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Gender and Suicide in the Elderly

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ABSTRACT: Gender is one of the most important predictors of suicide in the elderly. In North America, older women are less likely to be suicidal than older men. So far, suicidologists have either ignored gender differences or have focused on the presumed causes of older men's suicidal behavior. In this paper, the focus is on older women's low rates of suicidal mortality. On the basis of a review of the literature, several hypotheses are suggested. One is that gender differences in suicide mortality reflect differences in coping. Another hypothesis is that gender differences are influenced by gender norms of suicidal behavior. Directions for prevention are proposed.

Despite decades of scholarship on suicidal behavior in the elderly (see reviews by Kirsling, 1986; Lyons, 1984), and an even larger body of literature on gender and suicidal behavior (see reviews by Lester, 1969; Lester, 1979; Linehan, 1971; Neuringer, 1982; Wilson, 1981), very little work (Breed & Huffine, 1979) has been done to examine the interrelationship between the two. Theories of elderly suicide typically have been formulated in terms of a gender-neutral elderly person (Miller, 1978) or in terms of elderly males (Cath, 1980). Yet gender is one of the most important predictors of suicide in the elderly. In North America, older women are less likely to die of suicide than older men (McIntosh, this issue).

An earlier version of this article was presented at the pre-conference seminar, *Suicide and the Elderly*, held at the convention of the American Association of Suicidology, Boston, MA, in April, 1991. My thanks go to the editors of this special issue for helpful feedback on this revision, and to colleagues and friends Valerie Assetto, Julie Beyers, Karen Fondacaro, Jeremy Gersovitz, David Lester, Laura Solomon, and David Wohl for reading and commenting on different versions of this article.

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In this paper, the dimensions of gender and aging are central to an analysis of the theoretical and empirical literature on suicidal behavior. In contrast to the previous literature on elderly suicide, women's resilience rather than men's vulnerability will be the primary question. Attention to the characteristics of survivors rather than the liabilities of casualties may help with planning effective intervention and prevention. In recognition of the variations in rates and meanings of suicide in different countries, this paper will focus on research and theories from the North American (U.S. and Canadian) and British literature.

With regard to nomenclature, suicidal acts that resulted in the person's death will be referred to as "fatal" or "lethal" suicide acts—rather than "completed" or "successful" suicides, as they are often called in the North American literature. Suicidal acts that did not result in the person's death will be referred to as "nonlethal" or "nonfatal" suicidal acts—in lieu of the terms "attempted suicide" and "parasuicide" commonly used in the North American and British literature, respectively. As pointed out by Chesler (1972) and Lester (1989), a disadvantage of the traditional nomenclature is that it defines as successful a suicidal act in which the person dies; conversely, it erroneously implies that all persons who engage in life-threatening behavior attempt or intend to die. The term suicidal behavior, not otherwise specified, will be used in a traditional manner, that is, as an inclusive term referring to both fatal and nonfatal suicidal behavior, or whenever information is not available on whether one is dealing with fatal or nonfatal suicidal behavior.

Epidemiology

Complete information about gender patterns of death by suicidal behavior in the elderly is not readily available. The two main sources, national official suicide statistics and local epidemiological studies, have serious limitations. Neither source systematically categorizes all the information by both gender and age. On the one hand, official suicide statistics do not include information on variables such as occupation, socioeconomic status, or living circumstances (McIntosh, 1989). On the other hand, local epidemiological surveys typically include a broad range of variables but may be less representative of national figures. Furthermore, according to Kushner (1985), fatal suicidal behavior may be underreported for women due to a bias against recording women's death as suicide.

