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LOSING CONNECTIONS: A PROCESS OF DECISION-MAKING IN LATE LIFE SUICIDALITY

By

Mary Ann Bell

A Dissertation Submitted to the Faculty of the

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In partial Fulfillment of the Requirements
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As members of the Final Examination Committee, we certify that we have read the dissertation prepared by Mary Ann Bell

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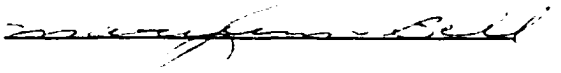
SIGNED: 

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DEDICATION

This dissertation is dedicated to my beloved grandmother, Anna Svab Bitsko. It was her love and belief in me that supported me through my most difficult times and continues to sustain me. She lives on in spirit with me each day.

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ABSTRACT

Late life suicide is a major public health problem in the U.S. with elderly white men at highest risk of completed suicide. This grounded theory study explored individual perspectives of suicidality with men aged 67 to 83 years. A basic social psychological process, *Losing Connections*, was identified from interviews. Three stages of this process were identified during which the effect of cumulative losses culminated in depression, prompted suicidal ideation, and led to a decision point for the individual. Loss was the key theme in stage one. Relationship, health, and role losses were identified with professional role loss being the most prominent. The second stage was characterized by depression and despair during which suicidal ideation was prominent. Progressive alienation and the resolution to die characterized this phase. In stage three, the struggle between wanting to die and deciding to do so presented a decision point. The decision point was surrounded by a balance of triggers and barriers, which was modulated by ambivalence. The informant perceived they had reasons to die (triggers), but made the decision not to die because of perceived consequences (barriers). Triggers prompting the decision point were thoughts of a deceased spouse, emotional pain, health problems, and feelings of uselessness and/or hopelessness. The most common barrier to suicide was consequences to family members. Religion was not a significant barrier. Instead, there was a general lack of religious connections among informants. Likewise, social isolation was not prominent, as informants retained connections with family members, friends, and community.

CHAPTER ONE

INTRODUCTION

Within our modern cultures we are experiencing the phenomenon of older adults killing themselves and attempting to kill themselves in ever-increasing numbers (Aldridge, 1998). Suicide has been part of the human experience since the beginning of time. It has been condoned by some philosophically as an appropriate choice for the older person, especially those who are physically ill and/or disabled. In primitive societies, suicide was conventional and at times obligatory for older adults when they had become a burden to their community (Alvarez, 1971). In Western industrialized nations, the rate of suicide is high, however our understanding of suicide in modern times is very poor.

The many definitions of suicide are reflective of a limited understanding of the phenomenon. There are as many definitions of suicide as there are theoretical perspectives. The definitions include different emphases on the intentions of the suicidal individual, the act itself, and the knowledge of the suicidal individual (Douglas, 1967). One commonly used legal definition of suicide is an intentional act of self-destruction by an individual who knows what s/he is doing and knows the probable consequences of the act (Whitfield & Southern, 1996). However, in the symbolic interactionist framework, a suicidal individual constructs meaning of suicide and motivation for committing it from collective values resting in the social context (Charmaz, 1980). Hence, in this view any definition of suicide rests upon individual interpretation. Since the symbolic interactionist perspective guided this study, suicide in this study was defined simply as, "voluntarily

taking of one's own life" (Thomas, 1993). Suicidality was defined as suicidal thoughts and behaviors.

Demographics of Late Life Suicide

Suicide is the 13th leading cause of death for older adults, those 65 years and older, in the United States (U.S.) (Leenaars, 1992). Suicide rates in late life began to increase in 1980 after a decrease from the previous 40 years. The rate stabilized in the 1990s. The proportion of older adults has increased in developed and developing countries due to increased life expectancy and a decrease in birthrate (Shah & De, 1998). These impending demographic changes portend an epidemic of suicides even if current suicide rates remain stable (Osgood, 1992).

