Do older adults attempt suicide for attention?[1]

Pessoas idosas tentam suicídio para chamar atenção?

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Abstract

This study analyzes part of the results of a multicentric national research that investigated suicidal ideation and suicide attempts in older adults. The text aims to question the so-called "attention seeking" behavior, used by health professionals and families of older patients when referring to their motivation for self-destructive behavior. This qualitative research used semi-structured interviews to thoroughly understand this phenomenon. We analyzed 12 cases of older adults with suicidal ideation and/or suicide attempts and reports from four professionals who expressed their opinion on the "attention seeking" behavior attributed to these patients. The data collected underwent dialectical hermeneutic analysis. The research focused on factors associated with situations faced by older adults, aiming to relate the feelings of those who idealized or tried to commit suicide and the "attention seeking" behavior. As a result, two major analytical categories emerged: attention seeking according to older adults; and attention seeking according to health professionals. The study showed that the connection family members or health professionals establish between "attention seeking" and intent to commit suicide is, in general, very tenuous; rather, it characterizes a proper manifestation that something is unwell in the older adult's life. We found a predominance of common-sense understandings about these facts that have no direct relationship with the desire or intention of self-inflicted death, but represent a difficulty in understanding feelings of isolation and loneliness.

Keywords: Suicide Attempt; Suicidal Ideation; Subjectivity; Older Adults.

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Resumo

Este estudo analisa parte dos resultados de pesquisa nacional multicêntrica que investigou ideações e tentativas de suicídio em idosos. O texto tem como objetivo problematizar a expressão "chamar atenção", usualmente empregada por profissionais de saúde e famílias que acompanham esses idosos para referir-se à sua motivação para o comportamento autodestrutivo. Trata-se de pesquisa qualitativa com emprego de entrevista semiestruturada, em que se buscou compreender profundamente o fenômeno. Foram analisados 12 casos de idosos com ideação e/ou tentativas de suicídio e relatos de quatro profissionais que se manifestaram sobre o comportamento de "chamar atenção" atribuído a esses idosos. O material coletado foi submetido à análise hermenêutica dialética. A pesquisa se ateve aos fatores articulados às situações na vida do idoso, buscando relacionar os sentimentos dos que idealizaram ou tentaram se matar e o comportamento do atribuído "chamar atenção". Como resultado, emergiram duas grandes categorias analíticas: o chamar atenção segundo a percepção dos idosos; e o chamar atenção para os profissionais de saúde. O estudo mostrou que a ligação que, em geral, familiares ou profissionais de saúde estabelecem entre "chamar atenção" e intenção de cometer suicídio é muito tênue, caracterizando-se mais propriamente como manifestação de que algo não corre bem na vida do idoso. Constatou-se o predomínio de compreensões derivadas do senso comum sobre esses fatos que não apresentam relação direta com o desejo ou a intenção de morte autoinfligida, mas uma dificuldade de compreensão dos sentimentos de isolamento e solidão.

Palavras-chave: Tentativa de Suicídio; Ideação Suicida; Subjetividade; Idosos.

Introduction

This article aims to dissect the so-called "**attention seeking**" behavior, often used by family members and health professionals when referring to episodes of suicidal ideation and suicide attempts of older adults.

The expression "attention seeking" has been widely employed in the **Psi-field** (psychology and psychiatry), in normative perspectives inspired by objectivist and instrumental models of care. In health services, professionals commonly refer to inconvenient, agitated, demanding and aggressive patients as people who "seek attention" (Freitas; Borges, 2014).

In clinical practice, it seems to prevail the understanding that "attention seeking" is a way of provoking, manipulating and expressing hostility against an authority, which must be repressed and discouraged by indifference.