The available evidence (see McIntosh, this issue, for a thorough review) indicates that, in North America, older women are less likely than older men to die as a result of suicidal acts. For white women, rates

of lethal suicide tend to peak around age 50 (Diggory, 1976; Manton, Blazer, & Woodbury, 1987). For non-white women, rates of lethal suicide remain low and fairly constant throughout adulthood and old age (Manton et al., 1987). Men age 60 and over have the highest suicide mortality of any age group (Manton et al., 1987), even though rates for young adults have recently been increasing faster than the rates for other age groups. Until recently, white males had the highest rate of lethal suicides; for white males, the peak risk periods are ages 45 to 50 and around age 80 (Manton et al., 1987). New studies, however, suggest that non-white males may be at great risk as well (Manton et al., 1987). Social isolation (Miller, 1978), living alone, being unmarried (single, separated, divorced or widowed—see Stenback, 1980, for a review), unemployed, and/or retired (Gardner, Bahn, & Mack, 1964; Stenback, 1980) are considered risk factors for suicidal death in older men.

Patterns of nonfatal suicidal behavior in late life are much more difficult to determine due to the lack of systematic and reliable archival data. It is usually reported that nonfatal suicidal behavior diminishes with age (e.g., Wilson, 1981). There is also evidence suggesting that, after age 65, men may equal (Pierce, 1987) and even outnumber women in rates of nonfatal suicidal acts (Jarvis, Ferrence, Johnson, & Whitehead, 1976).

Why are Older Women Less Suicidal than Older Men?

Physical Factors

Physical Strength

Earlier theories suggested that women are less likely to die of suicide because they are physically weaker than men (Lester, 1969): "The acts of firing a gun, plunging a knife, or kicking a chair away may be all the more difficult for a woman because of her lesser strength" (p. 342).

The possibility that the gender differences in suicidal mortality are due to difference in physical strength has been discredited (Lester, 1979). No particular physical fitness is required to pull a trigger. In fact men are most dangerous to themselves after age 75, when they are most physically frail.

Sex Hormones

Much attention has been devoted to the role of sex hormones in the suicidal behavior of women, and very little to the role of sex hormones in the suicidal behavior of men.

One of the most popular theories is that women's suicidal behavior is related to the menstrual cycle. Research on the association between

menstrual stages and suicidal behavior has persisted despite the lack of consistent evidence (see Neuringer & Lettieri, 1982, and Lester, 1988, for reviews). Changes in levels of estrogen and progesterone, premenstrual cramps, "menstrual messiness," and the presumed "helplessness" of menstruation have all been considered plausible precipitants of suicidal behavior. Similarly, the physiology of pregnancy has been investigated for links to suicide. The most peculiar aspect of these theories is the assumption of a connection between women's *normal* reproductive system physiology and psychopathology—an assumption that is reminiscent of the Victorian medical theory that women are vulnerable to periodic "reflex insanity" (Showalter, 1985). Interestingly, menopause has not attracted the attention of biological suicidologists. One reason may be that in the United States, suicidal behavior declines past midlife for women, a fact that challenges the assumption of intrinsic biopsychological weakness in women.

In contrast to the literature on suicide and female physiology, sex hormones have not been promoted as an explanation of suicidal behavior in men. The connection between reproductive physiology and "nervous disorders" is rarely made from men. Yet, one could easily postulate that older males' high rates of suicidal death are the result of a chronic *deficit* in estrogen or the toxic influence of testosterone.

Physical Illness

Physical illness or disability are often cited among the factors associated with suicide in the elderly (e.g., Sainsbury, 1963). According to the review of studies by Stenback (1980), physical illness plays less of a role in nonfatal than in fatal suicides.

A majority of older individuals who become sick and/or disabled do not kill themselves; therefore, the question is: What sets apart those individuals who become suicidal? According to a review of studies by Lyons (1984), characteristics that may interact with the illness and thus increase the risk of suicide include a strong need to be active and independent, a history of depression and hostility, and a proclivity toward brooding. The literature does not address whether physical illness is more of a precipitant of suicide for older men than for older women.

