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Research report

Why are suicidal thoughts less prevalent in older age groups? Age differences in the correlates of suicidal thoughts in the English Adult Psychiatric Morbidity Survey 2007

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ABSTRACT

Background: Suicidal ideation is more strongly associated with suicidal intent in later life, so risk factors may also differ by age. We investigated whether the relationship between suicidal ideation and established correlates varied by age in a representative population.
Methods: We used data from the 2007 Adult Psychiatric Morbidity Survey of England to assess the relationship between age and suicidal thoughts across 20-year age bands, using logistic regression, adjusted for survey weights. We used mediation analyses to assess the extent to which other factors mediate the relationship between suicidal thoughts and age.
Results: Reports of previous-year suicidal thoughts decreased with age. This was partly explained by (1) lower rates of reported child abuse (in those aged 75+), of depression, and of anxiety symptoms (in those aged 55+), factors all strongly associated with suicidal thoughts, and (2) higher rates of protective factors in people aged 35+, specifically homeownership and cohabitation. Rates of phobias, irritability and compulsions also decreased with age, and the association of these symptoms with suicidal thoughts was particularly strong in the youngest (16–34) age group. People who reported experiencing childhood abuse in all age groups reported more suicidal thoughts, suggesting abuse has lifelong negative effects on suicidal ideation.
Limitations: The response rate was 57%. Older people may be less likely to recall childhood abuse.
Conclusions: Sexual and physical abuse in childhood are associated with suicidal ideas throughout the lifespan, so screening for suicidal ideas in younger and older people should be routine and vigorous, and cover experiences in early life: management may require appropriate psychological interventions.

1. Background

Suicide is the 10th leading cause of death worldwide (Hawton and van Heeringen, 2009). Effective risk prevention requires identification of those most likely to experience suicidal ideation and make non-lethal suicide attempts, as these thoughts and behaviours greatly increase the risk of suicide. The risk factors for suicidal ideation and actions differ from those of completed suicide. In particular, middle aged men are at greatest risk of completed suicide (Office of National Statistics, 2013b), while suicidal thoughts, plans and intent are more frequently reported by younger women. The ratio of self-harm to completed suicide falls with increasing age from more than 200 to one in teenagers to less than 10 to one in people over 60 years of age (Hawton and Harriss, 2008). Physical frailty and a greater determination to die (Conwell et al., 1998) may conspire to increase the risk of death from each episode of self-harm in older people. Research in this age group has consistently shown that self-harm frequently involves strong suicidal intent (Salib et al., 2001). Thus, suicidal ideation may differ qualitatively in older people and their younger counterparts, and the established predictors might vary correspondingly. Some people exhibiting suicidal ideation in younger and midlife die by suicide before reaching older age, but most do not, as completed suicide is rare while suicidal thoughts are common. Thus surviving to old age cannot significantly explain the reduced suicidality among older people.

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Mental disorders are important predictors of suicidal ideation and completed suicide (Gunnell and Lewis, 2005). Epidemiological studies indicate that the prevalence of psychiatric symptoms and disorders (other than dementia) decreases with age (Alonso et al., 2004;McBride et al., 2013;McManus et al., 2009). The decrease in mental disorders in older age is concordant with the decrease in reported suicidal ideation. However, physical illness and disability are more prevalent in older age groups (Russell et al., 2009), and as they are associated with suicidal ideation this would tend to counteract the effect of reduced susceptibility to common mental disorders. Other consistent cross-national risk factors for suicidal ideation, plans and attempts include female gender, less education, not being married, and stressful life events (Nock et al., 2008).

Recent papers on childhood abuse, psychiatric disorder, and suicide attempts and ideation detail the impact of early trauma on adult psychiatric morbidity and behaviour, particularly suicidal acts and self-harm (Bebbington et al., 2009; Jonas et al., 2011). Although the quality of childhood care may be extremely important in determining the way in which older adults cope with the threats and losses to independence from ageing and its associated life events (Martindale, 2007), there is very little research linking childhood trauma, mental state and behaviour in older people. Some might question the ability of older people to recall their childhood relationships as accurately as younger adults, for whom the experiences are more recent. However, memories with powerful, personal emotional significance are usually maintained over the lifespan (Holland and Kensinger, 2010). While some studies have suggested that up to 40% of childhood abuse may be forgotten or repressed for a time, this forgetting does not appear to be associated with age (Berntsen and Rubin, 2002). While around 5% of people aged over 60 have dementia (Ferri et al., 2005), dementia often provokes the re-experiencing of trauma from childhood sexual assault, because early, implicit, traumatic memories become relatively more important as explicit, more recent memories are lost (Australian Institute of Family Studies, 2010). Thus, why should a seventy-year-old adult recall childhood trauma in any way differently from a forty-year-old?