The focus on "attention seeking" has existed since pre-psychoanalytic times, when psychiatry adopted rudimentary methods that are considered pejorative today (Foucault, 1977). In its foundation, the psi-clinic described hysteria as a disease that preferably affected manipulative women with emotional control difficulties. In a sense, psychoanalysis revives this concept by giving it notoriety and using it to understand the unconscious acting on the emergence of these symptoms. In psychoanalysis, a privileged theoretical sphere of its formulation, the central idea was that powerful unconscious motives operated behind this presentation, giving it meaning (Breuer; Freud, 1990). "Hysterical" symptoms would then be indirect ways of communicating conflicting contents of the unconscious, that is, of expressing blunt ways of symbolically representing a pain that could not be expressed otherwise. This understanding of hysterical people has been updated in the history of health care by derogatory labels associated with difficult, vehement and demanding patients, giving the word a pejorative meaning (Ávila; Terra, 2010).

On the one hand, the clinical regard unveils a language that requires translation; on the other,

it can paralyze the subject, when appropriated by common sense, understood as simply manipulation and spectacle (Foucault, 2005).

In the present study, the expression "attention seeking" was often repeated in interviews with family members and health professionals and associated with events of suicidal ideation and suicide attempt.

Regarding older adults, the disregard for both the signs they give and the problems they experience can be catastrophic and be associated with a high risk of death. Osgood and Thielmann (1990) highlight that a clear relationship between ideation, attempts and suicide can be perceived from verbal communications, behavioral indicators and other situations that constitute significant warning signs. Additionally, in Brazil, most older adults who committed suicide had attended a health service in the months preceding the act, and were not identified as at-risk patients (Cavalcante; Minayo, 2012). The family, in turn, often notices signs of dissatisfaction, hopelessness and withdrawal from life by older adults, but do not take them seriously. On the contrary, they tend to trivialize complaints as meaningless demands to "seek attention" (Figueiredo et al., 2012).

In the common sense, some attitudes that show ideation or suicide attempt are understood in a detached manner, prevailing the idea that "**who wants to commit suicide, does not give a heads up**." But data on ideation, attempt and suicide related to older adults contradict this statement. Beeston (2006) emphasizes that this age group has a very close proportion between attempts and self-inflicted death, which differs among young people. The author cites data from the United States, where this ratio is 30:1 among young people; in the general population, 8:1; and among older people, 4:1. If an older person talks about ending their life, this must be taken seriously.

Regarding health professionals, the contempt for the older person's manifestations of suffering goes against the concept of expanded or psychosocial clinic, which advocates a fundamental ethical commitment to the one who suffers, by an interactive and comprehensive care (Berenchtein-Netto, 2013).

This article presents a reflection on the various nuances in which the expression "attention seeking" appears in the speech of older adults interviewed about suicide attempts or ideations. It also analyzes the perspectives of professionals working with this age group.

Methodological trajectory

The study is based on the statements of 12 non-institutionalized older adults aged between 64 and 101 years old and four health professionals who participated in a qualitative research involving 60 older adults, "Study on suicide attempts in older adults from the perspective of public health," conducted in 13 Brazilian municipalities between 2012 and 2014 (Minayo; Cavalcante, 2013b; Cavalcante; Minayo, 2015).

One of the objectives of this study was to interview people from two groups – older adults who attempted suicide or had persistent suicidal ideation, and health professionals directly caring for older adults. The present study focuses on the recurrent use of the expression "**attention seeking**" by health professionals and family members, when referring to a supposed motivation for self-destructive behavior.

In this sense, there are some assumptions. According to Debert (1998), "old age," and by affinity "older adult, "old person," are culturally produced categories that refer to universal biological processes distinctly configured in societies, accepted by an institutionalized scientific discourse. This group is heterogeneous in several ways: (1) by age, in which there are those aged 60 to 74, considered young-old; those aged 75 to 84 years, considered middle-old; and the oldest-old, over 85 years old; (2) by gender (women experience the contingencies of longevity differently from men); and (3) by social and spatial living conditions, as authors such as Beeston (2006), Baltes and Smith (2003), Cavalcante and Minayo (2015), Koo, Kõlves and De Leo (2017) recall. Ultimately, each aging process is unique since, as Debert (1998) points out, contrary to the assumptions of developmental psychology, the course of life is not a unilinear sequence of evolutionary steps.

