Suicidal Ideation and Self-Determination in Institutionalized Elderly

Article *in* Crisis The Journal of Crisis Intervention and Suicide Prevention · February 2001

DOI: 10.1027//0227-5910.22.1.15 · Source: PubMed

6 authors, including:

Sylvie Lapierre
Université du Québec à Trois-Rivières
61 PUBLICATIONS **1,140** CITATIONS
SEE PROFILE

Réal Labelle
Université du Québec à Montréal
75 PUBLICATIONS **551** CITATIONS
SEE PROFILE

Suicidal Ideation and Self-Determination in Institutionalized Elderly

Andrée Fortin[1], Sylvie Lapierre[2], Jacques Baillargeon[2], Réal Labelle[2], Micheline Dubé[2], Jocelyne Pronovost[2]

[1]Private practice in Beauport, Québec, [2]Université du Québec à Trois-Rivières, Québec

Summary: The right to self-determination is central to the current debate on rational suicide in old age. The goal of this exploratory study was to assess the presence of self-determination in suicidal institutionalized elderly persons. Eleven elderly persons with serious suicidal ideations were matched according to age, sex, and civil status with 11 nonsuicidal persons. The results indicated that suicidal persons did not differ from nonsuicidal persons in level of self-determination. There was, however, a significant difference between groups on the social subscale. Suicidal elderly persons did not seem to take others into account when making a decision or taking action. The results are discussed from a suicide-prevention perspective.

Keywords: Suicidal ideation, elderly, institution, self-determination, decision, depression, rational suicide.

Research on suicide indicates that the suicide rate in many industrialized countries is highest among people over 65 (Gulbinat, 1996; McIntosh, Santos, Hubbard, & Overholser, 1994). Less interest is shown, however, in the suicidal behavior among older adults than in that found in adolescents and young adults (de Leo & Diekstra, 1990). Even fewer studies have been done concerning self-destructive behavior among the elderly in nursing homes. The best known is the work by Osgood, Brant, and Lipman (1991), which showed a rate of 15.8 per 100,000 for completed suicide (compared to 19.2 in the general community), and of 63.3 for attempted suicide (community data not available). The lower completed suicide rate in the institution could be explained by the 24-hour presence of staff members and the mental health resources offered by the facilities, but also to a possible lower reporting of cases to avoid stigma or scandal. However, when intentional life-threatening behaviors are considered (which include willfully and repeatedly refusing medications, food, or drink to bring about a premature death), authors report a rate of 227.8 for this type of behavior in nursing homes and a death rate of 79.1. This relatively high death rate could be explained by the poor physical health of older institutionalized persons which prevents them from surviving from any intentional life-threatening behaviors.

These data show that self-destructive behaviors in long-term care facilities are not a rare occurrence and should be the object of further study. Many psychosocial factors could play a role in the suicidal behavior of institutionalized elderly persons. Most of them have experienced a multitude of physical, psychological, emotional, social, and environmental losses considered to be risk factors for suicide (Lapierre, Pronovost, Dubé, & Delisle, 1992; McIntosh et al., 1994). The frustration of self-determination needs, which often prevails in long-term care facilities because of environmental regulations, could also be a risk factor for suicidal behavior (Rakowski & Cryan, 1990; McIntosh et al., 1994). Rakowski and Cryan (1990) indicated that the loss of control over one's life can have negative effects on self-esteem, physical health, life satisfaction, and can make the individual generally vulnerable to suicide. In a previous study, self-determination, defined as the will to decide and to behave in an autonomous fashion, was found to be significantly lower in institutionalized elderly and associated to helplessness, hopelessness, and a lack of self-esteem (Dubé, Alain, Lapierre, & Lalande, 1992). It is possible that a person who has lost the opportunity to decide for him- or herself and to behave independently could come to the conclusion that suicide is the only solution to escape a reduced quality of life.

