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Analysis of suicidal behaviour and social support among older adults in Poland and Sweden

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Abstract

Background. *Suicide among older adults is a significant global public health challenge characterized by high lethality and specific risk factors such as loneliness, chronic illness, and social isolation.* **Aim.** *To compare selected aspects of suicidal behavior, experiences of violence, and social support among older adults in Poland and Sweden.* **Materials and methods.** *A cross-sectional study was conducted (N=288) using an original anonymous questionnaire. Statistical analysis was performed using the chi-square test with a significance level of $p < 0.05$.* **Results.** *No significant difference was found in lifetime suicidal ideation (approx. 13% in both groups, p=0.932). Significant differences were observed in social participation ($p < 0.001$), emergency help availability ($p = 0.008$), and frequency of contact with relatives ($p < 0.001$), with Polish respondents relying more on informal networks and Swedish respondents on institutional support.* **Conclusions.** *Suicide risk in later life is strongly associated with social isolation. Prevention strategies should focus on strengthening interpersonal relationships and promoting active ageing, while accounting for different national models of social support. (Gerontol Pol 2026; 34; 89-97) doi: 10.53139/GP.20263416*

Keywords: *suicide prevention among older adults, older adults, suicidal ideation in later life, violence against older adults.*

Introduction

Suicide among older adults constitutes a major public health concern and remains one of the key challenges of contemporary gerontology and mental health prevention. Older adults are exposed to multiple suicide risk factors, including loneliness, bereavement, chronic illness, social isolation, economic difficulties, loss of autonomy, and experiences of violence [1,2]. Many of these factors are closely interconnected, as chronic illness, bereavement, and experiences of violence may contribute to the development of depression, anxiety, and other mental health difficulties that further elevate suicide risk [3]. Research demonstrates that suicidal behavior among older adults differs substantially from that observed in younger populations. Suicide attempts in later life are more frequently characterized by high lethality, lower ambivalence, and more deliberate planning, particularly among older men [4]. Studies conducted in European populations aged 65 years and over indicate a substantially lower ratio of suicide attempts to completed suicides compared with younger age groups, suggesting a higher probability that suicide attempts among older adults result in death [5].

Social relationships and support networks are recognized as important protective factors against suicidality in later life. Previous studies indicate that strong interpersonal relationships, participation in social and community activities, and access to emotional support may reduce suicide risk and improve psychosocial well-being among older adults [6,7]. Conversely, social isolation and the absence of meaningful interpersonal connections are associated with increased psychological distress, loneliness, and suicidal ideation [8,9]. Contemporary literature also highlights that loneliness and social disconnectedness are among the strongest psychosocial predictors of suicidal behavior in late life [9,10]. Participation in volunteering, educational initiatives, and community-based activities has additionally been associated with lower levels of depression, loneliness, and suicidal ideation among older populations. These findings highlight the need for age-sensitive suicide prevention strategies specifically adapted to the psychosocial and health-related circumstances of older adults. In addition to psychosocial determinants, recent research has increasingly emphasized the role of physical health and functional capacity in shaping suicide risk among older adults. Longitudinal analyses conducted on European populations indicate

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that mobility limitations may contribute to reduced social participation, increased loneliness, and greater psychological distress, thereby increasing suicide risk in later life. Functional disability may also intensify feelings of perceived burdensomeness and social disconnection, which are considered important mechanisms underlying suicidal ideation in late adulthood [10]. Although loneliness and social isolation have been extensively examined in the context of late-life suicide, considerably less attention has been devoted to the role of domestic violence and elder abuse. Emerging evidence suggests that exposure to psychological, physical, or economic abuse may contribute to depression, hopelessness, social withdrawal, and suicidal ideation among older adults. Given the hidden nature of elder abuse and its frequent occurrence within family relationships, understanding its relationship with suicide risk remains an important challenge for both research and prevention efforts. Older adults experiencing chronic loneliness are more likely to report hopelessness, depressive symptoms, and reduced quality of life. Furthermore, age-related changes such as retirement, bereavement, institutionalization, and declining physical health may intensify emotional vulnerability and contribute to suicide risk [2,9,12].

