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When growing old becomes a burden

Preventing suicide in old age

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Contents

Suicide prevention is possible

Nobody likes to talk about it. The problem nevertheless exists. All the facts point to an increased risk of suicide in old age. Of the over 10,000 people who take their own lives in Germany each year, 40% are aged 65 or older. They represent, however, only 22% of the total population. Every two hours in Germany, an older person aged 65 and over dies by their own hand.

Often, it is a quiet death, scarcely noticed by others. Behind the intention to kill oneself and the decision to carry out a suicidal act, there often hides a restricted living situation that appears to be hopeless. Problems are experienced as being no longer solvable. They mount up to create a severe crisis that either originated long ago or has been sparked by critical life events today. Subjectively, there is no longer any hope of change. To go on living under such conditions no longer seems to make sense. Loss of quality of life, for example, through physical or mental illness, experiences of loss, and social isolation, can grow into an unbearable situation. Suicidal acts in old age are often less to be understood as an appeal for help to others but more often as a last act in a life situation that seems hopeless.

Because of the often negative image of old age, a suicide attempt by an older person is often seen as more acceptable than one by a younger person. The terms 'Freitod' ('free death') or 'Bilanzsuizid' ('rational suicide'), sometimes used synonymously with 'suicide', suggest a freely taken decision to take one's own life. They are used especially in relation to older people because many conceive of old age as a personal and societal burden. Taking one's life at the end of a life 'lived' seems to many to be more plausible and acceptable than the suicide of a younger person, whose life can change for the better.

It is therefore not surprising that despite the higher risk of suicide in old age, only a few efforts are made to prevent the causes of suicidal crises and suicide attempts in this age group. There is also the fact that investment in suicide prevention – if made at all – appears to be more worthwhile for younger than for older people. There are too few offers of help for older people in crisis, and those that are available are not known or taken up too infrequently.

The purpose of this information brochure is to make readers familiar with the conditions which can lead to suicidal tendencies among older people and to indicate options for suicide prevention and crisis intervention. It is intended to stimulate consideration of an appropriate lifestyle and engagement with existential questions at life's end. Suicide prevention in and for old age begins very early; at its heart is a conscious preparation for old age.

This information brochure is intended for

- people who are are dealing with the subject of suicide and suicide prevention and who want to be informed
- people who are burdened with thoughts of suicide or who find themselves in a life crisis
- dependents and other carers who know older people in their vicinity who are at risk of suicide
- people who work professionally or voluntarily with older people

Three important questions are at the forefront in these situations

1. How can suicidal tendencies be recognized in older people?
2. How can suicide risk be prevented?
3. What options for help are there?

Suicide prevention is possible. This is clearly demonstrated by science and a wealth of practical experience. This is why the World Health Organization (WHO) has been calling on its member states to establish comprehensive national suicide prevention strategies for many years.

The authors of this information brochure are members of a working group that is part of the National Suicide Prevention Programme for Germany; it deals with suicidal tendencies and suicide prevention for older people and contributes to the improvement of the care situation.

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The life situation of people in old age and at life's end

There have always been older people. However, what is new in recent years is that large segments of the population can now live to a great age. Today, the high-aged are the fastest-growing group in the population. People in industrialized nations are thus coming ever closer to the age-old wish for a long life. On the other hand, there are many unresolved problems and anxieties because humanity, up till now, has had only little experience of this new situation. Will old age bring good years or bad? What will the health situation be like? What social changes will come to older people and to society in general?

Today, perceptions of old age still often have a negative tinge, although the idea of a 'general decline' in old age has been proved wrong. The image of old age today includes more colors. People are seeing more clearly the possibilities that this phase of life opens up and are taking advantage of them. It is, however, also true that, especially in extreme old age, the likelihood of falling ill or needing care grows.

Connected to this is the challenging task of accepting a growing number of cuts in independent living, cuts that threaten or may injure the sense of self-esteem. Nevertheless, a good half of over 90-year-olds lead their lives independently, and 70 percent suffer from no or only minor impairments in mental performance. Many older people live in their own homes, relying on their resources or being able to organize outside help when required. Others, among them those needing home care, can no longer handle their life as independently as they would like.

To some extent, people carry on their lives in old age as they used to when they were younger. But now they have new opportunities and tasks. If children and/or jobs previously took up a lot of time and energy, it now makes sense to organize the newly won free time. The day will be structured in a new way, and new horizons must be opened up for the remainder of life. Goals and plans contribute to people's well-being. In confronting the changed conditions, it is right to develop personal capacities and choices and to use the life experience gained in earlier tasks and crises.

Accepting old age and the finiteness of life are further tasks that challenge people into old age. Development in old age means recognizing that one's living situation also changes.

