

Suicide attempts and suicide ideation among the elderly in Uruguay

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Abstract *An investigation is presented into Suicide Attempts (SA) among the Elderly in Uruguay conducted in 2014 in a Public Health institution in Montevideo linked to a Claves/Fiocruz project. Starting with an initial project, semi-structured interviews were conducted with institutionalized individuals with a history of suicide attempts, as well as a review of the literature and research into preventive norms and actions by public health authorities in the country. The results reveal difficulties of individuals in talking about SA as well as shame associated with aging. There was also a major difficulty talking about family ties, confirming gender differences in the method of SA and greater suicide ideation among women, although the possibility of SA repetition does not appear to be a concern. The study elicits reflection on the importance of attention, care, quality of life and the effects of institutionalized life upon the elderly.*

Key words *Suicide attempts, Elderly, Uruguay.*

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Introduction

Results are presented of research into Suicide Attempts (SA) among the elderly in Uruguay conducted in 2014 at the “Dr. Luis Piñeyro del Campo” Geriatric Hospital-Center (HCGPC) in the city of Montevideo.

It is part of a multi-centric project, in which Brazilian, Uruguayan and Colombian researchers participated. The same theoretical-epistemological and methodological framework is shared by all countries, though a project was designed for Uruguay that included some specific aspects worthy of note:

Initially, it started out with a current analysis focused on various socio-historical and cultural characteristics linked to the globalization processes that altered the existential world of individuals and crossed over into social life in a phenomenon that Rebellato¹ termed “neoliberal culture”. The author argues that neoliberalism is not just a set of economic practices, but also a new culture that imposes different values with a significant impact on social bonds, including the most intimate ties such as family relationships. Among other signs, there is the growing individualism, permanent migration and relocation that often leaves the elderly unprotected due to the lack of access to family care and the absence of filial responsibility. Furthermore, the intrusion of the market into social and family relationships, which gives paramount importance to the constant multiplication of economic resources, looks upon old age as an unproductive stage. In addition to this, the concern about aesthetics and the quest for permanent youth generates further shame in the elderly, upsetting their identity and causing isolation and insecurity. For this reason, an assumption of this work is that in addition to mental illnesses like depression², classically associated with consummated suicide or a suicide attempt (SA), some aspects of the neoliberal culture are conducive to suicidal behavior especially among the elderly in Uruguay.

The preceding contextual analysis gave rise to a question that was a guiding force in the project: What does suicide represent in this culture and in these modern times?

A diachronic analysis indicates that the suicidal act manifests itself with different significances associated with honor, shame, courage – or its opposite – cowardice, though it is predominantly interpreted as a question of values. It is therefore understandable that the suicidal act is a scenario that represents social values and has a

meaning attributed by the subject of the act, enmeshed in the history of the individual and mediated by the socio-historical-cultural context.

It is considered here that context and significance are the key to understanding the SA, which justifies the methodology used in the investigation.

The next assumption is that suicide is a public health problem in the country. Between 1989 and 2012, the official figures of effective suicides in Uruguay show a steady increase in accordance with reports from the Honorary Committee for the Prevention of Suicide. That source claims that between 2007 and 2012 there were 3,293 cases, with a rate of 16.8 suicides per 100,000 inhabitants. In 2012, suicides were double the number of murders and greater than deaths from accidents, without taking into consideration that any of them could be a form of covert suicide. As in other countries, the phenomenon is predominantly male: in 2012, there were 81% males against 19% females. Similarly, the phenomenon manifests itself in two age groups: adolescents and the elderly.

In general, the events are concentrated in the provinces (67% in 2012) whereas Montevideo, with almost 50% of the population, records only 33% of the cases. The most affected provinces are Treinta y Tres (35.35%) and Flores (31.9%), although other provinces also have significant rates. The 2013 report reveals no significant change.

In that year, the Elderly Program of the State Health Services Administration (ASSE) published data on suicides during the years 2011-2012. Of the total of 1103 cases, 363 were for individuals aged over 55. In those years, 288 men committed suicide (144 each year) and while 44 women committed suicide in 2011, there were only 31 in 2012. The decade of highest incidence is between 60 and 70 years of age, which corresponds to 2% of cases. Most of these events occur in Montevideo and provinces surrounding the capital. This provides an overview of suicides that differs from that which is prevalent for the phenomenon in general in the country.