Another important issue concerns the underrecognition and undertreatment of mental health problems among older adults. According to the World Health Organization, mental health conditions in later life are frequently overlooked despite the growing prevalence of depression, anxiety disorders, and suicide among individuals aged 70 years and over [11]. WHO reports additionally identify loneliness, abuse, ageism, and lack of social support as major determinants negatively affecting mental health and quality of life in old age [11]. Previous studies conducted among older adults in Poland indicate that active health behaviors and social engagement are associated with higher quality of life and improved psychosocial functioning in later life [13]. Research conducted in Sweden additionally indicates that loneliness among older adults may constitute an important factor associated with suicidal behavior and emotional distress in later life [15]. Suicide prevention among older adults requires multidimensional public health strategies integrating psychosocial, medical, and community-based interventions [14]. Poland and Sweden represent two distinct social welfare models that differ in family structures, institutional support systems, and patterns of social integration among older adults. While support in Poland is more frequently based on informal family and community networks, Sweden relies more strongly on institutional and formal care systems [6-8]. Comparative analysis of these populations may therefore contribute to a better understanding of the relationship between social support, psychosocial functioning, experiences of violence, and suicidal behavior in later life.

Aim

The aim of the present study was to compare selected aspects of suicidal behavior, experiences of violence, social support, and social activity among older adults in Poland and Sweden. The study also sought to identify factors potentially associated with suicidal ideation and suicide risk in later life within the context of interpersonal relationships and psychosocial functioning

Materials and methods

The study had a cross-sectional design and was conducted among older adults in Poland and Sweden. In Poland, data collection was carried out between October and November 2023 in the Pomeranian Voivodeship, including the cities and localities of Gdańsk, Sopot, Owidz, Kręgi, Tczew, and Słupsk. In Sweden, the study was conducted between June and July 2024 in the Stockholm area. Participants in Poland were recruited through Senior Clubs, Universities of the Third Age, local senior organizations, and community centers. In Sweden, recruitment and distribution of research materials were conducted in cooperation with employees involved in *hemtjänst* services, which constitute part of the Swedish community-based support system for older adults. Data collection in Sweden took place both in elderly care facilities and in private homes of older adults receiving community support services. Recruitment in both countries was based on convenience sampling and voluntary participation. The study used an original anonymous paper-based questionnaire developed by the authors specifically for the purposes of the study. The questionnaire was developed in consultation with researchers and professionals experienced in suicidology, gerontology, and psychosocial support of older adults. The instrument was not previously standardized or psychometrically validated. The questionnaire consisted of 27 items, including 25 closed-ended questions, several allowing multiple responses, and 2 open-ended questions enabling respondents to provide additional comments related to the study topic. The questionnaire included items concerning suicidal ideation, suicide attempts, experiences of physical, psychological, economic, and sexual violence, social support, interpersonal relationships, and participation in social activities. Additionally, sociodemographic variables were collected, including

age, gender, and place of residence. The inclusion criterion was age 50 years or older and voluntary informed consent to participate in the study. Individuals younger than 50 years of age or those who did not provide informed consent were excluded from participation. Prior to participation, all respondents received written information regarding the purpose of the study, the voluntary nature of participation, the anonymity of collected data, and the possibility of withdrawing from the study at any stage without consequences. Participants were additionally informed that some questions concerned sensitive topics related to mental health, suicidality, and violence. The questionnaires were completed anonymously and deposited into secured collection boxes preventing identification of respondents and ensuring confidentiality of collected data. In Sweden, due to varying levels of functioning among respondents, some participants received technical assistance during questionnaire completion, including reading questions aloud and explaining the response procedure. This assistance was organizational in nature and did not interfere with the content of participants' responses. According to national regulations concerning anonymous questionnaire-based social research involving adult participants, formal approval from a bioethical committee was not required. The study was conducted in accordance with ethical principles for research involving human participants, including respect for participant dignity, confidentiality, psychological safety, and informed consent.

Results

This section presents the findings obtained from a comparative survey conducted among older adults in Poland (N = 188) and Sweden (N = 100). The results are organized according to the thematic areas addressed in the questionnaire and correspond to the tables presented in the article. The analysis includes sociodemographic characteristics, suicidal ideation and suicidal behavior, experiences of violence, social activity, and social support networks. In both countries, the largest proportion of participants belonged to the 70–79 age group, accounting for 50.00% of respondents in Poland and 27.00% in Sweden. Significant differences were observed in gender distribution between the study groups. The Polish sample was predominantly female, with women constituting 86.70% of respondents, whereas men represented 12.77%. In contrast, the Swedish sample demonstrated a relatively balanced gender distribution, with women accounting for 48.00% and men for 52.00% of participants. Differences were also identified in place of residence. Polish respondents more frequently resided in smaller urban areas, particularly towns with fewer than 50,000 inhabitants (28.72%) and cities with populations between 50,000 and 100,000 inhabitants (26.06%). Conversely, the majority of Swedish respondents (61.00%) lived in large metropolitan areas with populations exceeding 500,000 inhabitants, indicating a substantially higher level of urbanization within the Swedish sample. These demographic differences should be considered when interpreting psychosocial variables related to suicidal behavior, social support, and social participation among older adults in both countries.