Everyone has an entirely personal life history. We should note that there are no norms for contented aging. Right up to old age, the individual situation provides the benchmark. Excessive demands can affect health and well-being, but so can being under-challenged.

Thoughts about life's end are often bound up with existential questions about the meaning of the life lived so far and the ever-shrinking prospects for the future. Many people find their answers to these questions and life support. There are, however, also people who feel so burdened by their living situation and the future that they see no solution to their problems and can find no answer that makes sense to the existential issues of their lives. This existential crisis can, together with other burdens, lead to thoughts of bringing life to an end.

Early indicators and signals of suicidal tendencies

The onset of a suicidal mood is often announced through a feeling of 'constriction': sufferers report that they no longer have any interests, not even in their hobbies, their favorite sport, or cultural activity. They withdraw themselves from interpersonal relations. In their thoughts, they feel constricted 'as if in a vice', and tend to brood. Sufferers in the early stage of the suicidal crisis also often express thoughts such as: 'Nothing makes sense anymore...'; 'It would be best if I were no longer alive...'.

Direct suicide announcements ('I want to leave this life') or the insistent feeling that they have to kill themselves ('Do it first thing tomorrow...') have to be taken extremely seriously. But the 'calm before the storm' can also be a dangerous warning signal for suicide risk.

That is to say, if a person who earlier has had thoughts of suicide or who has expressed concrete suicidal intentions suddenly seems to relax and does not talk about suicide anymore, this can signify that they have by this point, already decided on suicide. Up to this moment, they have been in a tormented state in which they swung back and forth between 'I want to kill myself' and 'Maybe I will be helped.' This inner conflict is an expression of a severe crisis. The decision to commit suicide allows such people to appear relaxed suddenly. It is all the more shattering, then, if soon afterward they take their lives.

Early indicators and signals of a suicide risk can be

- feeling of constriction
- brooding, suicidal thoughts
- giving up familiar interests and activities
- withdrawal from interpersonal relations
- announcement of suicide (direct or indirect)
- unexpected appearance of calm after suicidal statements ('calm before the storm')

Development of suicidal tendencies in old age

Humiliations and crises

Becoming older is accompanied by social and physical changes, many of which can be experienced as restriction, loss, or humiliation. One's own options are, in many life situations, increasingly limited. The demands arising from this can usually be managed quite well by drawing on one's life experience. Self-assurance and inner security can increasingly compensate for external limitations and dependencies.

The life situation can, however, also become unbearable if there are not enough good and reliable counterbalancing choices and memories available. When contemporaries die, or life in the partnership changes in a distressing direction, a feeling of being left alone or of inner alienation can arise. If tasks become impossible or can no longer be done in the old way, the feeling of no longer being needed grows now and then.

Health problems can detract from the quality of life in fundamental areas. There is concern about being dependent on the help of the family or professional helpers in the future.

Anxieties, the sense of no longer being taken seriously, and a sense of powerlessness can all be experienced as unbearable. Then, in despair, there comes the wish to take one last decision into one's own hands and bring one's life to an end. This is often connected with the fantasy of finding endless rest and peace. One's death then appears to be the only way of becoming free of this tormenting situation. What is decisive here is less the severity of the external situation than the thought of no longer being able to deal with such a conflicted situation. Some older people find this kind of conflict insuperable. They nevertheless express hope of a change in their situation, even if they have no concrete idea of what that might look like.

This sometimes appears to outsiders as a contradiction: on the one hand, these desperate people hope for help, but on the other hand, they convey that they only want to be left alone.

If this ambiguous experience and behaviour can be better understood, many kinds of help are possible. We can gather a better understanding of why people in stressful situations consider taking their own lives by understanding their situation. We often encounter a repetition of stressful experiences beginning in childhood (e.g., separation, loss, illness, lack of appreciation, dependency, and helplessness), each of which is dealt with individually according to our previous experiences and chances. Especially in old age, when one is concerned about holding on to one's independence, the room for maneuvering in living and dealing with life can appear forbiddingly restricted. From this angle, older people do not find it easy to ask for support and help, which could contribute to making their current living situation more bearable.

Example

Before his wife's illness, thoughts of taking his own life had never come into the 70-year-old office worker's mind. Her breast cancer had been confirmed some eighteen months previously. There followed an operation and then radiation- and chemotherapy. The thought that his wife would die and that he would be left alone seemed unbearable to him.