Likewise, the gross gap between the male and female suicide ratio is close to 3-1 and, despite what one might think, most suicides are married (49%) to which 3% of people cohabiting in stable union must be added. In this respect, it should be stressed that in Uruguay, almost 50% of people over 60 are married³. Of the remaining 48% of cases, 21% are widowers, 18% are single and only 9% are separated or divorced.

With respect to the methods used in this period, most of the cases involved poisoning (181), followed by defenestration (jumping to death) (130), firearms (18 cases) and drowning (16), among other methods. Gender differences are also prevalent in the method: women opt for poisoning while men choose hanging and combined methods.

The quantitative data presented above reveal the pressing need to investigate SA.

It is necessary to mention other characteristics of Uruguay at this juncture, as it has a population of 3,286,314 inhabitants (2011 Census), in which 52% of the population is female and 48% male. The birth rate is the lowest in South America (2.1%), though life expectancy is high, currently standing at 76 years of age: 73 for men and 80 for women. Normal life expectancy is 67 years of age in general. The capital city of Montevideo has 1,305,082 inhabitants of which 15.4% are over 65. It is the largest urban agglomeration in the country while the rural population is only 5.34%.

According to ECLAC, Uruguay belongs to the group of countries with advanced aging⁴. It has over 600,000 inhabitants over 60 years of age, 35% of which are over 75 years old and 59% of the population is female. Indeed, 92.5% of the elderly population lives in urban areas, the highest density of individuals aged 65 and over being in the south of the country.

There is broad coverage of social benefits for the elderly, as 88% receive income from the State Social Security Bank (BPS) and another 8% from private social security providers. Furthermore, women receive 54.8% of benefits and this situation is the result of the feminization of aging and widows' pensions, which men also agreed to since 1998. The State also provides non-contributory social benefits such as the Pension for the Elderly since 1919. The Program of Assistance to the Elderly, which is part of the Equity Plan of 2008, aimed at people in distress between 65 and 69 years who are not recipients of other benefits.

The above data are a clear indication of the increasing aging of the Uruguayan population and its concentration in cities, especially the capital. It justifies the importance of this research to the country focusing on this age group and shows the relevance of launching the field work in the city of Montevideo.

It is important to add that healthy life expectancy raises the need to investigate the characteristics and possibility of access to the health system in the country, while coverage of social

benefits provides data about the possibilities of access to financial resources at a time of life when work is no longer an option. This will then make it possible to reflect on the quality of life among the elderly. The health system⁵ is organized into two sectors, namely public and private.

The public sector is financed by general revenues and covers most of the population (42.3%), especially in the countryside. It includes ASSE, which has 65 health facilities, 47 general hospitals, 12 specialized hospitals and 17 health centers. In addition, there is the Hospital de Clínicas of Universidad de la República (UdelaR); the Health Service of the Armed Forces and the Health Service of the Police; the medical services of the Municipal Authorities, BPS and autonomous entities.

Within the private sector there are the Public Medical Care Institutions (IAMC) covering 45.7% of health care. There are also partial health insurance programs and private institutions.

In 2005, the National Integrated Health System (SNIS) was created with the stated aim of universal access to health, seeking justice and equity in spending and financing, as well as the quality of healthcare. This generated three modifications to the system that existed until that time: (1) a comprehensive model that emphasizes Primary Health Care; (2) the Ministry of Public Health (MSP) became solely an overseer of the health system; (3) creation of the National Health Fund (FONASA) set up to receive compulsory contributions of residents over 18 years of age.

In the next section, the methodological design and the field work as well as its main results will be explained. Some issues will then be discussed and the main conclusions presented.

Methodology

A viewpoint shared with the project of the Latin American Center for Studies on Violence and Health (CLAVES) is that both attempted and consummated suicide are complex phenomena which can only be comprehended by listening to the verbal reports of individuals who recount their experience. Thus, the contextualization of the socio-historical moment, local specificities, the experiences of the individuals and the understanding and interpretation of researchers through a qualitative methodology are essential elements that are common to both studies.

The techniques and tools of the same project were adjusted for the characteristics of Uruguay.

Nevertheless, it is worth pointing out that:

Work began in 2013 with a researcher at the Faculty of Humanities and Education (FHCE) of UdelaR. Repeated efforts were made to obtain the approval of the Ethics Committee. It aroused great concern for the way in which the individuals were to be selected, recommendations on the difficulties that this topic can generate and questions about the tools that would be used. A demand was imposed to send Informed Consent forms duly translated and summarized before granting approval.