Table I presents respondents' answers regarding suicide deaths within their families. These findings suggest a comparable level of awareness and experience of suicide-related deaths within the family context in both countries.

According to table II, 28.72% of respondents in Poland and 21% in Sweden reported knowing someone personally who had experienced suicidal ideation. Most respondents in both countries indicated that they did not know anyone with such experiences.

Results (table III) suggest that personal experiences with suicide attempts in one's social environment are relatively rare in both countries but similar in scale, which

Table I. Knowledge of suicide in the family

Has anyone in your family died by suicide?	Poland N=188	100%	Sweden N=100	100%
Yes	21	11.17%	11	11%
No	167	88.83%	89	89%
I am not sure	2	1.06%	2	2%
I don't know	10	5.32%	7	7%

Table II. Knowing someone personally whom the respondent knows had suicidal thoughts

Do you personally know someone whom you know has had suicidal thoughts?	Poland N=188	100%	Sweden N=100	100%
Yes	54	28.72%	21	21%
No	133	70.74%	79	79%

allows for an assessment of the magnitude of this problem in both countries.

Results (table IV) indicate a similar level of occurrence of suicidal thoughts among seniors in both countries, and the most frequently reported reasons include a sense of being unnecessary, loneliness, lack of purpose, the death of a close person, and lack of money.

The table V presents the causes of suicidal thoughts among respondents from Poland and Sweden. These results suggest that a sense of social isolation and emotional loss are key factors leading to suicidal thoughts in both countries, which may indicate a need for emotional support for seniors in both countries.

The table VI shows that the majority of respondents in both Poland (95.21%) and Sweden (94%) have never had a suicide attempt. These results indicate that although suicide attempts are rare among the surveyed seniors, they do occur and may constitute a key indicator in the analysis of suicidality in this age group.

Table III. Knowing someone personally whom the respondent knows has attempted suicide

Do you personally know someone whom you know has attempted suicide?	Poland N=188	100%	Sweden N=100	100%
Yes	32	17.02%	16	16%
No	153	81.38%	84	84%

Table IV. Question about suicidal thoughts among respondents

Have you ever had suicidal thoughts?	Poland N=188	100%	Sweden N=100	100%
Yes	25	13.30%	13	13%
No (go to Question 9)	160	85.11%	87	87%

Table V. Causes of suicidal thoughts

What was the cause of your suicidal thoughts? (more than one answer may be selected)	Poland N=188	100%	Sweden N=100	100%
Lack of purpose	5	2.66%	2	2%
Loneliness	6	3.19%	5	5%
Illness	2	1.06%	3	3%
Lack of paid employment	0	0%	2	2%
Lack of hobbies	1	0.53%	1	1%
Disability	0	0%	0	0%
Physical impairment	0	0%	0	0%
Lack of money	5	2.66%	2	2%
Stereotypes	1	0.53%	2	2%
Lack of skills in using electronic devices (e.g., phone, computer)	0	0%	0	0%
Sense of being unnecessary	9	4.79%	3	3%
Death of a close person	5	2.66%	4	4%
Divorce	5	2.66%	3	3%
Husband's infidelity and lack of his interest in the family	1	0.53%	0	0%

Table VI. Question about suicide attempts

Have you had a suicide attempt in the past?	Poland N=188	100%	Sweden N=100	100%
Yes, once	7	3.72%	3	3%
Yes, 2–5 times	1	0.53%	2	2%
No, I have not	179	95.21%	94	94%