After the operation, the radiotherapy, and chemotherapy, it looked at first as if his wife had been cured. They made new plans together because they still wanted to do so many things. However, his health, too, was quite severely impaired after a kidney operation; they tried to deal with the cancer together, just as they had coped with their more or less serious illnesses in the past. When a suspiciously cancerous lung condition was found in a follow-up examination of his wife, which made immediate hospitalization necessary, he thought once more of taking his life. Since then, he told his family doctor that this thought had never left his head. He simply could not be on his own. The thought of bringing his life to an end once his wife died had become ever stronger and grown into a certainty. He had already considered how and where he would do it. He had no one, he wept. He could not get through it alone. The only reason he had not killed himself so far was that he did not want to burden his wife. He had to wait until she was dead, and then he would be 'deadly serious' about dealing with the matter. Why should he then go on living, for whom and for what? 'We have always done everything together. Without my wife, life has no meaning for me.'

Mental illness in old age

Approximately one in four people over 65 have a mental illness. Depression is the leading cause. Other mental illnesses among older people include brain disorders (dementia), anxiety, delusion, and addiction. Of these, it is the rate of dementia that increases in old age. Every psychiatric illness contributes to a higher risk of suicide. This applies particularly to depression. What appears to be responsible for this is that depression is typically accompanied by feelings of not being worth anything, no longer being able to be productive, suffering from life-threatening physical illness, and having made oneself guilty. —thoughts like this lead to a dead end.

No hope of help through treatment can be seen. Taking one's own life appears to be the only conclusion as a way of escaping from these tormenting thoughts.

It is therefore important to recognize mental illnesses in old age, especially depression, and to get across to the sufferer that this is 'in fact' an illness and that therapy can help. Dementia is still not sufficiently recognized and treated, partly under the false assumption that it is 'normal' for older people to withdraw and grieve.

The proper treatment of mental illness can reduce or bring the risk of suicide to a halt.

Signs of depression in old people

- low spirits, particularly in the morning
- joylessness, numbness
- diminishing drive and interest (typically, indifference to favorite things and activities)
- withdrawal from social relations

- reduced ability to concentrate
- fatigue and rapid exhaustion
- reduced feelings of self-worth and self-confidence
- feelings of worthlessness and irrational feelings of guilt
- negative expectations of the future
- unfamiliar anxiety
- suicidal thoughts

- sleep disturbance
- loss of appetite
- weight loss
- digestive disorders
- anxious body perception
- pains without organic causes

However, depression can also have other manifestations in old age, such as restlessness or irritability.

Dementia and suicide

Until a few years ago, people with dementia were not considered to be at particularly high risk of suicide. However, the scientific evidence now points very clearly in the other direction: people with dementia have an increased risk of suicide, especially in the first year after receiving a diagnosis. This also applies to the diagnosis of 'mild cognitive impairment'. The risk also increases if those affected are relatively young (under 60) at the time of diagnosis or if there are other risk factors, such as a previous suicide attempt or mental disorders.

In contrast, people in the later stages of dementia, when cognitive and physical impairments increase significantly, are at a lower risk of suicide than people without dementia. For this reason, the notification of a dementia diagnosis should be regarded as a so-called critical intervention and should be carried out with particular empathy, care, close support, and, if possible, with the involvement of relatives and other loved ones.

Physical illnesses in old age and their consequences for independence and life experience

Well-being and independence largely depend on maintaining bodily and mental functioning. Limitations or losses are usually experienced as major turning points. Physical illness has a particular significance in this respect.

Chronic physical illnesses, in particular, increase significantly in old age. Ultimately, their consequences significantly impact the people's quality of life and independence.

In the experience of geriatricians, the following conditions have a particularly lasting effect on the lives of older people

- chronic pain
- dyspnoea
- restrictions of movement, paralysis
- loss of excretory control (incontinence)
- reduction or loss of visual acuity
- reduction or loss of hearing
- falling and fear of falling

These conditions primarily affect mobility, later, is especially affected by these conditions; later, daily activities such as dressing and bodily care are also affected. The resulting loss of social contact can lead to loneliness and depression.

It is not only the actual restriction of activity but often its anticipation, which is a source of anxiety, diminished feelings of self-worth, dwindling sense of control, and helplessness. This process of working through helplessness demands special attention in order to learn acceptance and reconciliation of a situation.