The highest number of suicides occurs in the population aged 25 to 44 years, but the highest rate occurs among older adults, those 65 years and older (U.S. Bureau of the Census, 1996). These rates continue to increase dramatically as white men age (U.S. Senate, 1996). Older adults accounted for 21% of the suicides in the year 1993 when older adults were approximately 13% of the population (U.S. Bureau of the Census, 1996). There is a wide variation of suicide risk among subgroups within the older adult population. Elderly, white men were at the highest risk of suicide with rates of 29.4 per 100,000 in those aged 65 to 74, 48.9 per 100,000 for those 75 to 84, and 68.3 per 100,000 for those 85 years and older (U.S. Senate, 1996). Non-white men had the second highest rates with 16.7 per 100,000 for those 65 years and older. For white women, the numbers are much lower, with a high of 5.9 per 100,000 for ages 65 to 74. For women, the rate

decreases in later years. It is notable that suicide in elderly, non-white women is less than 3 per 100,000 (U.S. Senate, 1996).

Official suicide statistics are thought to under-represent the actual incidence of suicide, since the objective classification of a death as a suicide often lies with the medical examiner (Moscicki, 1995; U.S. Senate, 1996). A death may be self-inflicted, but if evidence to substantiate this is lacking, no suicide verdict is conferred (Aldridge, 1998). For example, deaths due to accidental poisoning or undetermined causes (Shah & De, 1998), fatal "accidents," and indirect destructive behaviors, such as refusal to eat or take prescribed medications, and are often not included in the official suicide count (Osgood, 1985; Szanto, Prigerson, Houck, Ehrenpreis, & Reynolds, 1997). Furthermore, classification is often complicated by social stigma and the emotional impact that a suicide can have on the family, hence the death may be otherwise categorized (Pearson & Conwell, 1996). Physicians may withhold an assessment of suicide in deference to family wishes. In rural areas, there may be little availability of technically precise services and less expertise among practitioners conducting autopsies and investigations into the circumstances of death.

As a group, older adults have a high completion rate, or an increased lethality rate, for first time suicide attempts (McIntosh, 1995). The estimated attempt to completion rate in older adults is approximately 4:1 (Draper, 1996), whereas for young people it is as high as 200:1 (Conwell, Duberstein, Cox, Herrmann, Forbes, & Caine, 1998). Maris (1992) estimated the lethality rate of suicide among the elderly at 90%. For the older adult, suicide is believed to be a planned, rational act (Hassan, 1995).

Compared to the young, there is less confusion, ambivalence, and distortion communicated in suicide notes (Leenaars, 1992). In addition to seriousness of intention, the older adult employs more lethal means, with firearms being the number one choice for elderly men (Achte, 1988; Maris, 1992). Shneidman (1996) noted that among older adults the first suicide attempt is likely to be the last. The implications for nursing professionals are: the older adult is usually not ambivalent about the decision to commit suicide and a suicide threat is always serious in the case of the older adult (McIntosh, Santos, Hubbard, & Overholser, 1994).

The literature is replete with research exploring the problem of suicidal behavior, however there is still little theoretical understanding of why the behavior occurs. There is also a large body of research about the characteristics of those who have completed and attempted suicide, however this has not lead to an understanding of the process of becoming suicidal and the relationship between social factors and suicidal behavior (Aldridge, 1998). Suicidal behavior must be understood in the social context. In order to do this, it is imperative to understand how a suicidal person makes sense of what they do. Gathering retrospective information does not further that goal. Rather, it is prospective inquiry that will aid in understanding an individual's life story.

Suicide is an abrupt ending of a life, which has far-reaching consequences for the individual, their loved ones, and society (Courage, Godbey, Ingram, Schramm, & Hale, 1993). In many Western societies, suicide is viewed negatively- a result of mental illness

or a sin (Buchanan, 1991). It is an act that prompts guilt and shame among survivors (Stillion & McDowell, 1996).

Bereavement from suicide is a difficult adjustment for surviving family members and friends. It is the survivors of suicide who remain behind to experience the intense grief and often social rejection and alienation which accompany the loss. The negative effects of suicide on close survivors are from two sources: society and self. The survivor is likely to feel social stigma and self-blame associated with the death (Charmaz, 1980). The survivors of suicide may be left with almost no social support. Not only are the survivors stigmatized by the community, many are beset by personal guilt that they failed to recognize suicidal intentions and/or intervene for a troubled loved one (Aldridge, 1998).