In the MSP and in ASSE, a request was made to prepare and present a project for the country and the difficulties to access the identity of the individuals with a history of SA for the privacy of medical records and doctor-patient confidentiality were raised. Thus, the work started from an initial project called "Suicide Attempts among the Elderly in Uruguay."

Finally, at the suggestion of the ASSE authorities, contact was established with the HCGPC where the research was then conducted. This institution is part of the network of state dependent services of ASSE and is also the national benchmark polyvalent center for the elderly.

This hospital provides care to people over 65 years of age through a comprehensive range of social and health benefits. As such, it has long-stay 280 beds organized into four units: High Dependency and Palliative Care; Semi-dependency; Psycho-geriatrics and Severe Dementias, a day center, a service of care and family integration; and a medium-stay unit for rehabilitation. Each of these services has structured admission and exclusion criteria.

It should be pointed out that the HCGPC is an institution that was built in 1922 to be an asylum hospice, which lasted until the early 1990s. Throughout that period, admission and organization were those of a "closed institution" for all purposes. For this reason, from 1997 onwards the assistance of international health agencies were called in to change this situation. It was completed in 2000 by joint action of the MSP and the School of Medicine, which resulted in a process of transition and complete restructuring that began in 2001. The administration was changed and new admission criteria and innovative organization of the geriatric center were established. The physical layout and environmental conditions were restored concomitantly seeking to enhance the quality of human resources. The above mentioned Care Units were reorganized by installing a system of care involving interdisciplinary teams

(geriatricians, psychiatrists, nurses, social workers) to plan, assist and supervise the work in each one of them defined on the basis of the profile of the needs of the users. The interrelationship status of residents by customizing clothing and signage were regulated. In line with the above changes, personalized care of multidisciplinary teams, which benefits the living conditions and health of the elderly, is perceived. The individuals interviewed live in this hospital; it was where the research was conducted and four of the five members of the research team work that was set up after the presentation of the project in the hospital. The fieldwork featured several phases:

Preparation of the interviews: The selection of the individuals was based on the review of the medical records of 138 patients in Semi-dependent and Psychogeriatric units. Those with histories of SA and existing situations were surveyed. They were then asked about their willingness to participate in the study, excluding those who, by the nature of their mental illness, could not consent, in compliance with international recommendations on clinical investigation of the Declaration of Helsinki of the World Medical Association.

Two women and two men agreed to participate in the study, who for reasons of anonymity will be identified as Norma, Enrique, Andrés and Julia.

Conducting the interview, first impressions and criticisms about the proceedings: The interviews were semi-structured in form, with consent given for voice recording. The orientation guide designed by the Brazilian CLAVES team was used. The basic tenet was to allow the individuals to speak of their own history, although the central topic was the SA and all that surrounds it. The interventions of the researchers sought to energize the interview, clarifying confused ideas or enquiring about aspects not addressed by the individual. All interviews were always conducted with the presence of the same two members of the team with defined but interchangeable roles in order to energize and dynamize them. The two roles involved one person directing the interview and the other being the observer.

Post-interview work: Immediately after the interview, time was set aside to analyze it. After each one, the group met for the preliminary analysis to complete or contrast the information with data from the clinical history and the situational analysis that the group of professionals could provide. It was considered important, given that they were dealing with institutionalized individ-

uals, to follow up on these patients to assess if the interview had generated aftereffects.

Upon completion of the field work, a task of general analysis and correlation was performed with the categories defined by CLAVES: relationship between the attempt with suicidal ideation, mental and physical illness and social factors.

The data obtained was cross-checked against those from other sources in a centralized database containing: (1) a literature review of publications in Uruguay; (2) a survey of practices and suggestions from health professionals on the subject; (3) a survey of rules, regulations and actions of the health authorities.

A daily work roster ordered chronologically was also implemented to gather the actions performed, the impressions of researchers, the suggestions and future projections that the investigation itself reveals. At all times, as already noted, the ethical standards established in the country were respected.

Results

A search in medical records showed that nine hospitalized individuals (6.5%) of the 138 that are in both units have a history of SA. Six are in the Psychogeriatric unit, namely four women and two men, and three are in the Semi-dependent unit, namely two women and one man. Two women were excluded for presenting cognitive impairment and acute delirium. Only four agreed to be interviewed. Of these, only two had made a suicide attempt in recent times, one in 2009 and another in 2012. The other individuals had a history of SA but at other times in their lives. In the four interviews conducted, three individuals provided information on the SA. However, Andrés denied that experience at all times, dismissing those who mentioned it and proved very uncooperative, even though he had been informed of the nature of the investigation and had voluntarily agreed to participate.