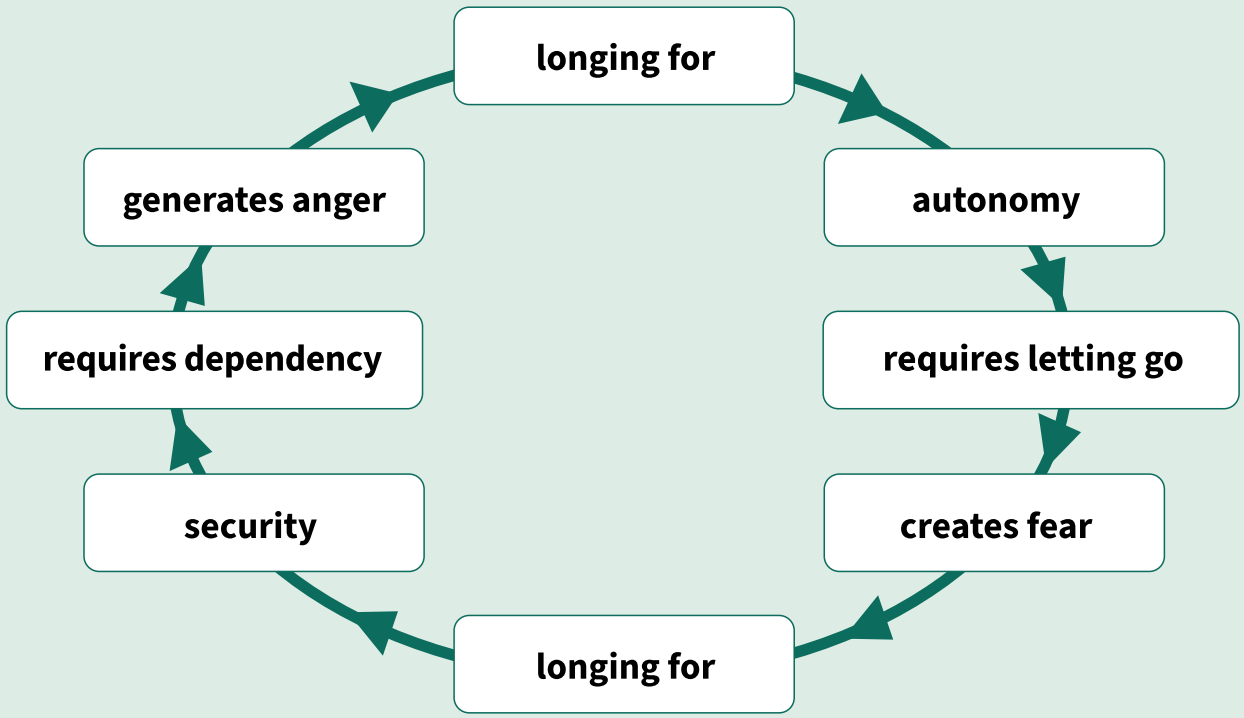
Blindness separates from things, deafness from other people

Loss of the partner

Loss of a partner, whether through separation or death, is an experience that can deeply disturb both lifestyle and well-being. This applies particularly when the prospects for a fresh start or change are diminishing. Losing a partner in old age often leads to loneliness, with the risk of isolation and the task of having to reorganize life under the conditions of advancing old age.

In terms of practical living, this often presents more significant problems for men than women. Reorganization is complicated if the partner is the sole emotional support. This emotional dependency can make it very hard as time goes by to find the space to stabilize oneself and organize life differently. That is why it is so important to maintain other social contacts right into old age

Figure 1: Conflicting needs for autonomy and for dependency



(Wedler, H. (2001), Umgang mit Suizidalität und Sterbewünschen im Alter (Dealing with suicidal ideation and the desire to die). Suizidprophylaxe 28 (4), S. 169)

Loss of independence

A primary motivation for the onset of the wish for suicide and death in old age is the feared or actual loss of independence (autonomy).

By this is usually meant

- losing the option of independently conducting everyday life and human relationships
- losing the ability to control bodily functions
- the feeling of being dependent on others and being at the mercy of someone else

The fear of losing independence and autonomy in our society usually fails to consider that there is never absolute independence in life: The desire for autonomy and security are complementary poles in a field of tension that transcends all phases of life.
Each individual has to find their position between these poles and, of necessity, to adapt to the changing phases of life.
Nobody can live permanently in complete autonomy or absolute dependency. Instead, what is required is to balance a certain amount of communal belonging with room for independent decision, even if – in the last resort – one or the other can now only be lived out in fantasy.

Autonomy means – and this is particularly true in old age – being thrown back on oneself, while security often also means unwanted dependency. Striving for poise and balance between the needs for autonomy and dependency helps meet the challenges of old age.

‘Does life still have meaning in old age?’

The further life moves towards its end, the more it becomes clear to each individual that the meaning of life does not come from the acquisition and hoarding of ‘goods’ because these all become worthless at death. Basing the meaning of life on a ‘legacy’ can lead to bitter disappointment. Instead, does life’s meaning arise in every phase of life, including old age, from the independent creation of one’s own life within a social context, i.e., in contact with and in exchange with this society?

Anyone who gives up on themselves, or only waits for others, or escapes from the feelings and thoughts of the present loses the meaning of life. The question of the meaning of life is thus independent of age. Advanced age can, however, contribute to giving up illusory, unfounded life goals, thus freeing up energy for the independent creation of one’s life.