The focus of this article, however, is the intense suffering caused by isolation, family relationships or with health professionals marked by myths and prejudices, regardless of social class, whether the person is a young-old or oldest-old and where they live. As Shneidman (1993, p. 145), father of Suicidology, puts it:

> All efforts to relate or correlate suicide with variables such as gender, age, race, socioeconomic status, or with psychiatric categories such as depression are not sustained because they ignore the only variable that is centrally related to suicide: an intolerable psychological pain, in a word, a **psychache**.

The sociodemographic data of the analyzed sample are shown below.

Chart 1 – Sociodemographic data of the older adults studied

Older adult	Gender	Marital status	Age/ Years	Location
1	male	married	84	Recife
2	female	widow	64	Fortaleza
3	female	widow	82	Recife
4	male	married	66	Manaus
5	female	married	64	Manaus
6	female	widow	71	Recife
7	female	widow	74	Manaus
8	female	married	60	Rio de Janeiro
9	male	married	73	Recife
10	male	married	63	Porto Alegre
11	female	widow	101	Dourados
12	male	married	82	Porto Alegre

The sources used for access to older adults were suicide attempt and ideation data from hospital records, information from professionals working in Primary Care and managers of Long-Stay Institutions (LSI).

The empirical work favored interviews and informal conversations with older people who were contacted via letters, phone calls and scheduled visits, with or without mediation by health professionals. Qualitative data were collected using an interview script – developed from the knowledge brought by national and international literature (Cavalcante; Minayo, 2015). This instrument of support to the interviewers began with the demographic and social characterization of the older adults and their families and favored aspects of their experiences: information about their way of life; assessment of the environmental atmosphere that preceded suicide attempts and the older adult's mental state before this event; assessment of the situation according to the degree of risk; impacts of the event on the health of the older adults and their families. Context elements such as the social characteristics of the localities where these older adults live were also collected and articulated with the experiential information.

The data discussed here were collected to understand the specificities of the situation of those who attempted suicide or had persistent suicidal ideations, from their own point of view and from the perspective of professionals involved in their care. The expressions analyzed in this article, attributed to the families, derive from the report of older adults and professionals.

From a floating reading of the interviews conducted, those that mentioned feelings or situations consistent with the expression "attention seeking" were highlighted. The cases underwent a process of comprehensive, interpretative, comparative and critical analysis, in a hermeneutic and dialectical perspective (Geertz, 1989; Minayo, 2015), based on the participants' statements. Each statement was identified by the group to which the older adults or the professional belonged, including information on gender, marital status and age for the former; and the profession and place of work for the latter.

We structured the discussion around two analytical categories emerging in the interpretative process around the expression "attention seeking": the perspective and experience of older adults; and the perspective and experience of health professionals.

The research project that originated the data was approved by the Ethics Committee under CAAE number 16283613.4.0000.5240, meeting all the requirements provided for in the Resolution of the National Health Council (CNS) no. 466/12. All study participants signed an informed consent form. Vulnerable participants were referred to reference services for follow-up and specialized care.

Results and discussion

For the older person, what does "attention seeking" mean? The answer to this question is offered in two topics that analyze the set of messages that older adults convey with their gestures: (1) their complaints regarding family members; and (2) what they say publicly in cases where attempts occur in the public space, in plain sight. In both cases, the event affects the family microcosm, the community and society. In this sense, Berenchtein-Netto (2013, p. 20, our translation) states: "we are talking about suicide in a society [...] deeply marked by oppression, inequality, competitiveness and individualism." Whether in the private or public spheres, taboo and prejudice against old age prevail, restricting the space and environment for older adults to talk about themselves, their desires and even their will to die. Regarding the studied health professionals, they appear unprepared to listen and deal with people in situations of intense psychological distress, such as suicidal behavior.