There are nonetheless more general problems relating to the investigation of childhood abuse, due to the pervasive stigma that attaches to it (Coffey et al., 1996). Collecting accurate information about it in epidemiological surveys remains methodologically challenging. The 2007 English Adult Psychiatric Morbidity Survey offers advantages in this respect, seeking to overcome the effects of stigma by using computer assisted self interview (CASI) in the section relating to abuse. The survey thereby provided information on suicidal thoughts, childhood adversity and mental health in a large sample of the English adult household population.

We investigated the correlates of thoughts of suicide in this representative population in order to identify disparities in their origins between younger and older age groups (16–34 years, 35–54 years, 55–74 years and 75+). Based on the existing literature, we hypothesised that there would be differences in the relationship between suicidal thoughts and age group moderated by the effects of mental illness, substance misuse, sociodemographic characteristics (Nock et al., 2008), physical ill health, social networks (Handley et al., 2014) and childhood abuse (Bebbington et al., 2009; Jonas et al., 2011).

2. Method

2.1. Sample

We used data from the 2007 Adult Psychiatric Morbidity Survey. Unlike previous surveys in this programme (Jenkins et al., 2009), it covered only England and there was no upper age limit. The sample was designed to be representative of people living in private households. The survey adopted a multi-stage stratified probability sampling design. The sampling frame was the small user Postcode Address File. One adult aged 16 years or over was selected for interview in each eligible household using the Kish grid method (Kish, 1965). Full details of the sampling method, procedure and quality control are published elsewhere (McManus et al., 2009). Ethical approval for the survey was obtained from one of the Research Ethics Committees of the National Research Ethics Service appropriate for non-clinical populations. The interviews involved computer-assisted personal interviewing (CAPI), with answers entered by the interviewers directly into a laptop. Particularly sensitive information was collected by computer assisted self-completion interview (CASI). The laptop was given to the participant for this. The respondents knew beforehand that the interviewer was unable to see the results of the self-completed parts of the interview, which included questions about childhood abuse. Fifty seven per cent of the eligible sample took part, and full interviews were successfully carried out on 7403 people; 7353 completed the CASI section on childhood abuse, while 50 people refused or were unable to complete this. Reasons given included: sight impairment, not being able to read, and refusal. Where this was the case respondents were offered the option of having the CASI questions read aloud.

2.2. Variables

We selected sociodemographic and illness characteristics previously identified as predictors of suicidal ideation (e.g. Nock et al., 2008).

2.2.1. Sociodemographic information

Standardised questions provided information about age, gender, cohabitation status and home ownership. Alcohol use in the past 6 months was recorded using the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993). Respondents with an AUDIT score of 8 or more were classed as having hazardous use of alcohol. Participants were asked about the number of adults they felt close to as a measure of their primary support network. This was dichotomised for analysis at a network size of >3 people, as recommended in previous literature (Brugha et al., 2003).

2.2.2. Mental illness

Non-psychotic psychiatric disorders were assessed in relation to the past week, using the Clinical Interview Schedule-Revised (CIS-R) (Lewis et al., 1992). This can be administered by non-clinically trained interviewers. It provides scores for symptoms relating to common mental disorders. We analysed the subscales individually (see Table 1). Scores of 2 or more were used to denote the presence of individual symptoms (McBride et al., 2013).

2.2.3. Physical health/disability

We included two variables measuring this. The first was a subjective item “My health limits moderate activities” yes/no from the SF-12 quality of life measure (Ware et al., 1996). Participants were also asked whether they needed help with any of seven Activities of Daily Living (ADLs). The ADLs were: personal care; mobility; medical care such as taking pills, having injections or changes of dressing; preparing meals, shopping, laundry and housework; practical activities such as gardening, decorating, or household repairs; dealing with paperwork; and managing money. This was developed from a previous measure (Bebbington et al., 2000).

2.2.4. Childhood sexual and physical abuse

Respondents were asked about different types and levels of abuse. It was possible to distinguish abuse occurring in childhood and adolescence (i.e. before 16 years) from that occurring in