Experiences of violence among older adults

The study additionally examined experiences of psychological, physical, economic, and sexual violence among older adults in Poland and Sweden. The results demonstrate differences in the prevalence of particular forms of violence between the analyzed groups. Experiences of physical violence were reported by 11.17% of respondents in Poland and 5.00% of respondents in Sweden. The majority of participants in both countries declared no such experiences (88.83% in Poland and 95.00% in Sweden). Among Polish respondents who reported physical violence, the perpetrators were most frequently family members (n = 21), followed by acquaintances (n = 4). One respondent identified a former husband as the perpetrator. Psychological violence was reported more frequently than physical violence in both countries. In Poland, 17.55% of respondents declared experiences of psychological violence, compared with 12.00% in Sweden. Most respondents reported no such experiences (81.38% in Poland and 88.00% in Sweden). Economic violence was reported at a similar level in both groups, affecting 6.38% of respondents in Poland and 7.00% in Sweden. The majority of participants in both countries did not report experiences of economic violence (93.62% in Poland and 93.00% in Sweden). Experiences of sexual violence were reported less frequently. In Poland, 4.26% of respondents declared experiences of sexual violence, whereas in Sweden this proportion was 2.00%. Most respondents in both groups reported no such experiences (95.74% in Poland and 98.00% in Sweden). Comparative analysis demonstrated that physical and psychological violence were reported more frequently among Polish respondents than among Swedish respondents, whereas the prevalence of economic and sexual violence remained relatively low and comparable between the groups.

Social activity and support networks

Comparative analysis revealed substantial differences between respondents from Poland and Sweden regarding social activity, interpersonal relationships, and support networks in later life.

Polish respondents reported higher levels of social activity outside the home. Leaving home several times per week was declared by 37.77% of respondents in Poland and 27.00% in Sweden, while daily social activity was reported by 13.30% and 10.00% of respondents, respectively. The proportion of respondents who did not leave home for social purposes remained low in both countries (3.72% in Poland and 3.00% in Sweden). Participation in organized social activities also differed significantly between the analyzed groups. In Poland, 88.83% of respondents declared participation in activities outside the home, compared with 43.00% of respondents in Sweden. Conversely, lack of participation in organized activities was reported by 57.00% of Swedish respondents and only 8.51% of Polish respondents. Most participants in both countries reported having relatives; however, differences were observed between the groups. In Poland, 94.68% of respondents declared having family members, compared with 89.00% in Sweden. The absence of relatives was more frequently reported among Swedish respondents (11.00%) than among Polish respondents (1.60%). Differences were also identified in the frequency of interpersonal contact. Frequent telephone contact with relatives, defined as daily or several times per week, was reported by 40.96% of respondents in Poland and 21.00% in Sweden. Regular in-person meetings with relatives were also more common among Polish respondents (27.66%) compared with Swedish respondents (11.00%). Lack of contact with relatives was reported by 6.00% of respondents in Sweden and 1.06% in Poland. The availability of social support in emergency situations differed between the analyzed groups. In Poland, 89.89% of respondents declared having someone they could ask for help in sudden situations, whereas this was reported by 81.00% of respondents in Sweden. Lack of available support was reported more frequently among Swedish respondents (17.00%) than among Polish respondents (6.38%). Support networks in Poland were primarily based on informal interpersonal relationships, including relatives (60.64%), neighbors (31.38%), friends (23.40%), and acquaintances (18.62%). In Sweden, these informal support networks appeared less pronounced, particularly regarding neighbors (11.00%) and friends (3.00%). At the same time, formal caregiving support was reported slightly more frequently among Swedish respondents (2.00%) compared with respondents in Poland (0.53%). Participation in senior-oriented institutions and programs also differed substantially between the countries. Participation in the University of the Third Age was reported by 49.47% of Polish respondents and 7.00% of Swedish respondents. Senior Clubs were attended by 39.36% of respondents in Poland and 18.00% in Sweden. In contrast, Nursing Homes played a more significant role among Swedish respondents (21.00%) than among Polish respondents (4.26%). Overall, the findings suggest that older adults in Poland more frequently function within informal family- and community-based support systems, whereas Swedish respondents appear to rely more strongly on institutional forms of support and organized care.

