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**STUDIES IN LOGIC, GRAMMAR AND RHETORIC 64 (77) 2020**

DOI: 10.2478/slgr-2020-0040



# Communicating with Elderly People in Suicidal Crisis in the Light of Helpline Worker Experience

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**Abstract.** The increase in suicidal behaviour among elderly people makes it necessary to take action in the field of broadly understood prevention. This includes helplines, which play an essential role in anti-suicidal measures. The aim of this study was to obtain information about the experience of Polish helpline workers in communicating with older people in suicidal crisis. The study was conducted among 106 helpline workers from various helpline centres across Poland. It proved that helpline workers in Poland have considerable experience in communicating with elderly people in suicidal crisis, albeit the majority of respondents feel they need additional training in the area of broadly understood suicidology.

## Introduction

In recent years, both in Poland and in other countries in Europe, there has been an increase in the elderly population (Hołyst, 2012). Older people experience many stressors related to solitude or a sense of loneliness, as well as somatic and mental conditions. The number of suicides or suicide attempts is growing among people aged over 65 (Hołyst, 2012). Subsequently, a major concern is to provide effective suicide prevention. This includes pre- and post-suicidal prevention, dedicated helplines being one of the methods. An example of research in this area is a study carried out in Italy based on the British Telehelp/Telecheck support line, used by 18 thousand people over 80, the majority of which are women (84%). A positive trend in suicide dynamics in this age group has also been observed (Conwell et al., 2011), for example in the United Kingdom, where old people are keen to use helplines (Catton et al., 2010; Preston & Moore, 2019).

The paper describes communication with older people in suicidal crisis based on a study conducted among helpline workers.

***Characteristics of suicidal behaviour in elderly people in the light of suicidology literature.*** Analyses of the motives of suicidal behaviour in elderly people should not ignore their often altruistic nature, for example, the desire to relieve family members involved in providing time-consuming care or the desire to obtain funds from insurance companies to help their relatives (Czabański, 2009). However, among the important motives, there are also those of egoistic or anomic nature. These include the desire to escape from physical pain, the fear of effects of progressive, incurable diseases, familial conflicts, or fear of social isolation; the desire to escape from financial problems (e.g. caused by unpaid debts or insufficient money to cover living expenses), and addiction problems (e.g. alcoholism, which is especially widespread among American seniors).

One can observe that suicidal behaviour in older people can be triggered when they evaluate their lives and conclude that they have not achieved anything and are surrounded by nothing but problems. In this situation, such a person will likely engage in suicidal behaviour.

As far as self-destruction methods are concerned, in the United States, old and very old people frequently use firearms to shoot themselves in the head (Frieson, 1991). American research shows that 71% of suicides among older people are committed this way, with elderly men using this method twice as often as women (Conwell et al., 2002). The research also demonstrates that elderly women often commit suicide by poison (33% of cases), whereas only 3% of men use this method (Beatrais, 2002; Salib & Green, 2003). In Poland, older people usually commit suicide by hanging.

Some authors draw attention to the phenomenon of ISDB (indirect self-destructive behaviours). ISDB includes behaviours such as avoiding eating, drinking or taking medications, which often lead to an elderly ill person's death (Osgood, 1992; Szanto et al., 2006). These types of behaviour are often described by carers in nursing homes. They are not usually regarded as suicidal acts, although many cases show the characteristics of suicide.

One should note the existence of factors which increase the risk of suicidal behaviour in elderly people. These include somatic diseases, chronic pain, dementia or Alzheimer's disease, schizophrenia, and addiction to alcohol or other psychoactive substances.

Another prevalent factor is social isolation which encourages self-destruction among older people. Some authors also emphasise risk factors such as a sudden change in the marital status (i.e. death of a spouse/partner) or helplessness in everyday life (Baumann, 2008).