The experience of meaning in life includes

- reflecting on oneself and one’s life
- activity (and one’s own will)
- willingness to adapt (to one’s own limitations, disability, illness, social circumstances, living conditions, fellow human beings)
- connectedness with other people

Religiosity and spirituality

Concerning suicide prevention, religiosity and spirituality can represent both a problem and a help. It is appropriate to broaden this again, especially when religious or spiritual experiences support a narrowing of personal outlook. On the other hand, the possibilities opened up by faith can help to break out of the narrowness of the current situation.

Suicide prevention, crisis help, and longer-term therapeutic options

Preparation for old age

It is always better to prevent a life crisis than to deal with it once it has taken hold. In terms of primary suicide prevention, old age and its consequences must not come as a surprise. Even if no one knows how it comes in each case, it is good to be prepared for what can come. Everyone has to make an effort for this.

Early engagement with the second half of life

By the middle years at the latest, everyone should become aware that they, too, will be old one day. Even before retirement and the associated loss of everyday working life, it is essential to set oneself sufficiently fulfilling tasks for the time after retirement. Even during working life, there are proven advantages of not standing on 'one leg' (work) only but growing a 'second leg': an activity that provides fulfilment.

In retirement, providing oneself with constant mental and physical activities for as long as it is possible is vital. If the children have left home, the partnership must also be newly defined in later years—roles and tasks in the family change.

Most people seek communication and support primarily within their age group. That applies in old age, too. It is, however, advisable to maintain contact with people of other age groups. Expectations of being supported exclusively by children and their families do not infrequently become a source of lasting conflict and disappointment.

Acceptance of aging and mortality

The health of the body and mind requires care and prevention. However, this should be geared towards age-specific needs rather than following the idea of staying young forever.

More than younger people, most older people can calmly and neutrally recognize that they have to die. Others accept these facts while avoiding having to confront the associated conflicts, especially when their life situation appears hard to bear.

Others can accept the fact that they have to die relatively well, whether they believe in a happy afterlife or not. Most older people, though, have a considerable fear of a long, drawn out, and wretched process of dying in pain and dependent on machines.

Preparatory planning is needed to ensure that the future, with its increasing limitations of physical, mental and social living conditions, does not suddenly surprise the aging person. This includes preparing a home suitable for old age, considering possible periods of illness and physical disability. The potential loss of the partner through death, with the subsequent life lived alone, must also be considered.

Acute illness can always, in old age, be the harbinger of death, and having a trusted and reliable family doctor available for this eventuality is of inestimable value. The extent of medical intervention at life's end should be discussed with him in good time and specified in a living will.

Finally, arrangements for one's death are essential: burial, insurance matters, access to bank accounts, and inheritance. They are a social aspect of provision for old age which should be made in good time.

Maintaining communication and social involvement

People need to be addressed and interact with others. This also applies to aging people who need communication. This must be cultivated and maintained until the end of life. This includes, in particular, contacts within the neighborhood and with friends, as well as participation in community activities.

Accepting help when ill or disabled

Early warning signs of illness should neither be ignored nor constantly worried over. No situation in the lives of older people should be the trigger for permanent withdrawal and self-anesthesia. It is therefore important to use medicines and alcohol carefully to maintain a daily rhythm, eat a balanced diet, and make sure of good, natural sleep.

Many aids are available to compensate for physical handicaps, including adaptations to the home, mobility of the bed, and help with hearing. Anyone who is disabled should take special care to receive competent information. Even before the onset of a disability, the importance of non-material and material possessions and their possible relinquishment should be thoroughly considered. Assistance from social institutions (e.g., outpatient services or homes) should be permitted in an appropriate form if necessary.

Once illness or disability has occurred, it is advisable to make use of offers of help and resources to relieve the burden. Excessive demands that could lead to a further deterioration in health should be avoided. It is important to adapt to what is possible and not to overestimate oneself. Many people find it difficult to accept that they need help and to accept assistance. In the course of life, however, there are always situations where this skill can be learned.

Talking with suicidal older people

It is not always easy to make contact and have a conversation with an older person who intends to take their own life. Suicide is still a topic that many people prefer to avoid. It raises fears and insecurities about doing something wrong or worse, increasing the other person's suicidal tendencies. In addition, the conversation can touch on crisis-related events in the helper's life.