What it means to "seek attention" according to the older adults interviewed

For an older person, "attention seeking" occurs when they find that their feelings, their presence or their speech fall into a void of meaning in their social environment, as seen in the speech of an interviewee: *I did this foolish thing* [suicide attempt] *because I despaired, because no one believed in my pain and not even the doctor knew what I had* (man, married, 84 years old). Older adults do not explain their act as something designed to "seek attention," but to express their feeling of despair at not being seen, heard and understood. It speaks, rather, of a person calling for recognition and denouncing total lack of empathy (Molon, 2011). Below are several examples of how this lack of understanding of the older adult is linked to suicidal behavior. We must clarify that, in general, older adults do not use the expression "attention seeking," employed by family members and health professionals. On the contrary, they see it as a symbolic violence that shows contempt and humiliation before their experience of deep suffering. What the older adults' statements suggest is their desire to be close, to participate, to share and to be recognized.

The literature points out that home is where most suicidal acts and behaviors of older adults occur (Minayo; Meneghel; Cavalcante, 2012). In the interviews, many said that they look for places where they can be alone and away from the eyes of family members. However, if they do not want to be pestered, they are deeply affected by the verbal abuse and contempt they are victims of. Sousa et al. (2014) points out that, in the different verbalizations of older adults about their situation, declarations on the desire to die is the first to emerge – which is generally disregarded, especially when said during family discussions. However, these statements may culminate in suicide, as seen in Conwell and Thompson (2008), Minayo and Cavalcante (2015) and Cavalcante and Minayo (2015).

The following statements point to some elements they complain about, such as contempt, neglect, impatience, speech disregard and isolation. *Sometimes I think my kids do not love me. How I wish they loved me! I love them so much! They are very important to me. But they do not even see me! I do not know if it is concern for their families* (woman, widow, 64 years old). In cases like this, it is clear the secondary and lonely place older women occupy at home, which is corroborated by another interviewee: *they could have more patience*

with me, give me more attention (woman, widow, 82 years old). In other words, many older people consider that when it comes to getting back the investments made on their children, they are left with nothing: *I worked hard, had two pulmonary emphysemas and two tuberculosis working in a bakery oven to get things for my children. But now that I need them, they do not remember me, they do not remember their father* (man, married, 66 years old).

In conflicting homes, some older adults create strategies in search of a place of respect and recognition, while others succumb. In the first situation, we have an interviewee who plays a passive-aggressive role towards her domineering daughter: *I stand there acting like a fool, so that she treats me well* (woman, widowed, 74 years old). "Playing the fool," although a form of concealment, shows resistance against the family's aggression. Another situation concerns an old woman accused by her granddaughter of taking money from her father. The interviewee lives alone in a small house at the back of her son's backyard, being able to only do household chores. Psychologically abused and visually impaired, she reports that her will to die is very strong. Her suicidal ideation, although considered a way to "seek attention" by her daughter-in-law and granddaughter, expresses her social isolation.

In cases of older adults with chronic and degenerative diseases, the family, tired of their complaints, often becomes hostile and ironic, even in the face of imminent risk of death. *My son teases me:* '*dad, you, at 84, have only a bad leg. I am in my mid-40s and my whole body hurts.*' (man, married, 84 years old). It is a way of disqualifying the other's speech and interpreting their experience as something trivial, silencing them. One interviewee pointed out that, after recovering from a suicide attempt, one of his children said to him: *'old man, watch out, try not to screw things up!'. They* [the children] *did not take what I did seriously* (man, married, 84 years old).