Social support, social participation, and quality of life indicators

Comparative analysis demonstrated substantial differences between respondents from Poland and Sweden regarding social participation, interpersonal relationships, and support networks among older adults. Polish respondents reported higher levels of social activity outside the home. Leaving home several times per week was declared by 37.77% of respondents in Poland and 27.00% in Sweden, whereas daily activity outside the home was reported by 13.30% and 10.00% of respondents, respectively. The proportion of respondents who did not leave home for social purposes remained low in both countries (3.72% in Poland and 3.00% in Sweden). Participation in organized activities differed significantly between the groups. In Poland, 88.83% of respondents declared participation in activities outside the home, compared with 43.00% of respondents in Sweden. Conversely, lack of participation in organized activities was reported by 57.00% of Swedish respondents and 8.51% of Polish respondents. The most frequently reported forms of activity among Polish respondents included the University of the Third Age (49.47%) and Senior Clubs (39.36%). In Sweden, participation in these forms of activity was lower (7.00% and 18.00%, respectively). Nursing Homes were reported more frequently among Swedish respondents (21.00%) than among Polish respondents (4.26%). Most respondents in both countries declared having relatives. In Poland, 94.68% of participants reported having family members, compared with 89.00% in Sweden. Lack of relatives was more frequently reported among Swedish respondents (11.00%) than among Polish respondents (1.60%). Differences were also identified in patterns of interpersonal contact. Frequent telephone contact with relatives, defined as daily or several times per week, was reported by 40.96% of respondents in Poland and 21.00% in Sweden. Regular face-to-face meetings with relatives were declared by 27.66% of Polish respondents and 11.00% of Swedish respondents. Lack of contact with relatives was reported by 6.00% of respondents in Sweden and 1.06% in Poland.

The availability of social support in emergency situations also differed between the groups. In Poland, 89.89% of respondents declared having someone they could ask for help in sudden situations, whereas this was reported by 81.00% of respondents in Sweden. Lack of

Comparative statistical analysis (Poland vs Sweden) (table VII)

Table VII. Statistical comparison of suicidal and social variables between respondents from Poland and Sweden (chi-square test)

Variable	Chi-square (χ^2)	p-value	Statistical significance	Notes / Interpretation
participation in activities outside the home	68.91	< 0.001	Statistically significant	A very strong difference; Polish seniors participate in outdoor activities much more often than Swedish ones.
frequent contact with relatives	14.62	< 0.001	Statistically significant	A significant difference in Poland's favour; Polish seniors maintain much more intense family relationships.
possibility of receiving help in emergency situations	7.15	0.008	Statistically significant	A significant difference: Polish seniors more often declare access to support in crisis situations.
knowledge of suicidal thoughts among acquaintances	1.84	0.175	Statistically insignificant	There are no significant differences between respondents from Poland and Sweden in terms of knowledge about suicidal thoughts among friends.
knowledge of suicide attempts among acquaintances	0.05	0.823	Statistically insignificant	No significant differences; the level of knowledge about suicide attempts in the community is similar in both countries.
lifetime suicidal ideation	0.01	0.932	Statistically insignificant	No significant differences; the incidence of suicidal thoughts among seniors in Poland and Sweden is almost identical.
experiences of physical violence	2.71	0.099	Statistically insignificant	No significant differences; results regarding the experience of physical violence did not reach statistical significance.
experiences of psychological violence	1.66	0.197	Statistically insignificant	No significant differences in the declared experience of psychological violence between countries.
experiences of economic violence	0.03	0.858	Statistically insignificant	No significant differences; the phenomenon of economic violence occurs at a similar level in both studied groups.
experiences of sexual violence	0.87	0.351	Statistically insignificant	No significant differences in reported experiences of sexual violence between countries.

available support was reported more frequently among Swedish respondents (17.00%) compared with Polish respondents (6.38%). Support networks among Polish respondents were primarily based on informal interpersonal relationships, including relatives (60.64%), neighbors (31.38%), friends (23.40%), and acquaintances (18.62%). In Sweden, lower percentages were observed for neighbors (11.00%) and friends (3.00%), while formal caregiving support was reported slightly more frequently (2.00% in Sweden vs. 0.53% in Poland). Experiences of violence were reported in both groups, although differences in prevalence were observed. Physical violence was declared by 11.17% of respondents in Poland and 5.00% in Sweden. Psychological violence was reported by 17.55% of respondents in Poland and 12.00% in Sweden. Economic violence occurred at a comparable level in both countries (6.38% in Poland and 7.00% in Sweden), whereas sexual violence was reported by 4.26% of Polish respondents and 2.00% of Swedish respondents. The prevalence of suicidal ideation was similar in both groups (13.30% in Poland and 13.00% in Sweden). Differences were observed regarding self-reported causes of suicidal thoughts. Polish respondents more frequently indicated feelings of being unnecessary (4.79%), lack of purpose in life (2.66%), and financial difficulties (2.66%), whereas Swedish respondents more frequently reported loneliness (5.00%) and physical illness (3.00%) as contributing factors. The findings indicate differences between respondents from Poland and Sweden in the areas of social participation, interpersonal relationships, support networks, and selected psychosocial experiences associated with later life.