The female SA occurred in the private domain (home and family) and the method used was overdose of medication or illicit drugs. The male SA was performed in public, throwing himself in front of a vehicle.

Although Julia and Andrés come from poor families and the remaining two from comfortably established families, in their life stories the effect of the economic aspects on their lives and their relationship with the SA was always observed. By way of example, Enrique went from living in

an apartment with formal employment to living on the streets and begging. Julia and Andrés reported performing unskilled and traditionally badly paid jobs: house cleaner, collecting bones or cardboard, or a street vendor. This aspect coincides with low schooling.

The religious affiliation (Catholic Christian) appeared in three of the four respondents, but only Norma admitted that she would not attempt a SA again for religious reasons.

Family conflicts appeared explicitly and implicitly in all of them. With Julia, it was directly linked to the SA; with Norma, it appeared as domestic violence because of the alcoholism of the couple; although the family conflict was also soon repeated, in this same case it was the daughter-in-law who called for her institutionalization. In both the male cases investigated, SA was related to the loss of family ties and partner. Alcohol and aggression appeared repeatedly in direct relation to the event. It should be added that social isolation and difficulties in relationships appeared in all cases: some claimed to be very selective with whom they relate, even when currently institutionalized, as Norma and Enrique admitted. Andrés tells of a situation of violence and a fight with someone because he was looking at him; or more forcefully, Julia declares that she does not want to have a relationship with anyone because "I prefer to be alone to avoid problems."

Whatever the case, since the individuals dealt with here are institutionalized individuals, loneliness and isolation are also evident in the few visits and the lack of attention they receive from family. This is a situation that is customarily hidden by means of a repeated explanation saying that they do not visit because they have no time or because they are working, as stated directly by Andrés, Norma and Julia.

It is in interviews conducted with women that thoughts of death or suicidal ideation arise. In one of them, Julia explicitly threatens to reiterate the SA, although it is expressed in the context of delusional thinking. The three individuals who reported having committed SA have similar events in their history. In the case of Enrique, it can be surmised that it was SA by self-neglect as he reported that he did not leave his room or eat, until a neighbor found him and he had to be hospitalized in a serious condition.

As for the relationship with mental illness, it can be said that from medical records and interviews this association occurs in all of them: either depressive disorder and/or accentuated personality traits and alcohol abuse disorder. It should be

added that Norma recounts in detail a suicide in her family history.

Although in almost every interview there appears at least one chronic physical illness: Psoriatic arthritis for Enrique; Parkinson's Disease for Julia; and arthrosis for Norma, that makes them dependent on special care, prevents or hinders mobility, only in the case of Enrique can the illness easily be associated with the act. It is important to emphasize that as a result of SA, Andrés has a left arm motor injury as a sequel of the injury.

Consulted about their state of mind after the interview, there was no negative impact therefrom and in two cases, it was assessed as positive.

The literature review shows that investigations conducted and published in Uruguay on suicide are scarce: between 1968 and 1990 there are only 7 articles published in specialized medical journals. The works of Dr. Lucero (1998⁶, 2003⁷) are almost pioneering⁸; recently in 2005, the Medical Journal of Uruguay published a paper on suicide among children and adolescents⁹. In other areas, the literature seems to be even scarcer, and by way of example, a 2011 work with a sociological approach, whose author claims that life insecurity, understood as a lack of expectations, vulnerability and difficulty imagining future prospects could explain the marked increase in suicides among adolescents, should be mentioned¹⁰.

The survey of legislation, actions and tools developed by the health authorities in relation to suicide in Uruguay shows that despite the importance of the problem and some sporadic works, measures were only taken in the year 2004¹¹ to create an "Honorary National Commission for the Prevention of Suicide." Its main objective was to design, facilitate, monitor and evaluate a National Suicide Prevention Plan that was passed in 2011 with goals established for 2015. The Plan considers suicide to be a multi-causal phenomenon that impacts on the individual, family and society over the course of several generations. The issue is addressed from interdisciplinary and inter-sectorial approaches to provide solutions and five pivotal strategic areas were elaborated from which actions are being carried out in primary health care. Starting in 2012, with the intention of creating a system of surveillance and monitoring of SA, an MSP Ordinance established a Compulsory Registration Form (FRO) of SA to be used by all health care providers. It involves compulsory notification of SA to MSP for epidemiological purposes. The FRO, effective from October 2013, lists personal data and health

coverage available to the individual, the method used and previous attempts and other relevant medical history. The data has to be submitted on a monthly basis in an online spreadsheet to MSP that contains all the information for the country.