A frequent misunderstanding surrounding older adults is the belief they are all naturally depressed. This prejudice naturalizes the physical and psychic suffering associated with suicidal behavior, belittling such a serious act by several facetious expressions found in their statements: *it is manipulation; it is just for attention*; *he has no reason to be like this*; *if* [the person] *really wanted to*, *they would have done it by now.*

Another form of misunderstanding is a kind of tenderness from afar. An interviewee from Manaus, for example, described her children as very attentive, because they constantly monitor her movements, calling her cell phone, asking where she is. But she remarks that, in actuality, they are unwilling to listen to her and have no patience with her complaints:

> *I do not have great friends who I can talk to, and then* [I should talk] *with my daughters. When I try to talk, they are like, 'Oh mom, you are causing trouble! You are thinking about something you are not supposed to.' So, I avoid even saying anything.* (woman, married, 64 years old)

This woman's case is emblematic, because to the contempt of her children is added her husband's sexist views. According to her account, the only time she was able to externalize her feelings, her husband unauthorized her in front of their children: *'oh, do not listen to your mother.'* Desperate, she threatened, '*then you will see what is going to happen next week! You will come in here and have a surprise*' (woman, married, 64 years old). With her feelings repressed, she spent several days thinking and looking for the things she would need to hang herself: the tree, whether the branch would support her weight, the rope, and the best occasion. Fortunately, her intent did not go beyond persistent ideation.

In the study that originate this article, public suicide attempts are less common in the participants' statements, but still remarkable. Some made a point of using public places, aiming to draw people's attention:

> *I lay down on the train line, the train beeping, I wanted to get up, but I could not. Then came a gentleman* [to help me]*, and my husband did not know what to do. Then this gentleman pulled me up. As soon as he pulled me out, the train passed.* (woman, married, 68 years old)

The same person described another attempt: *I ran away! That was when four cars stopped there on that track where there is a crossroads. They stopped and I stood in the middle, then a gentleman got out of the car and removed me* (woman, married, 68 years old).

Spectacular behavior is a form of eloquence that result from at least two processes: the subject's disconnection with their environment at that very moment; or exhaustion of the ways of translating the loneliness experienced, the misunderstood feelings and the foiled desires. Excluding the possibilities of communication, this type of gesture is a last cry for help, as shown in the reports.

The loneliness and isolation older adults suffer and complain about affect their mental health and increase their death-drive. According to Elias (2001, p. 8), several issues can cause the suffering of older adults, such as feelings of decay, social isolation, distancing from friends and family members:

> Their [older people] frailty is often enough to sever the aging from the living. Their decline isolates them. They may grow less sociable, their feeling less warm, without their need for people being extinguished. That is the hardest thing – the tacit isolation of the ageing and dying from the community of the living, the gradual cooling of their relationships to people to whom they were attached, the separation from human beings in general, who gave them meaning and security.

Similarly, in a wide literature review, Minayo and Cavalcante (2015) found that social isolation and loneliness are the main predisposing factors to suicidal behavior, being corroborated by Conejero et al. (2018). Agreeing with Shneidman (1993), these authors point out that suicide is always associated with an intolerable psychic pain that includes shame, guilt, humiliation, loneliness, fear and anger – feelings that derive from foiled essential psychological needs.

Gutierrez, Sousa and Grubits (2015) found older people who expressed a desire to die due to the loss of power and the place socially constructed in adulthood; the inability to emotionally process the absence of loved ones; difficulties in dealing with the lack of gratitude from family members; and a sense of uselessness at this point in life. Minayo and Cavalcante (2013a) analyzed the issue by gender, identifying that older women resent above all their family members' disinterest in their needs, the mental inadequacy to the limitations imposed by aging, the infantilized treatment received at home or in long-term institutions, and the feeling of loss of social function. As for men, the important factors reflect the fall in patriarchal power, retirement – which affects the fading of relationships built during life –, family conflicts and degenerative diseases, especially those affecting their sexuality (Minayo; Meneghel; Cavalcante, 2012).

In short, the absence of listening summarizes social isolation. Thus, we must reflect on what Gadamer (1999) defined as the core of the human being: one's ability to put oneself in someone else's place. This should constitute the attitude of both family members and professionals, but it is what is often lacking in relationships among generations and on the part of those who care for older adults. That is, many older people suffer and lose the meaning of life because those who care for them act as if their existence no longer matters: the living interrupt older people when they try to explain things, speak for them, talk about them and act as if they are not present.