Psychological Factors

Psychological Complexity and Flexibility

Several suicidologists have attributed women's lower rates of suicidal deaths to their being psychologically simple, mentally dull, passive, conforming, and suggestible. It has been said that women are not imaginative and intellectually complex enough to kill themselves (Durk-

heim, 1951); that they unquestionably accept traditional and religious prohibitions against suicide (Davis, 1904; Durkheim, 1897/1951); and that they passively accept the blows of life more readily than men (Durkheim, 1951; Neuringer & Lettieri, 1982). Men, on the other hand, being imaginative, critical, and in control, affirm themselves against adversity by killing themselves. These explanations have been extended to geriatric suicides. Passivity, suggestibility, and malleability were proposed by Breed and Huffine (1979) as the personality characteristics underlying older women's low rates of suicidal death.

It is interesting to note that the characteristics women display are pejoratively labeled, even if they are associated with adaptation and survival, and whatever characteristics men display are positively labeled, even when they lead to self-destruction. It is also worth noting that the same characteristics that are lauded in suicidal men may be described as pathogenic when studied independent of gender. In this regard, research on thinking in suicidal persons has suggested that suicidal individuals are less—not more—imaginative, less differentiated, and less mentally flexible than nonsuicidal individuals (see Levenson, 1974, for a review). According to research by Neuringer, Levenson, and Kaplan (1971), the suicidal person's rigid and polarized style of thinking is a lifelong dispositional tendency rather than a transient reaction to stress.

An alternative hypothesis is that women may be capable of more complex and flexible coping than men. According to Breed and Huffine (1979), women's flexibility is the result of socialization and developmental experiences. Many women experience several role shifts during adulthood: "As the child progresses through the developmental stages . . . the demands of the mother's role qualitatively shift and change. In addition, during this period of mothering, the woman may well be in and out of the labor market, further varying her roles" (p. 302). On the other hand, for many men, adult development tends to follow a relatively stable course, with work remaining a constant and often exclusive focus. According to Breed and Huffine (1979), a man "is not likely to experience major qualitative change after the first few years of adulthood and marriage. In his developmental process, each stage prepares him for the next, and the demands and expectations on him are consistent throughout—he is expected to be assertive, to seek mastery over his environment, and to strive for achievement" (p. 302).

Clinging to Life

Another theory of gender differences in rates of suicidal death is that women cling to life more than men (Schneider, 1954, cited in Lester, 1969). If one takes life expectancy as a measure of clinging to life, one may indeed conclude that women hold on to life more than men: Women have a seven-year advantage in life expectancy over men (Smith, 1990). Women are less likely than men to engage in self-destructive life-

styles, such as chronic use of alcohol and illicit drugs (Canetto, in press) or criminality (Al-Issa, 1982), or to die a violent death, such as in a motor vehicle accident or a homicide (Holinger, 1987). Whether women's avoidance of violent life-styles and deaths should be viewed as biological (Schneider, 1954, cited in Lester, 1969) or psychological clinging to life, socialized behavior or healthy resilience is debatable.

Intent

Gender differences in suicidal mortality are sometimes attributed to differences in intent. It has been postulated that women are more "manipulative" than men, and that they use suicide to communicate hostility or helplessness, not to achieve death, as do men (Stengel, 1964). According to Stengel, this is determined in part by the fact that other means of influence, such as physical intimidation, are not at their disposal to the same degree as to men. In any case, it is very plausible that many suicidal women do not intend to die; if more did, more would probably die. However, it is also very plausible that many men who died of suicide really intended to call for help, but their suicide "failed" and they actually killed themselves.

Not much is known about gender differences in suicidal intent in the elderly. There is some evidence suggesting that at least with regard to fatal suicides, older women and men may be similar in terms of expressed intent. In a classic study of suicide notes, Farberow and Shneidman (1957) found that a majority of older female and male suicidal victims had communicated an intent to die.

Psychological Disorders

Suicidal behavior is sometimes considered a manifestation of a psychological disorder. According to a review of studies by Stenback (1980), the percentages of suicidal individuals diagnosed as mentally disordered varies from 20% to 100%, depending on the stringency of the criteria.

