 2009; Pool & Geissler, 2005). Arnault (2009) extended the medical anthropological term 'idioms of distress,' which denotes the culturally specific experience of psychosocial and physical suffering, and proposed the phrase 'idioms of wellness or distress' to describe culturally distinct patterns of health promotion, wellness, and illness experience, meaning interpretation and help-seeking. Arnault defined the term 'idiom of wellness or distress' as "a collection of physical, emotional and interpersonal sensations and experiences labeled by the individual as optimal or abnormal, and identified as important" (2009, p. 260). Therefore, personal values and perceptions of whether they are right or wrong can influence one's well-being or ill-being.

Our study discovered that sometimes help-seeking behavior in older people who suffer from various stressors depends on the personal understanding and meaning of illness and suffering. Some case histories reported a contradiction between the individual perspectives on the deceased's illness and family members. The following example demonstrates this.

Premawathi was 82 years when she committed suicide in 2019. She has been suffering from abdomen pain for more than ten years and has had various treatments. In 2015, Premawathi's family members referred her to a consultant doctor. She was diagnosed with gastritis, which resulted in severe abdominal pain. She was advised to control certain food behaviors and get mental

relaxation to control the pain overall while continuing treatments. However, Premawathi vehemently refused to continue medical treatments and attend clinics because she interpreted that she had this pain due to an influence of a dead relative.

At the same time, some of her friends also believed the same and advised Premawathi to follow some ritualistic healing practices. Then family members took her to some places where such healing practices are performed, but there were no signs of recovering from the pain, only temporary mental satisfaction. However, Premawathi's family members understood that this ritualistic healing is an unscientific treatment and a money-wasting thing. Thus, her family members ignored such treatments and pushed her to follow medical treatments, but she repeatedly refused to follow medical treatments. Meanwhile, Premawathi showed behavioral changes like quick anger, outbursts, food rejection, and isolation, but family members understood these as her reactions since they refused to follow healing practices. Finally, this conflict ended up with Premawathi's death by suicide.

This case history invites us to revisit help-seeking behavior from the personal interpretation or psychoanalytical perspective and the discourse perspective. From Premawathi's perspective, the reason for her suffering was the invisible influence of a dead relative. She deeply internalized that belief and wanted to follow ritualistic healing methods to cure the pain. From a personal point of view, the last behavioral changes exhibited by Premawathi should be interpreted as personal symbols of her disappointment, i.e., locating the individual's experience within the cultural context (Obeysekere, 1981). From the discourse point of view, biomedical analysis is seen as more objective or scientific, while the other spiritual healings are seen as unscientific. Thus, the existence of alternative discourses is not approved by dominant discourses (Healy, 2005). This dichotomy, which favors the dominant discourse while the alternative is not accepted, has created an ideological contradiction about help-seeking behavior. This type of ideological contradiction can happen when there is a pluralistic medical system, including Western medicines and many indigenous and other local healing methods.

Conclusion

Our study revealed that old age dependency results from physical, psychological, and social vulnerability and is linked with the risk of possible depression and suicidal behavior. An attitude toward the meaninglessness of life also contributes to elderly suicide, which invites future researchers to explore elderly suicide from cultural, religious, and spiritual points of view. However, although the older people who died by suicide displayed possible depressive symptoms over a considerable period and gave early suicide warning signs before the suicidal act, they never received professional mental health care due to a fusion of personal and environmental factors: weak social networks; poor understanding of early suicidal signs by proactive social networks; negative attitudes related to old age culture; and a crisis of personal perspectives in help-seeking.

Among these affective factors, the lack of knowledge of family members and sometimes medical practitioners about old age mental problems and suicidal signs was a leading factor that reduced help-seeking in crises. As evidenced by the study, symptoms of older people's

mental issues are perceived as ‘less serious’ or ‘inherent characteristics’ related to old age. In general, this happens due to poor mental health literacy in society. Therefore, improving geriatric mental health literacy in society and promoting mental health services for the older community would be an effective preventive strategy for elderly suicide. In all these preventive efforts, the family should be treated as the central agency since older people mainly depend on their help.

As we have pointed out in the methodology section of this article, this study was carried out with conveniently selected participants from elderly suicidal families. Of course, this method of participant selection involves certain limitations that influenced the study’s findings. Primarily, the participants of this study were descendants of elderly suicidal families. Thus, one can question the validity of data gathered through a secondary person from the suicidal older person’s family because participants’ narrations may involve personal views and interpretations of the deceased. Further, secondary persons’ narrations may have little depth about the suicidal experience and help-seeking behavior of the deceased.

Another major limitation of this study is the lack of representation of ecological and socio-economic variations in the study group due to the use of a conveniently selected sample. Indeed, suicidal ideation and help-seeking behavior would be significantly influenced by many ecological and socio-economic determinants, including gender, ethnicity, regional diversities, and socio-economic status of older people. Therefore, this study does not adequately discuss the above aspects affecting professional help-seeking in elderly suicide. It is therefore suggested that future elderly suicide research should pay attention to these ecological and socio-economic determinants of professional help-seeking.

Moreover, future studies can focus on the elderly suicide survivors rather than those who completed suicides to avoid limitations involved with narrations of the descendants of elderly suicide. That method will allow the researchers to discuss the factors affecting professional help-seeking in elderly suicide from the risk populations’ perspectives.

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