Authors such as Almeida (2010) use the concept of "social death" to refer to situations in which older adults no longer have a voice in the world. This devaluation, in practice, tries to erase their autonomy, independence, their will and their desires. Excepting cases in which older adults have enough moral strength to defend their biography and remain open to a field of social possibilities and actions, even when aging brings several limitations minimized by will and resilience. For older adults who attempt suicide, social death usually precedes self-inflicted death.

Faria, Santos and Patino (2017), reflecting on Elias' (2001) work, state that the negative stereotype attached to older adults also stems from their difficulty of accepting their own condition, the signs of aging, the limitations imposed by disease, the

body's deterioration and social losses. According to the authors, most demographically young societies have an even greater tendency to see aging as something undesirable, marked by dependence, exclusion and stigmatization. They highlight, however, that all societies present the phenomenon of **repression of death and finitude**, expressed in many rites of passage or by simply avoiding and denying the topic.

The study that originated this article found a lack of social spaces for older adults who attempted suicide to transform their problems into something positive. But this can occur sometimes. Silva et al. (2015) point out that this event invariably causes great agitation in the core of primary relationships. In some cases, it mobilizes people to remedy the damage, showing a deeper and more active interest in older adults who attempted suicide, which results in a transitory or permanently improved intersubjective relationship. In others, the fact even promotes greater family union. The case of an older person who lived alone exemplifies this situation: despite having four children and six grandchildren, he spent his days aimlessly, sitting in front of his house. After attempting suicide by medication overdose, his children began to visit him regularly, control his medication and worry about his health, seeking support from a Community Health Agent. The support received, according to his testimony, has been important to lessen the feelings of sadness and loneliness. Similar is the story of a man who lived alone for 10 years after widowhood, until the day he jumped from the roof of his house. After this episode, his eldest daughter and a grandson began checking on him daily. Both cases show that, if, on the one hand, suicidal gestures constitute a cry of hopelessness in contexts of strong lack of emotional control; on the other, this extreme act may entail an opportunity to resume lost bonds and autonomy. This second option, however, is less frequent.

The meaning of "attention seeking" to Health professionals

In healthcare, common sense prevails when it comes to caring for older adults. According to Ramos and Lima (2003), the intervention tends to be restricted to a focal "treat and street" care, without understanding the person's context and network of relationships. In this context, the idea that a plaintiff or multi plaintiff older person wants to "seek attention" presents itself as an obstacle to care. A pejorative view is thus internalized, as a result of ignorance of the situations experienced by older adults. The same social stereotypes that shape many families mentality about older adults affect health professionals, when unprepared to treat this social group. One of them is the idea that older adults "are sad by nature":

> *We already know that older adults are sad by nature. And they hide it from the family. So, the family thinks the older person is isolated, that they are sick. It never realizes that they can enter a depressive process and does not believe they can come to do it* [kill themselves] *because they are just like that.* (Psychologist, Psychosocial Care Center [Caps])

The idea of "**nature**" appears in many statements. Felipe and Sousa (2014), when resuming Debert's reflections (1997, 1998), highlight old age as a social construction, historically defined mainly by scientific discourse and the interests of consumer society. Thus, prejudice emerges as natural, accompanying the evidence of physical and sometimes psychic limitations, without distinguishing what is age-related and what is a social barrier created to prevent the free expression of feelings, creativity and possibilities. This is what the Statute of the Older Adult (Brasil, 2003) and the so-called Madrid Declaration (ONU, 2002), which advocate a society for all ages, call attention to.

Another common stereotype among health professionals treats older adults as difficult, burdensome and manipulative human beings. Although many health professionals are aware that some behaviors can be classified as suicide attempts, they explain it as acts to monopolize care, magnify problems and "seek attention." Thus, physicians and other professionals neither question

older adults about the motivations associated with their desire for death nor take them seriously, which contradicts World Health Organization (WHO) guidelines (WHO, 2002, 2014).