The psychological condition most typically associated with suicidal behavior is depression (Stenback, 1980). Depression is more common in women than in men in adulthood (Weissman & Klerman, 1977), but not in late life, when rates of depression are the same for both women and men. Many investigators have suggested that this leveling of gender differences reflects declining rates for older women rather than increasing rates for older men (see George, 1990, for a review). Another condition often associated with suicide is alcoholism. According to Stenback (1980), chronic alcohol abuse is more commonly seen in nonlethal suicides than in lethal suicides, particularly among males over 65. However, chronic alcoholism is more commonly associated with nonfatal suicides under age 65 than with nonfatal suicides over age 65.

In sum, depression and alcoholism have been associated with suicidal behavior in the elderly. Most studies of the suicidal elderly do not provide information on diagnosis by gender; there is, however, some

evidence suggesting that both depression and alcohol abuse are common among older suicidal males.

Help-Seeking

According to another perspective, women are less likely to die of suicide because they are more likely to seek professional help. Studies of utilization of suicide prevention facilities have confirmed an association of availability of suicide prevention centers with reduction of suicide risk in women, especially young adult white women (Miller, Coombs, Leeper, & Barton, 1984).

Mental health services are underused by the elderly, and according to a study by Conwell, Rotenberg, & Caine (1990), by elderly male suicides in particular. Some researchers, however (Barracough, 1971; Miller, 1978), have observed that geriatric suicides are likely to occur after a recent visit to a physician. In an English study by Barracough (1971), half of the individuals over 65 had seen their physician within a week of death, and 90% had done so during the preceding 3 months. In Miller's research (1978), as many as 75% of the older men studied had visited their physician within a month of their suicidal acts. These data suggest that it is not simply that suicidal women are more willing to seek professional help, but rather that they are more likely to seek the appropriate kind of help for psychological problems. Older men may be less comfortable acknowledging psychological difficulties, and thus may tend to express such problems through physical symptoms. If their physician is not trained to recognize a suicidal crisis under the physical complaints, or does not act on it, the client's denial may be reinforced and the risk for lethal outcome may be enhanced.

Social and Economic Factors

Social Status

Suicide among elderly men appears to be more common among lower-than among middle- and upper-class males (Bock & Webber, 1972; Gardner et al., 1964; Sainsbury, 1963), but the relationship between suicide and social status is far from established. There is evidence (Gardner et al., 1964) suggesting that some middle-class men slip into the lower class before the suicide. It has been suggested that upper- and middle-class individuals are advantaged by their greater economic, work, and retirement options (Breed & Huffine, 1979). The same authors also cite evidence suggesting that adaptation to old age may be more difficult in working-class individuals, if they had been raised in an environment stressing conformity and dependence on external authority.

Theories of social status have yet to be applied to older women's suicidal behavior.

Poverty

Suicidal behavior in the elderly has been attributed to poverty (Stenback, 1980). Poverty is related to social class, because social class is constructed primarily on the basis of occupation and income.

In the United States, older women are more likely to experience financial strain than older men (Hess, 1990). Women age 65 and over who live alone have a median income of \$8,000, slightly higher if they are white, and only \$5,000 if they are African-American. This is in contrast to a median income of \$21,000 for white married couples. Households headed by older women are almost twice as likely as those headed by older men to have incomes below the poverty level of \$5,500 for a single person over age 65, \$6,900 for a two-person household. According to Hess (1990), these figures underestimate true poverty among older women, because many poor women move in with a child or become homeless.

Therefore, once gender is taken into account, the relation between poverty and suicide is no longer unequivocal. Older women are more likely to be poor but less likely to be suicidal than older men. One possible difference may be that, for many women, limited access to financial resources has been a longstanding problem, while for many men financial worries are unknown until retirement. Thus, for older men, having financial difficulties often is a new experience, while for women it may be something to which they have already "adapted." This suggests that a drop in income after achieving financial security may be more demoralizing and perhaps suicidogenic than chronic financial precariousness. Another possibility is that financial difficulties may be more humiliating for men than for women due to the emphasis on the male provider role.

Retirement

Suicidal behavior has been associated with retirement. According to this theory, retirement is suicidogenic because it brings about changes in income, social status, and family roles (Kirsling, 1986; Lyons, 1984).