However, Grassi (1990) mentioned that suicidal ideation can give elderly persons a feeling of control in situa-

tions of sickness and unbearable pain, and that patients might use suicide as a way to master the end of their life. Suicide would then be the last form of personal control over one's life (Grassi, 1990; Haight, 1995) and be considered a rational decision in the face of suffering and a lack of quality of life (Clarke, 1999; Werth & Cobia, 1995).

Most of these articles reported descriptive or case studies; no research has assessed *empirically* the presence of self-determination in suicidal individuals. The goal of the present study was thus to compare the level of self-determination of suicidal and nonsuicidal institutionalized elderly persons in order to see if this variable should be a factor to consider in the explanation of the suicidal process.

Method

Participants

We encountered significant difficulties in recruiting the sample. First, of the 13 long-term care facilities invited to participate in this study, only seven (54%) accepted the research proposal. Osgood and Brant (1990) reported a similar response rate (43%) in a survey asking administrators about elderly suicidal behavior in their long-term care facility. It seems that many nursing homes refused to admit the existence of self-destructive behavior in their facilities and those who did felt unprepared to deal with it. Second, with the financial cutbacks present in the health-care system, long-term facilities were centering their resources on physical care and were mostly unable to offer mental health services to residents except in crisis situations. Therefore, no mental health professionals were available to identify suicidal patients. We had to ask the health care personnel to help us find patients that *might be* suicidal. We presented them with typical warning signs and losses that could indicate a *possible vulnerability* to suicide (Lapierre et al., 1992). We asked to meet with patients who expressed direct verbal clues, like the expression of suicidal ideas, desire for death, or self-destructive behavior. But, knowing that elderly persons, especially men, often hide their intention of committing suicide (Lapierre, Pronovost, Dubé, & Delisle, 1993), we also asked to meet with all those who had difficulty adapting to life in the institution, who seemed depressed, unhappy, isolated, who frequently cried, or who had conflicts with the personnel about food or medications. These troubled individuals were then interviewed to assess their suicidal risk. Like Osgood (1985, p. 95), we believed that most elderly persons "readily discuss their suicidal feelings and intentions and are glad to be able to share their thoughts with someone who cares enough to ask." On the other hand, we were also aware that, being dependent on the staff for the detection of patients that could be vulnerable to suicide, we had no way of knowing whether the cases made available to us for the investigation might have been less suicidal to provide a positive reflection of the institution. This is clearly a limit in the interpretation of the data of this exploratory study. Obviously, it would be preferable to screen the entire nursing home population for suicidal residents, but this was not possible because of a lack of financial and human resources. Nevertheless, we believe that, by focusing on elderly people who seemed to experience various difficulties, we had more chance to identify enough suicidal persons to realize the study.

Sixty-six caucasian French-Canadian elderly persons without cognitive deficits were met individually, on a confidential and voluntary basis. A structured interview was used to obtain data on the participants' personal life (social, family, and caregiver relationships, self-perceived health and pain), their attitude toward death and suicide, and more precisely on their suicidal ideas. Affirmative answers to four specific questions of the structured interview were used to identify suicidal persons. This led to the identification of 11 individuals (7 men and 4 women) who reported serious suicidal ideations: They were already planning their suicide and had identified a method to kill themselves. (No data on validity and reliability are available for the structured interview. However, the questions used to identify suicidal persons were found in Beck, Steer, and Ranieri's (1988) Scale for Suicide Ideation.) The interviews with the other 55 individuals, chosen because they expressed low morale or showed behaviors that *could have been* a sign of a risk for suicide, indicated that they were not suicidal. They all answered negatively all four specific questions on suicide, even if their life situation was very difficult to accept.

Each suicidal person was then matched, according to age, sex, and civil status, with a nonsuicidal subject (n = 55) from the sample. Therefore, the final sample consisted of 22 subjects from 69 to 96 years of age (M = 80.3). Six were married, five were widowed.

Measures

Four questions from the structured interview were used to identify elderly persons with suicidal ideas:
1. "Did you seriously think about taking your own life?"
2. "Did it happen in the last 12 months?"
3. "Presently, are you thinking about killing yourself?"
4. " Have you thought of a way to kill yourself?"