The medical approach, usually a drug therapy, often incorporates in the clinical practice a type of moral and prescriptive treatment, full of prohibitions, instead of presenting positive and preventive proposals. Such was the case of a man shortly after being hospitalized for attempted suicide. The psychiatrist who treated him called the man's children and informed them of the diagnosis by saying: *'he has personality and behavior disorder.'* He explained, in simple terms, that this disorder led the man to a complete manipulative behavior. From then on, the children stopped seeing their father as someone who inspired care due to memory impairment, disorientation, speech problems, but as a manipulator who required increased attention. When asked, the man complained: *I do not know why my children turned on me. I lived more than 50 years with my wife, I miss her and today I am lonely* (man, married, 82 years old).

As in the example cited, mistaken or inadequate medical information can activate feelings of hostility and contempt in families, particularly in cases where the older person has a difficult, conflicting temperament and shows great affective deficiencies. This type of situation shows that the ignorance of the WHO guidelines prevails among physicians – so respected by family members –, who disregard the statements of someone who wishes to die or wants to kill themselves (WHO, 2002). A point that must feature in the treatment of professionals and in the information given to families is the association of the problems caused by isolation, the absence of comprehensive relationships or the presence of prejudices related to depression – a phenomenon that appears in almost all cases, as a primary or secondary diagnosis of suicidal ideations and attempts. The association between depression and the feeling of social isolation that is manifested in "attention seeking," particularly when combined with multiple comorbidities, aggravates the risk of suicide in older people (Cavalcante; Minayo; Mangoes, 2013).

In emergency services, a person's failed suicide plan, which leaves gaps for rescuing, is often criticized as a behavior to "seek attention," "waste public resources" and "wear of health teams." Proposals for secondary prevention in general are nonexistent and disregarded, as if outside the medical duty and absent from recommendations of the Ministry of Health (Brasil, 2004, 2013) and the WHO (WHO, 2002).

The omission of care is such that one interviewed psychologist remarked: *the professional usually thinks: the person has already reached this age, so why should I ask? They have not killed themselves to this day! Why am I going to try and detect this now?* (Psychologist, Caps). Health professionals not only ignore the risks associated with this stage of life, but they also disregard international recommendations, which asserts the professional's duty to guide older adults and their families (WHO, 2014).

The study found some professionals with a comprehensive vision and committed to the old person, particularly listening to them. On the topic, an interviewee said:

> *Everyone has their problems, but it is so good when you are treated by a doctor who is attentive, who just by looking at you knows that you are distressed, gives affection, attention, tells us to sit, takes our hand, looks into our eyes, makes small talk to assess our mental state.* (woman, widowed, 71 years)

Unfortunately, the humanized approach is something much more personal than institutional. Such is the case of a health agent praised by one of the interviewees: *the community health agent is the kindest person. She always comes by to see how I am doing, if I am taking the insulin right, she has been my community agent for 16 years* (woman, widowed, 71 years old).

There are profound deficiencies in the training of the different types of professionals who treat older adults and, in particular, those who care for patients with suicidal behavior. Regarding the reality of the services, a professional remarked that *for suicide attempts care is already low, for cases involving older people it is minimal,*

minimal, minimal! (Psychologist, Caps). Another professional added: *besides the lack of training for a correct diagnosis, there is no orientation on the flow to be followed regarding suicide attempt* (Psychologist, Caps).

> *In such cases, the person should be referred to the Caps for risk assessment. But most of the time this does not happen, either because health agents tend to interpret the act with contempt, assuming that 'it is for attention'; or because the professionals of the Basic Health Units lack the courage to approach such topic, since they see it as a 'hot potato'; or even because the diagnoses are ineffective in the other services.* (Psychologist, Caps).

However, the correct referral and treatment would protect older adults, giving them a chance to rethink their conduct, even if there are cases where nothing effective can be done to prevent someone from committing suicide. Officially, the mental health policy lacks specific guidelines for the care of older adults. When treated, they have their age-related specificities ignored, although there is no lack of practical references for the care of this population, made available by the WHO (WHO, 2002, 2014).