Furthermore, research shows that hospitalisation (often recurring) may significantly increase the risk of suicidal behaviour in older people. This is

likely caused by fear of the consequences of a developing medical condition and the fact that hospitalisation is a highly traumatic experience for many elderly people (Karvonen et al., 2008). In this respect, an interesting study was performed in Denmark by a research team under A. Erlangsen. Between 1996 and 1998, Erlangsen examined the lives of all Danes aged over 52 years. The study showed that during this period, 1184 respondents committed suicide. Subsequent analyses proved a correlation between hospitalisation and a higher risk of suicide. The highest threat was observed among men over 80 who had stayed hospital during the studied period (113/100,000 in comparison to the remaining population of 80/100,000) (Erlangsen et al., 2005).

It should, however, be noted that the most significant risk factor of late-life suicide is related to depression. A study conducted by Y. Conwell showed that 76% of older suicide victims suffered from some form of mental disorder, including 54% with severe depression and 11% with milder depression (Conwell et al., 2002). Studies conducted between 1991 and 2001 in people who engaged in suicidal behaviour showed that between 71 and 91% of suicide victims aged above 65 suffered from mental disorders before they died. In most cases, these were depressive disorders (Tsoh et al., 2005). These correlations were also confirmed by studies in elderly populations in Asia. Further studies concerning the correlation between the older age of suicide victims and depression were conducted by K. Suominem and N. Sachs-Ericsson (Sachs-Ericsson, 2006; Suominem et al., 2004).

Research carried out among older people reveals strong correlations between alcohol abuse and suicide. In Sweden, Belgium, and Portugal, the suicide rates in persons aged between 50 and 69 significantly correlate with the level of alcohol consumption. This also concerns older women, but only in Belgium and Denmark (Ramstedt, 2001). Moreover, there is a correlation between alcohol consumption and the suicide rate in women in the western federal states in Germany. Similar correlations concern older men in France. These findings are also confirmed by other studies (Blow et al., 2004; Pfaff et al., 2007; Pompili et al., 2010).

It should be stressed that women and men display different types of behaviour in relation to various crises. In general, women are more likely to ask for help than men and seek other people's advice in the face of problems. Men, on the other hand, are less inclined to ask for help, which is most probably related to a higher rate of suicidal incidents among them. Moreover, women seek medical treatment more often and more regularly than men, which increases the chance of diagnosis and recovery from disorders. These factors affect the current suicide rates among older men and women. Besides, the findings of Conwell et al. also show that suicide is more prevalent

among older widowers than widows. According to American data, among widowed people aged over 65, men are twelve times more likely to commit suicide than women (Conwell et al., 2002).

An important concern in the field of late-life suicide prevention is diagnosing the risk level. This is difficult for two reasons:

- Older people hide their suicidal intensions and usually plan the suicidal act considering all the possible details.
- The determination to die is much stronger in older people than in younger people.

Subsequently, it is of key importance to develop measures in the field of pre-suicidal and post-suicidal prevention.

***Helplines in Poland.*** Helplines in Poland date back to 1967. The first helpline began operating in Wrocław on the initiative of A. Bukowczyk. The helpline was run according to a professional model, i.e. assistance was provided by psychiatrists. The second helpline was established the same year in Gdańsk by T. Kielanowski. It was run according to a community-based model. The volunteers on duty included doctors, psychologists, teachers, lawyers, academic teachers and researchers, actors and artists, office workers, and homemakers (Kicińska, 2010).

In 1990, the Polish Society of Telephone Assistance was established. The same year, the association began publishing a magazine entitled *Nasza Gazeta – Telefon Zaufania* (Our helpline magazine) (Kicińska, 2010). Currently, there is a whole range of helplines in Poland run by both professionals and volunteers. In many Polish cities, helplines are based on both the professional and community-based models (Kicińska, 2010).

Research exists that shows the specifics of communication functioning within the operation of helplines. A feature of this communication is the anonymity of both parties and its non-visual character (Kicińska, 2010; Preston & Moore, 2019). Of note is the fact that communication is often disrupted, especially when the caller is an older person.