The economic impact of suicide is considerable. It is estimated for each fatal attempt, at least ten persons make a non-fatal attempt at self-harm. Many of these attempts result in the need for urgent medical attention and often can result in irreversible disability necessitating nursing home placement and skilled nursing care for the duration of life (Diekstra, 1998). This estimate does not include the many non-fatal attempts, which remain unknown to or unrecorded by health care agencies. Inestimable resources are expended each year for medical and psychiatric treatment, hospitalization, social interventions, and pharmaceuticals necessitated by depressive illness and suicidality (Diekstra, 1998). Furthermore, in human terms, suicidality is responsible for increased

morbidity, mortality, and abiding misery, which decrease quality of life for older adults (Teitelbaum, 1995).

Despite a large body of suicide literature, identifying the causes of suicide in late life and establishing effective preventive measures have remained illusive (Lester & Tallmer, 1994). Research studies have predominantly used the technique of psychological autopsy to explore causation in suicide. This is a retrospective examination of an individual's psychological life, especially lifestyle, behaviors, and thoughts during the weeks and months prior to the death (U.S. Department of Health and Human Services, 1996). The psychological autopsy employs suicide notes, extant medical records, information given by significant others concerning the suicide victim, and the expertise of mental health professionals in an attempt to provide an understanding of the suicide (Stillion & McDowell, 1996). This method has produced a prototypical risk factor profile for older adults. The risk factors include: 1) situational risk factors, including multiple losses, stressful life events, and social isolation; 2) family history of violent behavior or mental illness; 3) mental illness, including depression; 4) exposure to suicidal behavior; and 5) biological factors, such as low neurotransmitter levels in the brain (Moscicki, 1995). These risk factors or the relationship among these risk factors comprise the core of suicide inquiry, however it is important to note that the factors identified and their relationships to suicide have low predictive power since "many people experience a number of these risk factors and do not kill themselves" (U.S. Senate, 1996, p. 73).

Although research on risk factors is essential in understanding late life suicide, few researchers have explored precipitant factors (Osgood, 1985). With one notable exception (Courage, Godbey, Ingram, Schramm, & Hale, 1993), there is a dearth of qualitative research from the individual perspective. The only qualitative study identified in the literature employed a grounded theory approach to explore the meaning of suicide for older adults (Courage et. al, 1993). The study sample was comprised of community residing older adults (N=18) without a history of clinical depression or previous suicide attempt. The following themes were identified as important to study participants: a desire to participate in the timing of death, acceptance of suicide as an alternative in response to certain life events, and the response of older adults to suicidal ideation among their peers (Courage et. al, 1993). This type of qualitative inquiry gives insight into how older adults view death and suicide, as this current study is anticipated to do.

The study reported here differed from extant studies because it involved older adults with suicidal ideation and suicidal behaviors who described factors involved in deciding whether or not to kill themselves. Little is known about the phenomenon of suicide as recounted from a personal perspective. One explanation may be that we as individuals and a society no longer identify with people in distress, instead maintaining a distance. It may be a personal sense of helplessness in the face of such distress, which causes us to objectify such persons and label them as different or beyond help (Aldridge, 1998). As health care professionals, many still seek their success in cures. In this paradigm, death is the ultimate failure. Disease has identifiable causes and proscribed

treatments. Suicidal behavior challenges these ideas because the cause is complex, multifactorial and not amenable to a simple, successful treatment regimen. Too often, the focus of mental health care is treating individuals without considering the circumstances within which they live their lives (Aldridge, 1998).

Current theories on suicide have revealed a multitude of perspectives, however none have fully explored the social aspects. This study sought to elucidate what is currently unknown about suicidality from the individual perspective across the trajectory of suicide. The proposed study focused on the processes involved as the older adult makes a decision to either attempt or not attempt suicide. The results of this study are anticipated to provide valuable information about the subjective experience that may provide new perspectives on suicide prevention and intervention for older adults.

Purpose of Study

The purpose of this study was twofold: 1) to explicate the nature of the processes involved in decision-making in suicidality from the perspective of the older adult, and 2) to develop a grounded theory of these processes.

Research Question

The focal question of this research study was:

What are the processes involved in decision-making surrounding suicidality for older white men?

Background and Significance

This research study focused on decision-making surrounding suicidality in late life. Late life was defined as the period of life for adults who have reached the chronological age of 65 and older. The symbolic interactionism perspective underlying this grounded theory study focused this inquiry on the social perspective of suicide.