We conclude that institutionalized power relations in health services and families often contribute negatively to the comprehensive care of older adults at risk of suicide. Even in high-risk cases, where many physicians usually prescribe hospitalization, we have alternatives to preserve or improve the affective bonds of older adults. Hospitalization, or even continuous outpatient care, should occur as a last resort. If an older person usually considers themself useless or a burden, increased frequent visits to the doctor with a family member reinforces this feeling, as we see in the report of a professional to whom an patient had complained: *look, see what you did, now my son will be even more mad at me, because he will have to bring me here several times* (Psychologist, Caps). Rather, health professionals should make home visits and have a follow-up plan, particularly for those at higher risk.

The training of health professionals is a critical aspect when thinking about improving care for older adults. In a recent study, Silva Filho and Minayo (2018) observed that medical schools hardly discuss the topic and some medical residency programs do not even address it. The challenges for the health system are vast: (1) lack of training and knowledge about this stage of life and the issues of suicide, prevention, therapeutic management and risk assessment; (2) lack of access to specialized treatments and reference services in most locations; (3) presence of ingrained stereotypes and prejudices against older people; (4) prevalence of technical views that reduce aging and suicide to biological phenomena or common sense.

As Minayo (2008) advises, we must criticize the pseudo-objectivism of the techniques; develop intersubjective exchanges with people, understanding them as full social beings; offer care that includes the human experience of older people; understand them in their biographical and social context; and focus on the truth produced by face-to-face encounters.

Final considerations

This article addressed the behavior of older adults who plan or attempt suicide, often considered by family members and health professionals as an "attention seeking" strategy. Yes, it is for attention, but with another connotation, which requires being interpreted as a cry for help, a desperate way to mobilize a social environment that is indifferent to their needs. According to Shneidman (1993), the feelings expressed by the interviewees who considered themselves isolated, abandoned or misunderstood do not resist sociodemographic differentiations when hearing the concrete cases. Interestingly, of the 60 older adults who composed the main research, 12 reported discomfort with the concept of "attention seeking" and, in this subset, we have an even number of men and women, age cuts are more or less balanced as well as the distribution of marital status.

Both the family environment and the health services that treat older people show a lack of

knowledge about the process that leads to self-inflicted death, often the object of taboo, prejudice and silence. The difficulties add up because older people are often victims of contempt, neglect, impatience, speech disregard and social isolation.

In Brazilian society, the idea that suicide should stay out of the debates and training of professionals also prevails. Being a taboo, to desire death is always disturbing. In older adults, this desire questions their whole life and that of their families. Those close to them tend to erase the idea or disregard it. Such behavior means that those who are suicidal have no room to speak and be heard – and when they do, they usually become victims of ironies, being accused of seeking attention.

Invest in the training of health professionals is crucial to change this situation. With the growth of the older population, it becomes increasingly important to know the peculiarities of this group, aiming at its quality of life and adequate care. This approach requires criticism and relativization of the biomedical model and investment in comprehensive care, expanding listening to the various dimensions that singularize the human experience. For a professional who listens to an older adult (excepting cases of dementia or other disabilities), everything they say and confide is pertinent and relevant. Their speech has an existential truth that needs qualified interlocutors. Only when recognized as a subject, in a welcoming context, does the individual find their place in the world.

In situations where older people's suffering was listened to with respect, the chances of their death wish being replaced by the desire to live increased, bringing positive changes for them and their families. We must demystify the use of the expression "attention seeking" both by family members and health professionals, denouncing its destructive power in intersubjective relationships and its disrespectful nature to older adults and their suffering.

The critical reflection on the processes discussed here highlights the need to talk (and not be silent) about the topic of suicide and follow the paths already proposed by international health policies for promoting care to older people in a state of physical, mental and social suffering; the best way for them not to plan or try to anticipate their death.

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Authors' contribution

All authors collaborated to data collection and analysis, manuscript writing and revision. Minayo conceived the study and coordinated its implementation.

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