## Materials and Methods

The study included 106 helpline workers from various centres across Poland. The study was conducted in 2017 based on the questionnaire technique. The questionnaire included both closed- and open-ended questions. Hence, the analysis was both quantitative and qualitative (the latter based on responses to the open-ended questions).

The aim of the study was to obtain information about the experience of Polish helpline workers in communicating with older adults in suicidal crisis. Another objective was to identify the barriers in such communication, as well as the coping methods of helpline workers dealing with older people with suicidal thoughts. Furthermore, it was essential to determine the respondents' needs (if any) for training in suicidology.

The analysed data was expressed as median, minimum and maximum values, interquartile ranges, or percentages, as appropriate. A comparison of two unpaired groups was performed using the Mann–Whitney U-test. Categorical data was analysed with the $\chi^2$ test, and the relationship between variables was analyzed with Spearman's rank correlation coefficient. All results were considered significant at $p < 0.05$. Statistical analyses were performed with STATISTICA 13.0 (StatSoft Inc.).

## Results

The study conducted on helpline workers in Poland was innovative. So far, suicidology literature in Poland has not dealt with the issue of helpline workers' communication with elderly people in suicidal crisis.

The study was conducted on 106 respondents (64 women and 42 men). The analyses considered the helpline workers' length of service (Table 1, Table 2).

**Table 1. Helpline workers' length of service**

| Code | Length of service | Number of respondents | Percentage |
|---|---|---|---|
| 1 | Under a year | 29 | 27.3% |
| 2 | Up to 2 years | 18 | 17.0% |
| 3 | Over two years to 3 years | 15 | 14.2% |
| 4 | Over three years to 4 years | 14 | 13.2% |
| 5 | From over 4 years to 5 years | 14 | 13.2% |
| 6 | Over 5 years | 16 | 15.1% |
| Total | | 106 | 100.0% |

The majority of respondents had experienced communicating with an older person in suicidal crisis ($n = 86$; 81.1% of respondents). The numbers of respondents with such experience in the groups of women (79.7%) and men (83.3%) were similar ($p = 0.639$). This shows that there is no

**Table 2. Length of service in relation to the experience of communication with an elderly person in suicidal crisis**

| Length of service | Experience – instances of communication | Percentage in the respective 'length of service' group |
|---|---|---|
| Under a year | 11 | 37.9% |
| Up to 2 years | 16 | 88.9% |
| Over 2 years to 3 years | 15 | 100.0% |
| Over 3 years to 4 years | 14 | 100.0% |
| Over 4 years to 5 years | 14 | 100.0% |
| Over 5 years | 16 | 100.0% |
| Total | 86 | 81.1% |

correlation between the respondents' gender and their experience in communication with an elderly person in suicidal crisis ($p > 0.05$).

The analyses also included the length of service and the frequency of communication with an elderly person in suicidal crisis according to the respondents' gender. There were no significant differences ($p > 0.05$) between men and women as far as the length of service ($p = 0.731$) and the frequency of communication with an elderly person in suicidal crisis ($p = 0.215$) were concerned.

The median for the length of service in each group, as well as in the whole group, was between over 2 years to 3 years. Both groups included respondents with a minimum length of service of under a year and a maximum length of service of over 5 years.

The median for the frequency of communication with an elderly person in suicidal crisis in the whole group of respondents, as well as in the groups of women and men, was between 2 and 5 times a year. In both groups, some respondents had had no experience in the area. Among women, the maximum frequency of communication was 12 times in year, whereas in the group of men, the frequency was even higher at 12 times a year.

The majority of respondents provided support to elderly people in suicidal crisis more frequently than 2 to 4 times a year or more frequently than 6 to 11 times a year (Table 3). Hence, most respondents had multiple experiences of communication with an elderly person in suicidal crisis.