What to keep in mind when talking to suicidal older people

- Non-judgmental conversation in which openness and trust prevail and the suicidal older person feels accepted in their distress
- Openly address death wishes, suicidal thoughts and intentions
- Take suicidal tendencies seriously; do not trivialize them, but also do not dramatize them
- Discuss reasons, accompanying circumstances, and acute triggers
- Understand and include life-history contexts
- Explore possibilities for support in the social environment (e.g., caregivers, social services, medical help)
- Make an offer to continue the conversation (address fears; point out further counseling and help options) and make arrangements

Options of help in crisis

If a crisis arises, such as loss, grief, or constricted social interaction, contact must be sought with friends and trusted individuals, especially with the trusted family doctor. In some cases, psychotherapeutic help is appropriate. If the crisis is very acute, the first point of contact is the telephone counseling service and local specialized crisis services.

National and regional/local contact addresses and contact persons can be found at the end of this information brochure.

If there has already been a suicide attempt, the emergency doctor must be called and a hospital admission initiated.

After surviving the acute phase following a suicide attempt, crisis intervention comprises

- clarification of the current (psycho-social) situation.
- setting the course: What happens next?
- motivation to accept ongoing help
- and support with reorientation in the changed post-crisis situation.

Psychological disturbances require appropriate treatment (with psychotherapy and, if necessary, psychotropic drugs). Furthermore, the psycho-social network offers many choices for receiving help. The family doctor's practice can also be a first port of call, especially if it is already familiar.
In a crisis, relatives and carers often need to talk things over and be supported (e.g., to relieve feelings of guilt).

Help at the end of life

Many people are afraid of a protracted and painful dying process, especially if it is associated with pain and helplessness. Many people are unaware that professional help is available for terminal illness and the dying phase.

Supporting people at the end of life does not just involve a short period of a few hours until death occurs but can extend over a comparatively long period of months or even years. This is particularly true for people with dementia, who require a great deal of support of varying intensity in the last two years of their lives or longer. Like other people suffering from neurodegenerative diseases, they are entitled to hospice and palliative care. As part of hospice work and palliative medical and nursing care, the physical, psychological/emotional, social, spiritual, and material needs and wishes of the terminally ill are addressed. The aim of this care is to enable the seriously ill or dying person to lead a life that meets their very personal needs and their particular way of dealing with the prospect of their imminent death by alleviating their physical and emotional suffering. In outpatient work, attempts are made to take account of the wish of more than two-thirds of the population to be able to die at home. End-of-life care also includes support for relatives and surviving dependents.

The German Medical Association has drawn up (on February 18, 2011) principles for medical end-of-life care, in which the doctor's options for action are described in detail. According to these principles, the patient's wishes - if possible, specified in advance in a living will - are always decisive and authoritative for all medical measures. Relatives can support medical professionals in determining the patient's presumed wishes if their decision-making capacity is limited or unavailable.

In addition, the German Medical Association has published (on 25.06.2021) guidelines on the medical handling of suicidal tendencies and death wishes. According to this, the doctor's tasks include talking about suicidal tendencies and tiredness of life, providing information, mediation, and offering help in the event of serious illness and death. Assisted suicide, on the other hand, is not a medical task but an individual decision that is not prosecuted under professional law. As far as dealing with death wishes and suicidal tendencies is concerned, the International Code of Ethics for Nurses is decisive for nursing. According to this code, nurses have no duty to cooperate in the case of a wish to end life prematurely.

Help for relatives

The loss of a person, especially through suicide, is a physically and emotionally very stressful event for relatives. As a result of the death, the bereaved can become emotionally and socially unbalanced. There is often an increased susceptibility to illness and - especially in the first few months - an increased risk of suicide. Surviving relatives, therefore, need their support and guidance to help them through this difficult time.

At the end of this information leaflet, you will find contact addresses and contact points that are particularly concerned with the problems of the bereaved. It may be helpful to join a group whose members have suffered a similar loss. Help may also be available from your family doctor's practice, with whom relatives may already be familiar

Technical terms

Palliative Care: It is based on four pillars: palliative medicine, palliative care, spiritual support, and psychosocial support. The focus is no longer on healing and prolonging life but on alleviating symptoms and promoting quality of life. Palliative care can be provided on an outpatient basis at home, in residential communities or care facilities, hospitals, and specialized facilities. If necessary, special outpatient palliative care (SAPV) can be integrated.

Hospice work: Care at the immediate end of life takes place either at home (support by mainly voluntary, trained professionals) or in specialized inpatient facilities (hospice).

End-of-life care: This includes individual medical help to reduce suffering, pain therapy and care, as well as personal psychosocial and spiritual help to ensure care and support, mobilize existing resources, and communicate with words and without words.

Change in treatment goal: Healing and life-sustaining measures are terminated in favour of palliative treatment and care or not started at all.

Assisted suicide: Suicide in which another person provides the means of suicide, which the person who has decided to die administers to themselves

Killing on demand: An act carried out by another person and leads to the death of the person who requested the act.