The literature on retirement and suicide has described retirement from a male's point of view. It is usually argued that (for men) retirement implies a loss in income, prestige, meaningful and structured activity, and interpersonal relationship (Lyons, 1984; Miller, 1978). Role ambiguity may be created. As Lyons puts it: "there are no longer superiors to admire one's work and offer promotions and no positions . . . to seek" (p. 381).

Women, like men, go through retirement at midlife. Retirement may mean different things depending upon whether the woman is employed

or not. For employed women, the issues of retirement are probably similar to those faced by employed men. For women, especially for homemakers, retirement may mean retirement from the reproductive and parental roles. Menopause and the children's departure from home would be its markers. A particularly severe loss of meaningful roles may be created for women whose self-esteem centered around being a mother (Suter, 1976). Retirement for many older women may also mean adapting to the husband's retirement and adjusting to his presence in the home territory. Coping with the husband's difficulties with retirement may exacerbate the wife's stress. A peak in suicide rates for women and men at midlife suggests that the years around retirement (ages 45 to 55 for women and ages 65 and over for men) may be quite demanding for both.

In sum, retirement is associated with changes in social status and family roles. For many men, especially men from older cohorts, these changes may be precipitated by retirement from employment; for women, these changes may be triggered by lessened involvement with parenting, and in younger cohorts, retirement from employment or both. These changes may explain the increased vulnerability to suicide for both women and men at midlife. For women this vulnerability to suicide appears to be over by age 55, while for men it seems to continue into older ages.

Living Alone

Living alone is frequently assumed to be a precipitant of suicidal behavior among the elderly (Sainsbury, 1962). This theory is thought to apply equally to older women and men. No empirical studies to date have examined this issue in terms of gender directly. However, a review of information on elderly persons' living arrangements by gender suggests that living alone may be a better predictor of suicidal behavior for older men than for older women.

Older women are much more likely to live alone than older men (see Hess, 1990, for a review). There are 6.5 million women age 65 and over living alone, in contrast to fewer than 2 million men. In the United States, women age 65 and over are almost half as likely as their male age-peers to be married. Women living alone are at higher risk of being placed in an institution than men, especially if they become physically unable to care for their household. Only 18% of disabled wives are cared for by their spouses, in contrast to 55% of disabled husbands.

In sum, older women are more likely to live alone, but they are less likely to be suicidal than older men. One reason may be that living alone may be more normative for older women than older men. Another reason may be that older men who live alone tend to be more isolated than older women who live alone (Stenback, 1980).

Bereavement and Widowhood

Many have linked suicide to the loss of a spouse (Kirsling, 1986; Lyons, 1984). Risk for suicide is considered to be particularly high in the first 6 weeks after the loss and when bereavement is associated with alcoholism (Essa & Howell-Burke, 1984). Risk may remain elevated for up to 5 years following bereavement (see Lyons, 1984, for a review).

Although widowhood is a predictor of suicide in both women and men, the effect seems to be stronger for men than for women. In the United States, females age 65 and over are 3.5 times more likely to be widowed than their male age peers. Older widows are also less likely to have the opportunity to remarry than older widowers. Widowers, however, are at higher suicidal risk than are widows (Bock & Webber, 1972; MacMahon & Pugh, 1965).

One reason bereavement is associated with greater risk of suicide for males than for females may be that many older men depend on their wives for emotional support. Older women appear to have more emotional connections with friends than do older men (Zarit, 1980). Although men have a greater quantity of social contacts through work, it appears that these contacts lack the quality of emotional support that women's contacts have. Losing a spouse may thus disrupt social support and emotional functioning more for a man than for a woman.

Another reason may be that many older men depend on their wives for their personal care and the running of a home. For many men, losing a spouse may involve becoming responsible for their personal and household care for the first time. Losing a spouse may thus disrupt personal stability and physical well-being more for a man than for a woman.

It is important to remember that for women, too, losing a spouse involves stress and discontinuities. For example, many women depend on their husbands for financial security and the management of the family assets. Becoming a widow may involve being responsible for one's own finances for the first time. Losing a spouse rarely threatens a man's financial status the way it does for a woman.