The study showed a significant correlation ($p < 0.05$) between the length of service and the frequency of communication with an elderly person in suicidal crisis ($p < 0.001$). This is a meaningful positive relationship ($r = 0.72$), i.e. the longer the length of service, the higher the frequency of communication with an elderly person in suicidal crisis.

**Table 3. Frequency of communication with an elderly person in suicidal crisis**

| Code | Frequency | Number of respondents | Percentage |
|---|---|---|---|
| 1 | No experience of communication with an elderly person in crisis | 20 | 18.9% |
| 2 | 1 experience a year | 18 | 17.0% |
| 3 | 2 to 5 experiences a year | 26 | 24.5% |
| 4 | 6 to 11 experiences a year | 22 | 20.8% |
| 5 | 12 experiences a year | 12 | 11.3% |
| 6 | Over 12 experiences a year | 8 | 7.5% |
| Total | | 106 | 100.0% |

This is confirmed in the subsequent comparison of the length of service in relation to the frequency of communication with an elderly person in suicidal crisis between respondents divided into two groups according to their declared experience of communicating with an elderly person in suicidal crisis.

The length of service of respondents with experience of communication with an elderly person in suicidal crisis ($n = 86$) and of those with no such experience ($n = 20$) differed significantly ($p < 0.001$, Figure 1). The length of service of respondents with experience of communication with an elderly person in suicidal crisis was longer (median = over 3 years to 4 years) than that of respondents with no such experience (median = under a year).

The frequency of communication with an elderly person in suicidal crisis also differed significantly ($p < 0.001$) between respondents with experience of communication with an elderly person in suicidal crisis (median = 2 to 5 times in a year) and those with no such experience (median = 1 time a year). The frequency of communication with an elderly person in suicidal crisis was higher in the group of respondents who declared experience of communication with an elderly person in suicidal crisis (Figure 2).

Another aspect of the analysed data was the information concerning the respondents' additional training needs in the field of suicidology.

An analysis of the length of service between respondents with additional training needs in the field of suicidology ($n = 89$) and those with no such needs ($n = 17$) demonstrated significant differences between the groups ($p < 0.001$, Figure 3). Respondents with training needs were characterized by a shorter length of service (median = up to 2 years) than respondents with no such needs (median = from over 4 years up to 5 years).

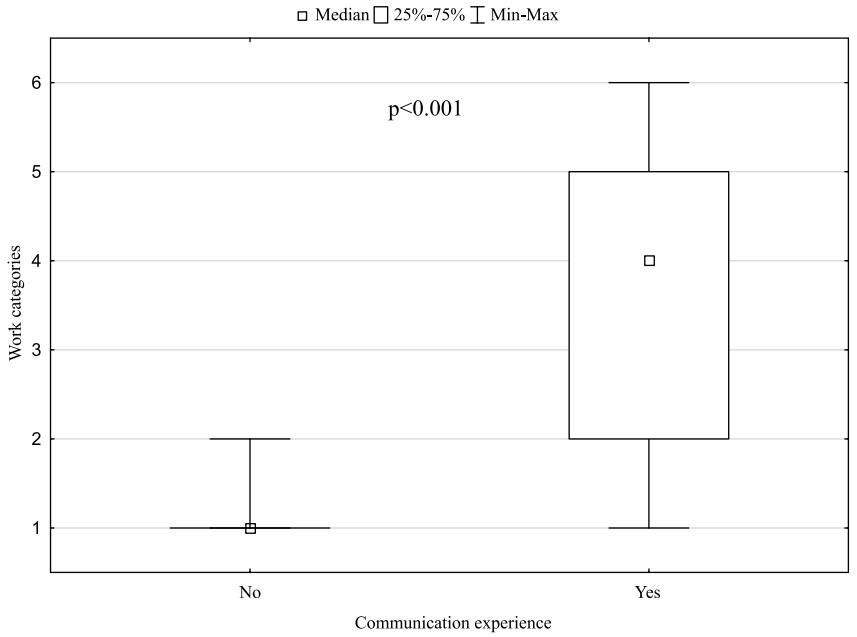


**Figure 1. Length of service according to the declared experience of communication with an elderly person in suicidal crisis**