Discussion

Since the research was conducted in an institution of permanent internment for the elderly, it is necessary to point out some of its features. In March 2008, a study was conducted in the HCGPC¹² to assess the impact of comorbidity (presence of two or more diseases) in the quality of life of institutionalized elderly individuals. "Quality of life" is a broad concept that includes both the objective health status of a person and other indicators related to the economy, education, environment, legislation and the health system. It also has subjective and personal aspects, because it is the perception of individuals of their position in life in the context of the culture and the value systems in which they live, although linked to their own objectives, expectations and concerns. International studies show that older people place inestimable value on satisfaction with life¹³, although this can be interpreted in various ways. Some argue that the elderly tend to have lower aspirations making the differences between their goals and achievements lower¹⁴. Others argue that quality of life is best when people have opportunities to achieve their personal goals and when they have the capacity and support to meet the demands and expectations of their immediate environment¹⁵⁻¹⁷. In the aforementioned study, 65 patients were investigated in the Semi-dependent Unit: demographic data, presence of polypharmacy and of comorbidities. In addition to this, a functional, cognitive, emotional and spiritual assessment was performed using internationally tested tools: the WHOQOL-OLD^{17,18} and WHOQOL-BREF¹⁹ questionnaires. The results indicated that the quality of life is affected by polypharmacy, functional dependency and depression; no significant differences between those with or without comorbidity were detected. Women have a better quality of life. Nevertheless, a low prevalence of depression was found, which does not tally with other studies involving institutionalized patients²⁰. The vast majority are not worried about death, are not afraid to die or suffer when the time of death arrives. It highlights that 94% of respondents claimed to be believers. There is a good

perception of their physical well-being and functioning of the sensory organs, not relating the deficit of any of these organs with the ability to relate to other people or perform activities. What is most affected is autonomy and intimacy, complaints which, together with the desire for more daily activities, emerged as insistent demands in interviews that are also identified as SA risk factors by previous research in other countries. Furthermore, both the aforementioned study and the interviews showed that in these patients some risk factors appear identified by the international literature as associated with SA, such as depression (albeit not severe) and other mental illnesses or comorbidity. However, it is necessary to add that since 2001 when significant changes in the management and treatment approaches in HCGPC were introduced, there have been no SA. Whatever the case, it should be added that the category of institutionalization and its effects was not considered specifically in the project, though the results suggest that these aspects should be investigated in greater depth in future research. In principle, the interviews made it possible to visualize the more classic effects of institutionalization such as Andrés' passive compliance with the physician's request to participate in the interview. However, afterwards he resisted and from fear of being expelled from the hospital, he said: "meanwhile do not pester me," stated in a humorous way; or the insecurity he feels at going outside when refusing to leave although he has appropriate authorization. These aspects were perceived with great insightfulness in a statement by Norma who said: "this is another world, the world outside and the world in here ... I do not know how I will return afterwards ... and I know I have that stay here, so I'd rather not go." It is resignation, compliance with an unchosen life that reveals the lack of family support²¹. Although the classic visions of institutionalization highlight its harmful effects, within the scenario of this investigation it does not appear to have a negative impact. According to the specialized literature, the absence of relatives or friends, loneliness and social isolation are elements to consider in relation to SA. Therefore, in a closed institution the form of management, the environment and institutional climate, care and personalized attention and ongoing respect for the rights of individuals can benefit the individuals. Furthermore, institutionalization in many cases presupposes an objective improvement with respect to the safety and preconditions of existence, i.e. the quality of life of