Legal aids and rules

From the legal point of view, there are several options for making provision for life's end, especially in the case that one is limited in the ability to express one's own will.

Living will, health care proxy, legal guardianship

In a living will, all citizens can specify in writing at any time which medical measures they want or do not want in the event that their capacity for self-determination is impaired. Living wills are binding in Germany regardless of the date of issue unless there are specific indications that the person concerned has changed their mind. Living wills must refer to specific agreement and treatment situations. They must be presented to the attending physician.

To meet these criteria, it is advisable to seek detailed advice from a doctor you trust or from specialist advice centres when drafting a living will. Ethical, legal, and medical issues relating to drafting a living will are dealt with thoroughly and practically in a brochure published by the Federal Ministry of Justice and Consumer Protection (www.bmjv.de).

Relatives or other trusted persons need a power of attorney to act on behalf of the person concerned if they can no longer make decisions on their own and manage their affairs. - In this case, spouses can represent each other in matters of health care for a maximum of six months under certain conditions (Section 1358 BGB).
- The power of attorney can relate to the living situation, medical care, and property matters. It is possible to deposit a power of attorney with a central register of precautionary powers (https://www.vorsorgeregister.de/). Authorities and banks generally only recognize powers of attorney if they have been notarized.

Suppose a person can no longer act independently or manage their affairs. In that case, a guardian can be appointed by the local court (guardianship court) at their request or at the suggestion of another person to manage the person's affairs. In a care directive, you can determine who should take over the care if necessary. The court is obliged to observe this wish. The Federal Ministry of Justice and Consumer Protection provides information on current guardianship law (www.bmjv.de).

Legal rules on suicide prevention and euthanasia

The protection of life on the one hand and free self-determination on the other are the high-ranking ethical principles of our society enshrined in the German Basic Law. With increasing age, and especially near the end of life, these two principles can conflict if the question of the meaning of continued life arises for older persons as their degree of freedom is increasingly and irreversibly restricted. There is no uniform ethical position in our society for evaluating this situation. Several areas still need to be regulated by law and the case law is not yet uniform. Different legal regulations exist in European countries.

The current legal framework in Germany is as follows

- Suicide and attempted suicide are not punishable.
- Section 217 of the German Criminal Code (prohibition of the commercial promotion of suicide) was repealed by the ruling of the Federal Constitutional Court on February 26, 2020.
- Assisted suicide is currently not regulated by law (as of 12.2023).
- Killing on demand is prohibited and punishable.
- Omission or termination of life-sustaining therapeutic measures is permissible under certain circumstances. The aim is to reduce suffering and allow the patient to die.
- The administration of medication to reduce suffering is justified in the final phase of life, even if this means accepting a possible shortening of life. In this case, too, the sole aim is to reduce suffering.
- In German case law, an act of suicide is interpreted as an 'accident'. The primary aim is, therefore, to provide help for survival. Jurisprudence tends to avoid imposing penalties for failure to render assistance in cases of free responsibility.

Contacts

In the event of acute life crises, which can also include suicidal tendencies and suicide attempts, there is a wide range of national, regional, and local contacts and support services that you can turn to. Which facilities and professional groups (e.g., doctors, psychological psychotherapists, counsellors) can be contacted depends on the particular crisis, its urgency, and the care structure and availability of local help facilities.

Nationwide

Deutsche Gesellschaft für Suizidprävention e. V.
(German Society for Suicide Prevention e. V.) DGS Geschäftsstelle,
c/o PD Dr. Gerd Wagner, Klinik für Psychiatrie und Psychotherapie,
Universitätsklinikum Jena,
Philosophenweg 3, 07743 Jena, Germany
E-Mail: dgs.gf@suizidprophylaxe.de
www.suizidprophylaxe.de
Under 'Hilfsangebote' ('Offers of help') you will find the addresses of crisis support facilities in your area. The services of the crisis services are free of charge

Nationales Suizidpräventionsprogramm für Deutschland (NaSPro)
(National Suicide Prevention Program for Germany) www.naspro.de
An expert network that brings people and institutions together for joint suicide prevention activities and coordinates them. Information on objectives, basic data, structure, organization, working groups, and contact options.

Telefonseelsorge
(Telephone counseling)
www.telefonseelsorge.de
Telephone nationwide (toll-free)
0800-1110111 and 0800-1110222

Arbeitskreis Leben e. V. (AKL) – Hilfe in Lebenskrisen und bei Selbsttötungsgefahr (in Baden-Württemberg)
(Working Group for Life e. V. (AKL) – Help in life crises and at risk of suicide (in Baden-Württemberg))
www.ak-leben.de
Here, you will find the contact addresses of the AKL in Baden-Württemberg. The services of the AKL are free of charge.