Overall, the data on geriatric elderly suicide are consistent with data on suicide and marital status through adulthood: Marriage is better protection against suicide for men than for women (Gove, 1972).

Sociocultural Factors

Method

A common assumption in the past has been that women's greater rates of suicide survival are due to their use of less lethal methods.

Method was traditionally seen as an indicator of intent. It was believed that women are less intent on killing themselves and thus choose methods that leave more room for rescue (Dublin, 1963; Furst & Ostow, 1979).

A challenge to this view has come from the work of Marks and Abernathy (1974) and Marks and Stokes (1976). Their respective studies of suicide methods by gender and region suggest that socialization and familiarity with various methods is a more powerful determinant of method choice than gender alone. In the American South, for example, Marks and Abernathy found that firearms are the most common method of suicide for both women and men.

Choice of method also varies according to cross-cultural and historical circumstances. In Asian-Americans, for example, suicide by hanging is being replaced by suicide by firearms, concomitant with the individual's degree of assimilation into the American culture (McIntosh & Santos, 1986). Similarly, in England and Wales there has been a decrease in female suicide by overdose and an increase in suicide by vehicle-exhaust poisoning and suffocation (McClure, 1987).

Only one study of methods of elderly suicide by gender is available (McIntosh & Santos, 1986). Overall, McIntosh and Santos' findings confirm prior evidence that the association between method and intent may be mediated by cultural accessibility. For example, in the United States, older white females are more likely to use poison, older black females firearms, and older non-white (but not black) females hanging; McIntosh and Santos also noted an increase in use of firearms in most of the groups studied, an indication perhaps of diminishing cultural distinctiveness and easier access to firearms.

Gender-Appropriate Deviance

According to sociocultural perspectives, the frequency of and mortality from suicidal behavior in women and men at different stages of life are influenced by social rules about gender- and age-appropriate deviance.

It has been suggested that, in many Western cultures, nonlethal suicides are more common in women because such acts are considered "feminine;" while lethal suicides are more common in men because they are considered "masculine" (Dublin, 1963; Linehan, 1973; Neuringer & Lettieri, 1982; Wilson, 1981). According to Suter (1976), nonlethal suicide is "feminine," since it combines personal helplessness with the idea of rescue by someone else. Says Chesler (1972): "Suicide attempts are the grand rites of 'femininity', i.e., ideally, women are supposed to 'lose' in order to 'win.' Women who succeed at suicide are, tragically, outwitting or rejecting their 'feminine' role, and at the only price possible: their death" (p. 49). Neuringer and Lettieri (1982) state that "suicidal gestures are an expected, and even socially sanctioned, behavior in

unhappy women" and that "their attempts certainly receive less disapproval than similar behavior in men" (p. 22). They argue that it is more acceptable for women to express their emotions and needs and ask for help; while for men, the expectations are "to be strong, stolid and not to publicly express their weaknesses" (p. 22).

The "femininity" of nonlethal suicides and the "masculinity" of lethal suicides have been supported by studies by Linehan (1973) and White and Stillion (1988). On the basis of her observations, Linehan (1973) speculated that social acceptability influences the kind of suicide chosen when suicidal behavior is considered an option. For women, the social acceptance of nonlethal suicidal acts may promote chronic self-injurious behaviors, while social pressure against suicidal death may be a deterrent to killing oneself. Conversely, for men, the pressure against surviving suicide may lead them to act out the most drastic and dangerous of suicidal acts, even if their crisis is relatively minor and their intention is not to die. White and Stillion (1988) studied the reactions to troubled suicidal and nonsuicidal targets and found males to be most unsympathetic to suicidal male targets, while females were equally sympathetic to all troubled targets. According to White and Stillion, "attempted suicide by troubled males may be viewed by other males as violations of the sex-role message of strength, decisiveness, success, and inexpressiveness" (p. 365).