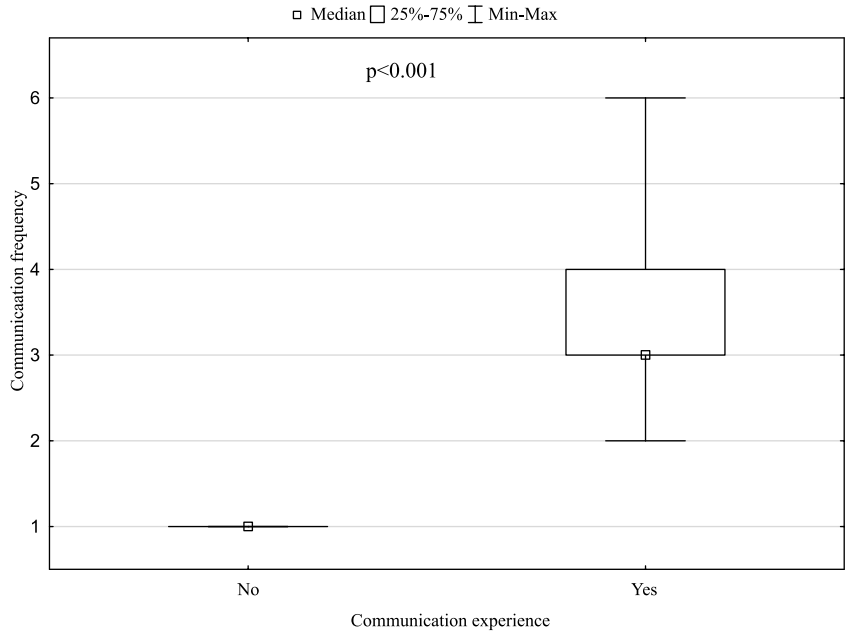


**Figure 2. Frequency of communication according to the declared experience of communication with an elderly person in suicidal crisis**

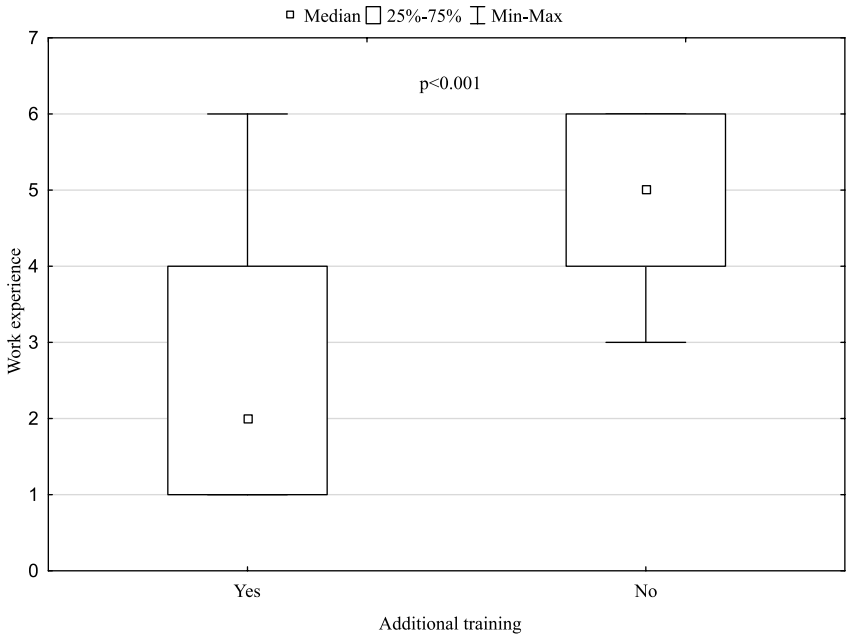


**Figure 3. Length of service according to the training needs in the field of suicidology**

A comparison was also made between the frequency of communication with an elderly person in suicidal crisis and the declared training needs in the field of suicidology. The respondents who declared such needs (median = from 2 to 5 times a year) differed from those without such needs (median = from 6 to 11 times a year, $p = 0.001$). The frequency of communication with an elderly person in suicidal crisis was higher in the group that did not declare any additional training needs (Figure 4).