These questions originated from a provincial survey on mental health which included few items on suicide (Gouvernement du Québec, 1993). They are also found in Beck, Steer, and Ranieri's (1988) Scale for Suicide Ideation and are often used by researchers to determine the presence of suicidal ideas.

The subjects also filled out three questionnaires: a general information questionnaire, the Psychological Autonomy Questionnaire, and Geriatric Depression Scale. The first provided sociodemographic information about the participants. The Psychological Autonomy Questionnaire measured self-

determination (the will to decide and to behave independently) in elderly persons. It contains 28 statements divided into three subscales: dynamic, capacity, and social. The internal reliability coefficients were .89 for the main scale and .60 to .81 for the subscales. A factor analysis, based on an independent sample (N = 239), indicated that the items showed correlations of .45 to .62 with a main factor explaining 27% of the variance (Lamy, Dubé, Lapierre, Alain, & Lalande, 1994). The *dynamic subscale* refers to the ability to take into account one's own feelings and motivation when making a decision or taking action. It is measured with items like: "I rely on my feelings to make a decision." The *capacity subscale* refers to the individual's determination to maintain or promote physical, cognitive, and social abilities in order to keep one's autonomy. For example: "I choose activities that will help me keep my physical abilities." Finally, the *social subscale* refers to the respect one has for others when making personal decisions or taking action. It is evaluated with items like: "I am concerned with others while pursuing my own interests."

The 30 statements of the Geriatric Depression Scale (GDS) take into consideration normal physiological and psychological changes associated with aging in the evaluation of depression (Yesavage et al., 1983). The Cronbach consistency coefficient was .89 for the French translation.

Results

Characteristics of the suicidal and the nonsuicidal groups are presented in Table 1. There was no significant difference between the suicidal and the nonsuicidal group on the time spent in the facility (M = 39.2 months), level of education, self-perception of health when subjects compare themselves to people their own age nor when they compared themselves to people living in the facility, the level of pain, the level of satisfaction with pain medication, the number of years they have had health problems, and self-evaluation of the quality of their sleep. However, there was a significant difference on the level of satisfaction with the relations with children (t(11.4) = 2.64, p = .02) and on the level of satisfaction with family relationships (t(14.3) = 3.21, p = .006). The suicidal group was significantly less satisfied with family relationships and relations with children than the nonsuicidal group.

There was no significant difference between men and women on the level of depression and self-determination. However, more men (7 out of 26 = 27%) than women (4 out of 40 = 10%), from the initial sample of 66, were identified as being suicidal. As Osgood, Brant, and Lipman (1991) showed for other types of suicide behaviors (overt completed suicide, overt attempted suicide, intentional life-threatening behavior causing death and not causing death), suicidal ideations seem to be considerably higher in males than in females living in long-term care facilities.

Results (see Table 2) indicated that the level of self-determination was lower in the suicidal group (M = 94.6; SD = 20.3) than in the nonsuicidal group (M = 103.3; SD = 11.1), though the difference did not reach significance. On the other hand, results showed a significant difference between the groups on the social subscale (t(20) = 2.27, p = .03), which refers to the respect of others when making a decision or taking action. It seems that the suicidal group considered significantly less than the nonsuicidal group the

Table 1. Characteristics of the suicidal and nonsuicidal groups.

Variables	Suicidal *M (SD)*	Nonsuicidal *M (SD)*	*t*
Age	80.5 (8.2)	80.1 (7.4)	– .08
Months in institution	42.5 (61.9)	35.9 (35.4)	– .30
Level of education	8.3 (4.1)	8.2 (2.9)	– .06
Perception of health compared to same age	3.9 (1.1)	3.0 (1.0)	–1.99
Perception of health compared to people in facility	3.5 (1.1)	2.7 (0.8)	–1.75
Level of pain	2.7 (1.2)	2.2 (1.5)	– .93
Satisfaction with pain medication	2.5 (0.8)	2.1 (0.8)	–1.29
Years of health problems	5.7 (4.7)	9.6 (10.9)	1.10
Quality of sleep	3.0 (1.3)	3.5 (1.0)	.89

Note: All *t*-tests have 20 degrees of freedom. There are no significant differences.