It is also possible that suicide is more common among the elderly than among the young, because historically suicide has been considered a reasonable solution for older individuals (Osgood, 1985). With regard to attitudes toward nonfatal suicide, there is evidence suggesting that nonfatal suicides are thought to be most "understandable" when performed by older women (Stillion, White, Edwards, & McDowell, 1989). The same study also found that older women received the least amount of sympathy and young women the most sympathy for their nonfatal suicidal behavior.

In sum, studies on the acceptability of suicide suggest that elderly males may be encouraged to kill themselves by cultural norms defining lethal suicide as masculine and developmentally reasonable. For elderly females, the social norms regarding suicidal behavior appear to be complex and contradictory.

Discussion

Older women are less likely to kill themselves than older men. Do older women have special advantages that protect them from suicide? An adequate answer to this question is not possible at this time given

the scarcity of pertinent empirical data. On the basis of this literature review, it is, however, possible to suggest some preliminary hypotheses.

First, social and economic factors are not likely to account for older women's resilience. In fact, many older women live in conditions that, in older men, have been thought to precipitate suicidal behavior. For example, older women tend to live alone following divorce and widowhood; they also tend to have fewer financial resources than men.

Retirement and physical health factors do not explain women's resilience either. For many women, as for men, the transition to retirement is difficult. Older women, like older men, experience physical illnesses and disabilities. According to a review by Hess (1990), older men are more likely than older women to be able to afford costly medical services, to have short hospitalizations, and to have a spouse who can care for them at home. Older women tend to remain longer in acute-care beds and to be transferred to long-term care facilities or discharged to the care of an adult daughter or other female relatives. Older women are also more likely than men to end up in nursing homes: Three out of four nursing home residents are women.

What then accounts for older women's relatively low rates of suicidal deaths? There are indications that gender differences in coping may be important with regard to risk for suicidal behavior. Specifically, older women may have a more flexible and diverse ways of coping than older men: Compared to older men, older women may be more willing and capable of adopting different coping strategies—"passive" or "active," "connected" or "independent"—depending on the situation. There is evidence to suggest that women's flexible coping is not innate, but rather the product of socialization and developmental experiences.

One component of flexible coping involves the capacity and/or willingness to accommodate and adapt to situations. As Breed and Huffine (1979) have suggested, older women may be more capable and willing to adopt "passive" coping strategies than older men. Gender differences in adaptability and willingness to compromise are likely to be the result of socialization and developmental experiences (see Suter, 1976, for a review). Women are socialized to be sensitive to and to make room for other people's needs. Partly as a result of this, women's development involves many role changes and conflicts. Women are also discouraged from using aggression for conflict resolution. Finally, unlike men, many women experience significant changes in body functioning during adulthood—for example, when they become mothers—an experience that may prepare them for physical changes in late life (Breed & Huffine, 1979). Men, on the other hand, are socialized to always try to be in control and "shape the world" according to their needs. Whenever a conflict with others arises, men are likely to be encouraged to use forceful means to assert their will. As a result, men may come to late

life with unrealistic expectations and a limited range of coping strategies. Being accustomed to controlling work and money, they may find the economic and work restrictions associated with retirement threatening. Having experienced their bodies functioning as fairly constant through adulthood, men may find the experience of physical aging disturbing.

Another component of flexible coping involves the capacity and/or willingness to be active, resourceful, and independent. Many older women may have had a limited experience with being financially independent and often suffer economic hardship following divorce and widowhood (Holt & Datan, 1984). However, most older women have extensive experience being active, resourceful, and independent with regard to personal care and socioemotional needs (see Troll & Turner, 1979, for a review). Most older women are also used to taking care of their households. After being responsible for the emotional and social welfare of their families, many older women maintain a well-developed network of friends. On the other hand, many men have extensive experience taking care of themselves financially but limited experience being active and resourceful with regard to taking care of their personal needs (Troll & Turner, 1979). Most men depend on women for their personal care and emotional well-being. Many men also rely on women for their social needs, such as keeping in touch with friends and family. Many men defer to women regarding the responsibility for their most personal relationships, most notably the emotional and practical responsibilities of being a parent. As a result, men may come to late life with a limited range of interpersonal skills and a total dependence on women for emotional connectedness. Having been nurtured all their lives by women, many men may not even have developed an appreciation for their own emotional needs. Having been socialized to expect being taken care of by women, they may experience taking care of themselves as abandonment. Without their partners, they may be unable or unwilling to provide themselves with even the most basic physical care, psychological sustenance, and social contacts.