Deutscher Hospiz- und Palliativ-Verband e. V.
(German Hospice and Palliative Association e. V.)
www.dhpv.de
Under 'Service/Hilfe finden' ('Service/Find help') you will find the contact addresses of the palliative care services.

Deutsche Gesellschaft für Palliativmedizin e. V.
(German Association for Palliative Medicine e. V.)
www.dgpalliativmedizin.de/
Under 'Service' you will find contact addresses and information.

Deutsche Stiftung Patientenschutz für Schwerstkranke, Pflegebedürftige und Sterbende
(German Foundation for Patient Protection for the seriously ill, those in need of care, and the dying)
www.stiftung-patientenschutz.de
Telephone advice under
Dortmund: 0231/7380730
Berlin: 030/28444840
Munich: 089/2020810
Advice, checking and registration of advance care documents/patient directives.

Regionally and locally

First point of contact on site
- Telephone counselling (see above)
- Crisis support facilities (see above)
- Arbeitskreis Leben – Hilfe bei Selbsttötungsgefahr und Lebenskrisen (AKL) (Baden- Württemberg) (see above)

Via the local telephone directory, brochures, Internet addresses (e.g. 'Guide for older people and their relatives' of the municipalities and districts)

Psychosocial facilities
- Geriatric psychiatric advice centers
- Outpatient hospice services (see above)
- Advice centers for older people/senior citizens' offices
- Counseling centers (marriage, family, life issues, addiction)
- Social psychiatric services

In an emergency
- Emergency doctor/rescue service (Tel. 112)
- Fire department (Tel. 112)
- Police (Tel. 110)
- Ambulances at clinics (local telephone directory)

Medical, therapeutic, and pastoral care services
- General practitioners
- Specialists in psychiatry and psychotherapy
- Specialists in psychosomatic medicine and psychotherapy
- Psychological psychotherapists and therapists
- Pastoral counselors (under 'Kirchen' ('Churches') in the local telephone directory)

Help for relatives
- AGUS e. V. – Angehörige um Suizid (– Relatives around suicide)
  Tel. 0921/1500380
  www.agus-selbsthilfe.de
- BeSu Berlin, counseling for suicide survivors and relatives of those at risk of suicide
  https://www.besu-berlin.de/

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Further information on suicide and suicide prevention
Nationales Suizidpräventionsprogramm für Deutschland (NaSPro) (National Suicide Prevention Program for Germany)
www.naspro.de or www.suizidpraevention.de

Deutsche Gesellschaft für Suizidprävention (DGS) (German Society for Suicide Prevention)
www.suizidprophylaxe.de

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Editors
Dr. Uwe Sperling
Prof. Dr. Arno Drinkmann
Heike Kautz M.Sc.N
Prof. Dr. Eva-Marie Kessler
PD Dr. Ute Lewitzka
Prof. Dr. Reinhard Lindner
Prof. Dr. Gabriele Röhrig-Herzog
Dr. Katharina Roscher
Prof. Dr. Barbara Schneider Dr. Anne Schornberg
Prof. Dr. Tillmann Supprian

Previous members
Monika Bauer
PD Dr. Heinrich Burkhardt
Kristjan Diehl
Prof. Dr. Norbert Erlemeier
Daniela Hery LL.M. (MedR)
Prof. Dr. Rolf D. Hirsch
Dr. Peter Klostermann
Dipl. Psych. Silvia Renken
Dr. Sylvia Schaller
Pfrin. Christine Schoeps
Prof. Dr. Martin Teising
Dr. Claus Wächtler
Prof. Dr. Hans Wedler
Prof. Dr. Joachim Wittkowski

Journalistic advice
Manfred Otzelberger, Bayreuth

Translation
Petra Reece, Sprachschule ICH KANN's, Baden-Baden

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NATIONALES
SUIZIDPRÄVENTIONS
PROGRAMM

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DGS
Deutsche Gesellschaft für Suizidprävention

When growing old becomes a burden

Suicide prevention in old age
Suicides are a major health policy and individual problem.
The National Suicide Prevention Program for Germany (NaSPro) is the expert network for the exchange and knowledge transfer on suicide, suicidality, and suicide prevention in Germany. It was founded in 2001 on the initiative of the German Society for Suicide Prevention.

Old people are particularly at risk of suicide. Their life situation can deteriorate so much due to physical and mental stress that they no longer want to continue living. The public takes little notice of this. It is easy to overlook the fact that prevention, crisis support, therapy, and the reduction of suffering are also possible in old age. The aim of the Working Group for Older People is to provide information about the background and signs of suicidal tendencies in old age. It shows ways to help prevent suicidal developments.

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