Table 2. Mean differences between nonsuicidal and suicidal elderly persons on self-determination, dynamic subscale, capacity subscale, social subscale, and depression.

Variables	Suicidal *M (SD)*	Nonsuicidal *M (SD)*	*t*	*p*
Self-determination	94.6 (20.3)	103.3 (11.1)	1.24	n.s.
1. Dynamic	45.8 (8.6)	48.5 (5.8)	.87	n.s.
2. Capacity	32.9 (12.1)	37.1 (5.9)	1.03	n.s.
3. Social	15.9 (1.8)	17.6 (1.8)	2.27	.03
Depression	20.4 (1.8)	9.5 (7.4)	–4.69	.001

Note. All *t*-tests have 20 degrees of freedom.

impact of their behavior on others when they made a decision or took action. Results also indicated that suicidal participants were significantly more depressed (M = 20.4; SD = 1.8) than the nonsuicidal persons (M = 9.54; SD = 7.4; $t(11.2) = -4.69$, $p < .001$). Significant correlations were observed between depression scores on the GDS and two of the self-determination subscales: the capacity subscale ($r(20) = -.46$, $p < .05$) and the social subscale ($r(20) = -.44$, $p < .05$). People with higher depression scores on the GDS tended to be less determined to maintain or promote their physical, cognitive, and social abilities; they were also less likely to respect others when making personal decisions or taking action. But when suicide is controlled for, the correlation between depression and the social subscale disappears ($pr(19) = -.18$, $p = .44$), while the correlation with the capacity subscale is maintained ($pr(19) = -.44$, $p < .05$).

Complementary analysis of the questions asked in the structured interview added that suicidal elderly (7 out of 11) felt rejected significantly ("Do you feel rejected by the people around you?") more often than nonsuicidal subjects (2 out of 11): χ^2 (1, N = 22) = 4.7, $p < .05$. However, it should be noted that they had confidants in the same proportion as the nonsuicidal group (70% of each group said they had confidants) and they even had more friends (7 out of 11 said they had friends) than the nonsuicidal group (4 out of 11).

Discussion

The current debate on rational suicide, discussing the right of older adults to commit suicide when negative aspects of life outweigh the positive, warrants research on self-determination during the suicidal process. The absence of a significant difference between the suicidal and the nonsuicidal group on self-determination indicates that the discussion remains open. Subsequent research on self-determination and suicide should increase sample size, but also be prepared for difficult conditions in sample recruitment since suicide is still a sensitive topic in many nursing homes. Studies could also consider the entire suicidal process since suicidal ideation is different from suicidal attempt and completed suicide. It is possible that a higher level of self-determination could become present later in the suicidal process, when the intention to kill oneself becomes crystallized into a suicidal attempt. But elderly persons who are determined to kill themselves probably would refuse to participate in such a research since they are less ambivalent about their decision and would not take the opportunity given to them to express their suicidal thoughts. It is also possible that a lower level of self-determination could appear later in this process since lower self-determination is usually associated with hopelessness (Dubé, Alain, Lapierre, & Lalande, 1992), which is often related to depression and suicidal ideations.

The fact that the present research studied an institutionalized sample makes us also wonder if the results might be different in a community sample, where self-determination is generally higher (Dubé et al., 1992) and where help is not readily available in the environment. In subsequent research, it could also be interesting to use different types of measures of self-determination and develop suicide probability scales adapted to an older population. In conclusion, the results of this exploratory study show that further research is indeed needed to clarify the possible role of self-determination in the suicidal process of older individuals.