The last stage of the statistical analysis was to show whether there was a relationship between additional training needs in the field of suicidology and the declared experience of communication with an elderly person in suicidal crisis. The p-value obtained from the analysis of the contingency table was of little statistical relevance ($p = 0.056$). Hence, it cannot be stated that a relationship between the variables on a nominal scale ($p > 0.05$) exists. Nevertheless, the obtained data and the presented findings demonstrate that the respondents' need for training is related to little or no experience of communication with an elderly person in suicidal crisis and supports the notion of need to provide training in the discussed area.

The respondents were also asked to identify barriers in communication with people aged over 65 in suicidal crisis. Responses were also collected

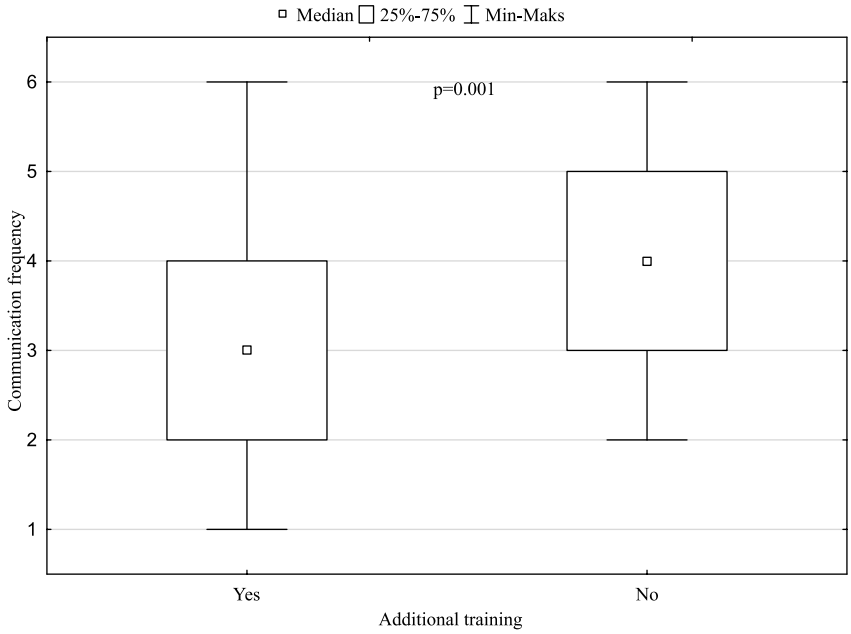


**Figure 4. Frequency of communication with an elderly person in suicidal crisis according to the training needs in the field of suicidology**

from those respondents who had not had any direct experience so far but had obtained knowledge from their senior colleagues.

Based on the responses, physical and mental barriers were identified. The physical barriers included the elderly people's inarticulate speech caused by post-stroke conditions, medications, alcohol abuse, poorly fitted dentures, as well as hearing impairment. These barriers were mentioned by 78 respondents (73.6%). The mental barriers included the elderly people's distrust and anxiety ($n = 62$, i.e. 58.5% of respondents). Moreover, the respondents noted that elderly people sometimes lost the thread of conversation, suddenly stopped talking, or repeatedly covered the same topic. According to the respondents, this was likely caused by memory loss, dementia, or other mental disorders ($n = 47$, i.e. 44.3%). Some respondents also tried to identify the communication barriers, for instance, problems with focusing on what the elderly person tried to say (often with many digressions and stories unrelated to the main topic). Some respondents also admitted that they had problems with patience. On the whole, these were mentioned by 34 respondents (32.1%).