the elderly. This seems to be one of those cases and could be the counterpart of what the international literature indicates as another risk factor, namely "the lack of social support." As stated at the beginning of this paper, a question about the significance of suicide in the context of a neoliberal culture was the initial focus of the project in Uruguay. Upon hearing the experiences of individuals directly involved and seeking to ascertain the significance of each experience, the shame associated with SA arises forcefully in all cases. In recounting the event, although the chronological time has elapsed, words falter, thinking is slow and the voice is less audible. It is an emotional report that can only be made after establishing a rapprochement, but about which it is always necessary to ask questions directly and make efforts to ensure that details and information necessary for the objectives of the investigation are added. The reports are riddled with judgments about themselves. For example, Norma says, "I was very immature" as justification; or Andrés who adamantly denies the event and those who say so by saying "I am not one of those," which could suggest that they have negative value judgments about SA. Another aspect that emerged during the interviews was the matter of shame about old age and disease, sometimes stated directly as did Enrique when he said that he did not want to be filmed or seen, which is why he does not participate in the cultural activities of the institution. Similarly, Norma is sorry for herself and refuses to leave the hospital even though she may do so; or the insistence of Andrés who does not want to leave because he claims he has no money even though he asks for authorization every month. Not wanting to be seen also is refusing to show that one is living in "the Piñeyro," which shows the convenience of having briefly analyzed the history of the institution and the associated social stigma that still affect those interned.

Conclusions

This research into suicidal attempts and ideation is focused on institutionalized elderly individuals. Attempting to investigate SA presupposes overcoming some obstacles that interfere with that knowledge. Initially it requires obtaining the approval of the health institutions to access the necessary information and getting authorization to make the project viable. One obstacle was to coordinate actions between different institutions

and breach the institutional taboo around a very sensitive issue. All this required making adjustments to the initial project if it was effectively desired to conduct the research. One difficulty is the invisibility of the individual due to the interplay of doctor-patient confidentiality and the reluctance of SA individuals to talk about the fact.

However, the specific configuration of the research team and the place where the field work was eventually conducted is considered a strength. The research aroused the interest of professionals who voluntarily merged work and research. Even though multiple theoretical objections to the involvement of the researcher in the investigation could be made, that decision made viable, facilitated and enriched the project to allow for further research to analyze the subsequent effects on respondents. It also gave some insight into the importance of SA in the referred population, as 6.5% of admissions had lived through that experience at some point in their lives, an aspect not taken into account until now by the institution. Likewise, the results suggest a different facet of institutionalization among the elderly. It highlights the importance of care, safety and personalized attention in an interdisciplinary work environment and opens up new options to reexamine the quality of life among the institutionalized elderly. The research makes it possible to identify needs and demands of patients related to their quality of life, which are at the same time risk factors identified by the international literature regarding SA. All this should be taken into consideration by the hospital institution.

The field work showed the adequacy of the methodology vis-à-vis the research objectives; it also showed the need to make some adjustments to tools such as the Free and Informed Consent and the Orientation guide for interviews to be applied to institutionalized individuals.

Work with the individuals showed SA to be associated with shame either by denying it during the interview, or the need to rationalize the act

in the middle of the report, or it could even be one of the reasons that influenced the refusal to participate. The interviews showed the presence of religious beliefs that may well influence this sentiment though the shame also appears in the dislike of old age. It may also be due to not having money, being in a protective enclosure to avoid being seen and a negative image of old age in line with the neoliberal culture of the context. The information corroborates the gender difference in the method used in the SA, greater ideation in the female sex and the close and widespread association with relationship difficulties and the experience of the other as conflict or absence. Likewise, it can be due to the presence of mental illness with at least one other chronic disease.

The literature review showed that there is little research conducted and published that is accessible on the act occurring in Uruguay. There are no official figures on SA. It is possible to affirm that until now, there are no studies on SA among the Elderly in Uruguay, let alone from the perspective of the individuals themselves.

Analysis of the state of the art suggests that the visibility of the phenomenon was made possible by professionals who in their daily work perceived its impact on the population's health. Working with a suicide or a SA led them to develop theoretical investigations first; then, after thoughtful and systematic clinical practice, to propose practical solutions geared towards care.

Even though in recent years the health authorities have given signs of acknowledging suicide as a problem for the health of the population creating agencies and tools to work on prevention, these are recent actions that still generate major questions. As their implementation is very recent, the results are unknown, but concerns have emerged about doctor-patient confidentiality, and the mandatory and almost public circulation of the identity of the SA and some gaps in the Ordinance on destination and location of the Compulsory Registration Form (FRO) in health centers.

Collaborators

MCH Fachola, R Lucero, V Porto, E Díaz and MA París have participated equally in each of the stages of preparation of this article.

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Article submitted 06/03/2015

Approved 16/03/2015

Final version submitted 18/03/2015