Suicidal ideas in this sample are related to depression, a potentially treatable condition. Depressive thinking is characterized by negative interpretations of the ongoing situation, distortion of reality, constriction of thinking, and problems assessing possible solutions to personal difficulties (Beck, Rush, Shaw, & Emery, 1979). In the context of depression, can we really talk about informed decision-making and free choice (Clarke, 1999)? Suicide in the institutionalized elderly must be recognized as a cry for help and not as a "reasoned behavioral expression of legitimate preference for an earlier death" (Conwell, Pearson, & DeRenzo, 1996, p. 152). Intervention should be oriented toward improving the quality of life (Kerkhof & de Leo, 1991; Schneewind, 1994) in long-term care facilities and toward psychotherapeutic assessment and intervention of depression. Correlation analyses also showed that depression was related to a lack of respect toward others, but controlling for suicide makes this correlation disappear, making suicidal ideations an important variable in the relationship between depression and respect for others when making decision or taking action.

The results obtained on the dynamic subscale indicate that the suicidal group, as much as the nonsuicidal group, took their emotions and their needs into consideration when making decisions and taking actions—but the difference on the social subscale showed that they did not seem to consider those of others. According to Richman (1993), many elderly persons do not realize the impact of their self-destructive behavior on their family because they have negative beliefs about themselves and their relationships (especially family relationships). Since they are centered on their frustrated social needs (to be appreciated, to be respected, to be useful) and their negative perception of their environment (feeling rejected, dissatisfaction with relationships with children and family), they disregard the effect of their behavior on people around them. The data did not tell us whether these feelings and perceptions were related to some aspects of living in an institution or particularly linked to the suicidal individual's personal beliefs. This could be evaluated in a subsequent research. However, the data show the importance of working closely with the family and significant others because feelings of rejection and difficulties in considering the impact of their behavior on others seemed to differentiate suicidal subjects from nonsuicidal. Recent studies tend to confirm that relationship problems are a prominent factor in suicide in old age (Draper, 1996), and that older people with self-rated poor family relations have a positive attitude toward suicide

(Seidlitz, Duberstein, Cox, & Conwell, 1995). In this context, Richman's (1993) family therapy with suicidal people seems recommended.

References

Beck AT, Rush AJ, Shaw BF, Emery G. *Cognitive therapy of depression.* New York: Guilford, 1979.

Beck AT, Steer RA, Ranieri WF. Scale for suicide ideation: Psychometric properties of a self-report version. *Journal of Clinical Psychology* 1988; 44:499–505.

Clarke DM. Autonomy, rationality and the wish to die. *Journal of Medical Ethics* 1999; 25:457–462.

Conwell Y, Pearson J, DeRenzo EG. Indirect self-destructive behavior among elderly patients in nursing homes. *American Journal of Geriatric Psychiatry* 1996; 4:152–163.

de Leo D, Diekstra RFW. *Depression and suicide in late life*. Toronto: Hogrefe & Huber, 1990.

Dubé M, Alain M, Lapierre S, Lalande G. *Relations entre l'autonomie et certains facteurs psychologiques (actualisation de soi, support social, résignation acquise, niveau d'espoir) chez les âgés et les très âgés* (Relations between autonomy and certain psychological factors (self-actualization, social support, learned helplessness, level of hope) in the old and very old). Research report (No. RS-1617088). Trois-Rivières: Université du Québec, Laboratoire de Gérontologie, 1992.

Draper B. Attempted suicide in old age. *International Journal of Geriatric Psychiatry* 1996; 11:577–587.

Gouvernement du Québec. *Santé Québec. Rapport de l'enquête sociale et de santé: 1992–1993, Volume 1* (Québec Health. Report from the social and health survey: 1992–1993). Québec: Les Publications du Québec, 1993.

Grassi G. Memoria autobiografica e fantasie di morte nell'anziano (Autobiographical memory and death fantasies in the elderly). *Rivista Sperimentale di Freniatria e Medicina Legale delle Alienazioni Mentali* 1990; 114:150–155.

Gulbinat WH. The epidemiology of suicide in old age. *Archives of Suicide Research* 1996; *2*:31–42.

Haight BK. Suicide risk in frail elderly people relocated to nursing homes. *Geriatric Nursing* 1995; 16:104–107.

Kerkhof A, de Leo D. Suicide in the elderly: A frightful awareness. *Crisis* 1991; 12:81–87.