In addition, the study also considered the helpline workers' strategies for handling communication with elderly people in suicidal crisis. They were

asked the following open question: 'What should you remember about when communicating with an elderly person in suicidal crisis?' The respondents provided various answers, which can, nonetheless, be grouped as follows:

- Try not to interrupt the older person, concentrate on listening to what he or she has to say ($n = 37$, i.e. 34.9% of respondents). Some respondents added that they should appreciate the fact that the elderly person decided to call the helpline, which proves that he or she is trying to save their life.
- Approach the elderly person with respect ($n = 51$, i.e. 48.1%).
- Try not to judge the elderly person who is considering suicide ($n = 28$, i.e. 26.4%).
- Try to find out who can provide support to the older person in their community ($n = 49$, i.e. 46.2%). This means finding out if the older person at risk of suicide has a support network in their community, which helps to undertake further intervention.
- Try to convince the elderly person to contact their support person(s) ($n = 42$, i.e. 39.6%). This group of answers also included suggestions that the elderly person should be asked to provide the support persons' contact details, so that the helpline worker could talk to them about the elderly person and his or her suicidal crisis, and to warn them about the threat of the elderly person engaging in suicidal behaviour.
- Express your opinion on the provided information only when asked by the elderly person ($n = 21$, i.e. 19.8% of respondents). Some respondents ask the elderly person if he or she wants them to present their proposal for solving the problem that triggered the suicidal crisis ($n = 14$, i.e. 13.2% of respondents).

Another question concerned the helpline workers' need for training provided by experts in suicidology. The vast majority of respondents ($n = 89$, i.e. 84.0% of respondents) expressed their need for additional training in providing advice to people in suicidal crisis. First of all, they mentioned the need for improving and broadening their knowledge of methods of communication with children and young people in suicidal crisis ($n = 41$, i.e. 38.7%), as well as methods for resolving situations that triggered a young persons' suicidal crisis ($n = 33$, i.e. 31.1%). Some respondents also specified the need for training in the field of supporting people orphaned by suicide ($n = 24$, i.e. 22.6%). The matter of communicating with elderly people in suicidal crisis was also expressed among the respondents' fields of interest. The need for training in this area was mentioned by 19 respondents (17.9%). Other types of training that the respondents would be keen to attend included those covering methods of communication with terminally ill patients who

consider suicide ($n = 7$, i.e. 6.6%), identifying the symptoms that suicide is likely ($n = 6$, i.e. 5.7%), and methods of communication with various institutions involved in the process of helping a person in suicidal crisis ($n = 4$, i.e. 3.8%). 17 of the helpline workers declared a need for training in the field of suicidology but did not indicate what specific concerns the training was to address (16.0%).

## Discussion

Polish suicidology literature contains only a small number of papers directly concerning suicidal behaviour in elderly people (Baumann, 2008; Binczycka-Anholcer, 2005; Czabański, 2014; Tucholska, 2006; Makara-Studzińska & Madej, 2015; Rosa, 2013). The papers only focus on the general principles of providing helpline support (Bejger, 2014; Kicińska, 2010; Sanders, 2004).

An examination of both Polish and international suicidology literature confirms the innovative character of the study reported in this paper, which focused on the experience of helpline workers in communication with elderly people in suicidal crisis.

The study demonstrated that the vast majority of respondents had experienced communication with elderly people in suicidal crisis. Some respondents had experienced such situations often: most frequently from 2 to 5, or as much as from 6 to 11 times a year (approximately every fifth respondent).

The respondents had the skills to identify barriers in communication with elderly people in suicidal crisis. They were also able to identify the principles one should observe when communicating with elderly people in suicidal crisis. The respondents believed that they should express their opinions concerning the information they hear only when the older person asks for their advice. This was likely the result of the strongly internalised principle developed within the framework of 'Telephone Good Samaritan' (the first helpline, dating back to 1953). According to this principle, the person on duty should not impose their beliefs on the callers or influence them in the field of politics, philosophy and religion (Kicińska, 2010).