So far it has been argued that socialization influences risk for suicide through its effects on coping. Socialization may also have an impact on suicide through definitions of gender-appropriate suicides. There is evidence that suicidal death in older men may be reinforced by an association of lethal suicide with masculinity and aging (Linehan, 1973; Stillion et al., 1989; White & Stillion, 1988). Older men may correctly anticipate being ridiculed and disliked if they survive suicide. On the other hand, suicidal behavior may be discouraged in older women by contradictory norms and the expectation of low sympathy.

Gender differences in coping and suicide rates have implications for the prevention of suicide. In terms of primary prevention, the focus should be on gender socialization experiences and roles. Traditionally,

work has been considered the key to men's mental health. Thus, the typical recommendation for suicide prevention has been to keep men busy. For example, Osgood (1985) has suggested that men be given the opportunity to extend their working years past age 65. In principle, it maybe a good idea not to force men or women to retire on the basis of chronological age. Some individuals are interested and able to work past age 65. At the same time, for men to continue investing all of their energies into work as a way to "avoid" suicide may be a regressive solution.

It is very likely that relationships, not work, are the key to suicide prevention in older men. Social isolation and living alone (Stenback, 1980) are considered risk factors for suicidal death in older men. It may be that older men are most prone to suicide when relationships, not work, are missing (Cumming & Lazar, 1981). Thus, what older men may benefit from is relationship experiences and responsibilities. Relationship experiences may promote the flexibility of coping and socioemotional connectedness that many women enjoy. Furthermore, feeling responsible for a relationship may be a greater incentive to live than feeling responsible for a job. It has been argued that women are less likely to kill themselves because they consider the effect of their suicides on their loved ones (Kaplan & Klein, 1989). A man who feels responsible for another person's well-being might reject suicide just because that person could be upset by it.

An emphasis on relationships does not imply that work is not important to a person's mental health. Rather, a balance of work and relationship commitments may be the best protection against suicidal despair. This balance may be most easily achieved if both women and men are encouraged to pursue a variety of interests and talents, within and across gender roles. Meaningful participation in the world of labor has diminished women's vulnerability to emotional disorders (see Kaplan & Klein, 1989, for a review). It is very well likely that assuming relationship responsibilities will strengthen men's emotional resilience, including the resilience to suicide.

In terms of secondary prevention, two factors seem crucial: the ability to ask for help and the response to the call for help. While it is most important to ensure that suicidal men become more capable of seeking appropriate help, it will also be important to make sure that professionals become more sensitive to indirect clues of suicidal intent. A key person in this role is the physician. Research (Barraclough, 1971; Miller, 1978) has indicated that as many as 75% of suicidal elder persons visit their physicians before killing themselves. Education of the physician in the recognition and psychological management of the suicidal client will be necessary. Physicians should be aware that depression and suicidal

behavior in the elderly may be masked by vague physical complaints (Essa & Howell-Burke, 1984; Victoroff, 1984). Physicians should also be careful about prescribing potentially lethal drugs, as a majority of those attempting suicide by overdose obtained the drugs from their physicians (Benson & Brodie, 1975).

Several directions for research ~~be~~ be fruitful. To learn more about women's successful coping, it might be useful to study older women who, according to traditional male parameters, should be at risk of suicide but are not, and unravel the source of their resilience. To learn more about the development of men's suicide vulnerability, it might be interesting to explore the relation between gender-role adherence and late-life suicidal behavior. One would expect older men who kill themselves to be fairly conventional with regard to gender-role expectations. It might also be interesting to explore gender-role rigidity in the families of origin and personal background of men who die of suicide. One would expect suicidal men to come from a cultural background in which adherence to sex-roles was highly valued.

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