Discussion

The present study examined selected aspects of suicidal behavior, experiences of violence, social participation, and support networks among older adults in Poland and Sweden. The findings indicate important differences between the analyzed groups, particularly in the areas of social integration, interpersonal relationships, and access to informal support systems. One of the most important findings concerns social participation and interpersonal connectedness. Respondents from Poland demonstrated significantly higher levels of participation in activities outside the home, more frequent contact with relatives, and greater perceived availability of support in emergency situations. Statistical analysis confirmed significant differences between the groups in social participation, frequency of contact with relatives, and perceived social support. These findings are consistent with previous studies emphasizing the protective role of social integration and interpersonal relationships in reducing psychological distress and suicide risk among older adults [6,7,10]. The results support earlier research indicating that loneliness and limited social connectedness constitute important psychosocial risk factors in later life. Previous longitudinal studies have shown that reduced social participation and mobility limitations are associated with higher levels of suicidal ideation among older adults [10]. Similarly, WHO reports identify social isolation and loneliness as major determinants negatively affecting mental health and quality of life in old age [11]. The higher proportion of Swedish respondents reporting limited social contact and lack of available support may therefore reflect broader differences in patterns of social integration between the analyzed countries.

Although descriptive differences were observed regarding experiences of physical and psychological violence, statistical analysis did not demonstrate significant differences between Polish and Swedish respondents in most forms of violence. Nevertheless, the relatively higher prevalence of violence reported among Polish respondents remains clinically and socially important. Violence against older adults may negatively affect emotional well-being, feelings of safety, and psychosocial functioning, particularly when occurring within family environments. Previous studies indicate that exposure to violence and neglect may contribute to depression, anxiety, loneliness, and increased vulnerability to suicidal behavior in later life [11]. The prevalence of suicidal ideation was similar in both groups, and no statistically significant differences were identified between respondents from Poland and Sweden. This finding may suggest that suicidal thoughts among older adults are associated with multidimensional psychosocial and health-related factors that transcend differences in national welfare systems. However, respondents differed regarding the subjective causes of suicidal ideation. Polish respondents more frequently reported feelings of being unnecessary, lack of purpose in life, and financial difficulties, whereas Swedish respondents more often indicated loneliness and physical illness. These observations correspond with previous gerontological research emphasizing the complex interaction between psychosocial, economic, and health-related determinants of suicidality in later life [1-3]. The findings additionally suggest the presence of two different models of psychosocial functioning in later life. Older adults in Poland appear to function more frequently within informal family- and community-based support systems, whereas Swedish respondents may rely more strongly on institutional and formal support structures. Previous studies conducted in Sweden have similarly demonstrated that formal care systems often

coexist with weaker interpersonal and neighborhood relationships among older adults [7,8]. At the same time, Polish studies indicate that family relationships and local social networks remain central sources of emotional and practical support among seniors [6].

Several methodological limitations should be acknowledged. The study used a convenience sample and the recruitment process differed between countries. In Poland, participants were recruited primarily through senior organizations, Universities of the Third Age, and community centers, which may have resulted in overrepresentation of socially active individuals. Consequently, the results should not be generalized to the entire older adult population. Furthermore, the study relied on self-reported data and an original questionnaire rather than standardized psychometric instruments. The cross-sectional design also limits the possibility of establishing causal relationships between variables.

Despite these limitations, the study contributes to a broader understanding of suicidality, violence, and psychosocial functioning among older adults in different sociocultural contexts. The findings highlight the importance of strengthening social participation, reducing loneliness, supporting interpersonal relationships, and improving access to psychological and community-based support for older adults. The results also support the need for age-sensitive suicide prevention strategies addressing both social isolation and violence in later life.

Conclusions

The present study highlights the important role of social participation, interpersonal relationships, and support networks in the psychosocial well-being of older adults. Although the prevalence of suicidal ideation was comparable among respondents from Poland and Sweden, the findings suggest that the social contexts associated with later-life suicidality may differ between the analyzed countries. Older adults in Poland appeared to rely more strongly on informal family- and community-based support, whereas Swedish respondents more frequently reported loneliness and limited social connectedness. These observations emphasize that social isolation, reduced interpersonal contact, and limited support availability remain important factors associated with vulnerability in later life, regardless of national welfare systems. The findings underline the need for age-sensitive suicide prevention strategies focused on strengthening social integration, reducing loneliness, promoting meaningful participation in community life, and improving access to psychological and social support services for older adults. Future longitudinal and cross-cultural studies are needed to further explore the relationship between social functioning, violence, and suicidality in ageing populations.

Conflict of interest
None

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