Lamy L, Dubé M, Lapierre S, Alain M, Lalande G. L'autonomie fonctionnelle et la santé perçue comme prédicteurs de l'autonomie psychologique des personnes âgées. (Functional autonomy and subjective health as predictors of psychological autonomy of elderly persons). *Revue Québécoise de Psychologie* 1994; 15:23–46.

Lapierre S, Pronovost J, Dubé M, Delisle I. Identification of suicidal behavior in the elderly. *Suicidal Behavior: Proceedings of the XVI Congress of the International Association for Suicide Prevention* 1993; 312–315.

Lapierre S, Pronovost J, Dubé M, Delisle I. Risk factors associated with suicide in elderly persons living in the community. *Canada's Mental Health* 1992; 40:8–12.

McIntosh JL, Santos JF, Hubbard RW, Overholser JC. *Elder suicide. Research, theory and treatment*. Washington, DC: American Psychological Association, 1994.

Osgood NJ. *Suicide in the elderly. A practitioner's guide to diagnosis and mental health intervention.* Rockville, MD: Aspen, 1985.

Osgood NJ, Brant BA. Suicidal behavior in long-term care facilities. *Suicide and Life-Threatening Behavior* 1990; 20:113–122.

Osgood NJ, Brant BA, Lipman A. *Suicide among the elderly in long-term care facilities*. New York: Greenwood, 1991.

Rakowski W, Cryan C. Association among health perceptions and health status within three age groups. *Journal of Aging and Health* 1990; 2:58–80.

Richman J. *Preventing elderly suicide*. New York: Springer, 1993.

Schneewind EH. Of ageism, suicide, and limiting life. *Journal of Gerontological Social Work* 1994; 23:135–150.

Seidlitz L, Duberstein PR, Cox C, Conwell Y. Attitudes of older people toward suicide and assisted suicide: An analysis of Gallup poll findings. *Journal of the American Geriatrics Society* 1995; 43:993–998.

Werth JL, Cobia DC. Empirically based criteria for rational suicide: A survey of psychotherapists. *Suicide and Life-Threatening Behavior* 1995; 25:231–240.

Yesavage JA, Brink TL, Rose TL, Lum O, Huang U, Adey M, Leirer VO. Development and validation of a geriatric depression rating scale: A preliminary report. *Journal of Psychiatric Research* 1983; 17:37–49.

About the authors:

Andrée Fortin did this research as part of her master's thesis from the Université du Québec à Trois-Rivières. This pilot study was supported by a grant from le Fonds Institutionnel de Recherche de l'Université du Québec à Trois-Rivières. Andrée Fortin is now a psychologist in private practice in Beauport, Québec, Canada, working with the institutionalized elderly.

Sylvie Lapierre is an Associate Professor at the Department of Psychology of the Université du Québec à Trois-Rivières and the Director of the Research Laboratory in Gerontology. Her main interest lies in the area of hope and despair in the elderly.

Jacques Baillargeon is an Associate Professor at the Department of Psychology of the Université du Québec à Trois-Rivières and does research on cognitive deficits in old age.

Réal Labelle is an Associate Professor at the Department of Psychology of the Université du Québec à Trois-Rivières and a researcher with the CRISE, the Research and Intervention Center on Suicide and Euthanasia.

Micheline Dubé is Full Professor at the Department of Psychology at the Université du Québec à Trois-Rivières. She directs an intervention program helping retired and elderly individuals to increase their well-being with the realization of their personal goals.

Jocelyne Pronovost is a Full Professor at the Department of Psychoeducation of the Université du Québec à Trois-Rivières and works primarily on suicidal behavior in young people.

Address for correspondence:

Sylvie Lapierre
Department of Psychology
Laboratoire de Gérontologie
Université du Québec à Trois-Rivières
3351 des Forges, Trois-Rivières
Québec, Canada, G9A-5H7
Tel. +1 819 376-5085
Fax +1 819 376-5195
E-mail Sylvie_Lapierre@uqtr.uquebec.ca