A significant percentage of respondents expressed the opinion that they should not interrupt the older person and that they should focus on listening, thus developing their emphatic skills. Furthermore, the respondents believed that they should approach the caller with respect. This corresponds with the findings of studies conducted by B.L. Mishara et al. According to these,

the qualities sought in a helpline worker include empathy and respect for the elderly caller. These qualities are essential in encouraging a positive change in the caller (Mishara et al., 2007a, Mishara et al., 2007b).

The respondents of the study pointed out the need for continuous development of their knowledge and skills in providing support, also to elderly people in suicidal crisis. They indicated that there were many areas in the field of suicidology which they should learn. Unfortunately, there are no international studies where this issue is addressed, albeit a research team under R. Willems has indeed concluded that volunteers need training and coaching on how to talk to difficult callers (Willems et al., 2020). There are, however, papers on specific training offered to helpline workers and volunteers. An example is the study conducted by researchers in Australia (Hunt et al., 2018) involving 149 helpline workers and volunteers. The participants underwent extensive training to develop their ability to provide support to people in situations of grief and loss, with alcohol and drug problems or in suicidal crisis. The study lasted three months, during which the participants were required to conduct 67 contact hours supervised by trainers (Hunt et al., 2018).

Since there are no papers on communicating with elderly people in suicidal crisis, it is hard to compare the findings of the presented study with other studies conducted in Poland.

International authors who write about helpline support in a more general way noted certain issues that have not been included in this paper, for instance, the negative mental impact of helpline work (Cyr & Downick., 1991; Kitchingman et al., 2017; Roche & Ogden, 2017), as well as the effectiveness of helplines as seen by elderly people (De Leo et al., 2002; Morrow-Howell et al., 1998). Another study has demonstrated that both helpline workers and volunteers display symptoms of professional burnout. Such symptoms were observed in 54% of respondents ($n = 39$). In 75% of these respondents, the symptoms appeared in their first year of work. These included lowered enthusiasm (77%), a sense of stagnation (18%), frustration (39%), and apathy (28%) (Cyr & Downick., 1991). Yet another study involving 210 helpline workers (78.1% of which were women) was conducted by T.A. Kitchingman et al. The findings showed that 28.1% of respondents showed extreme symptoms of psychological stress, whereas several respondents (2.9%) admitted having suicidal thoughts (Kitchingman et al., 2017). The issue was also confirmed by A. Roche and J. Ogden (2017). In yet another study, many volunteers showed symptoms of burnout, stress, frustration, and irritation, which may have been caused by their insufficient experience in communicating with people in need of support (Willems et al., 2020).

However, none of these studies specifically addressed communication with elderly people in suicidal crisis.

Studies conducted in the United Kingdom have demonstrated that telephone interventions have a positive effect on older people, specifically on their mental and social functioning. Telephone counselling programmes, for example, Tele Help/Tele Check, have become particularly effective in suicide prevention, ensuring relationships between the elderly callers and counsellors based on mutual trust (De Leo et al., 2002; Morrow-Howell et al., 1998).

## Conclusions

The study on which the paper is based was unique, both from the perspective of Polish suicidology literature and the wider European and American ones.

There is a need for further research concerning helpline workers in Poland. Studies should be conducted among larger numbers of respondents to provide a statistical reflection of this specific professional group.

The study demonstrated that the respondents had expert knowledge of how to communicate with elderly people in suicidal crisis. Such knowledge was obtained from the respondents' experience of frequent contact with older people at risk of engaging in suicidal behaviour. At the same time, a significant majority of respondents signalled the need for specialized training in the field of broadly understood suicidology. This shows that there is a need to for the provision of a comprehensive offer of trainings for this particular professional group. It should most probably be developed by the Polish Suicidology Society or by the expert group appointed by the Ministry of Health, who are working on creating the national programme for preventing depression and suicide.

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