Assessing Suicide Risk

Despite having seen a physician prior to their deaths, for many the risk for suicide is either not identified or the suicide is not prevented (Osgood, 1992). In a seminal study, Barraclough (1971) noted 90% of adults had communicated their suicidal intentions to a physician within three months of their deaths with 50% doing so in the week prior to their death. This statistic has changed little in the past twenty years as researchers estimate that approximately 75% of older adults who die by suicide have seen a physician within a month of their deaths (Firestone, 1997; Mellick, Buckwalter, & Stolley, 1992).

Accurate prediction of suicide has remained elusive despite current knowledge of consistently identified risk variables, such as loss, lack of social support, and mental and physical illness (Rickelman & Houfek, 1995). A major problem concerning accurate prediction of suicide is that it is a relatively rare event, even in high-risk populations, and the factors for predicting suicide are imprecise (Fremouw, Perczel, & Ellis, 1990). Furthermore, there is no combination of indicators that can be used to accurately identify whether a particular individual will attempt suicide; neither rating scales, demographic information, nor clinical judgment (Lester, 1992; Motto, 1992; Tallmer, 1994).

Depression is a key risk factor in late life suicide, hence it is imperative that older adults be appropriately evaluated for depression. Multiple barriers have been identified to improving the recognition and treatment of depression in primary care settings. These include: poor recognition of depressive symptoms by both the physician and client, lack of education, ageism, ineffective treatment, client noncompliance, time constraints, comorbid illnesses, and poor reimbursement for treatment. Furthermore, improved recognition does not always lead to improved treatment for suicidality in the older adult (Callahan, Hendrie, Dittus, Brater, Hui, & Tierney, 1994).

Health care professionals may be unsuccessful in preventing suicides in older adults because the risk factors and clues may not be recognized (Tallmer, 1994). Most who die by suicide communicate their intentions to a health professional prior to the suicide attempt, either overtly or through clues. Shneidman, Farberow, and Litman (1970) identified prodromal clues as precursors to suicide that may exist days, weeks or even months before the suicide occurs. These clues may be situational, verbal, behavioral, and syndromatic in nature. Verbal clues include, expressing a specific wish to end life or indirect clues, such as, expressions of hopelessness. Situational clues may be a recent crisis, such as loss of a loved one or illness. Behavioral clues include explicit events, such as a suicide attempt, or implicit clues such as marked changes in behavior or giving away possessions. Finally, syndromatic clues are psychological syndromes associated with suicide, such as depression or marked anxiety (Shneidman, Farberow, & Litman, 1970).

The primary care setting is the most common venue for healthcare access by older adults. Research supports that at least half of clients receiving mental health care do so through their primary healthcare provider (Jacobs, Kopans, & Reizes, 1995). Therefore, the role of primary care clinicians, such as advanced practice nurses, in assessing older adults for depression and potential suicide risk is significant (Lyness, Noel, Cox, King, Conwell, & Caine, 1997). As managed care becomes more prominent, so will the role of health care professionals as gatekeepers, or those deciding when a client needs a referral to a mental health care clinician. It is incumbent upon all primary care clinicians to recognize the symptoms and varied presentations of depression in older adults and factors related to suicide risk. Depression, a major risk factor for suicide, is both underdiagnosed and undertreated in the older primary care population (Eisenberg, 1992). If prevention and intervention efforts are be effective, clinicians must understand the factors related to suicide risk and individual decision-making processes related to suicidality and suicide. This study sought to elucidate factors contributing to risk and how these relate to suicidality.

Significance of the Study for Nursing

In Healthy People 2000 (1990), one of the targeted objectives was to decrease the national suicide rate for special populations. The goal included a 15% reduction in the suicide rate for elderly white men. With the current rate exceeding 20% for all older white men, this objective remains unmet. Decreasing the suicide rate for older adults was once again added to the updated objectives for Healthy People 2010 as a public health

issue requiring national attention. Nursing has targeted these objectives as important to improving public health. This research was significant for the following reasons: 1) the continued high rate of suicide in older adults, especially males (Stillion & McDowell, 1996); 2) the high rates of depression, a treatable, major risk factor for late life suicide (Kral & Safinosky, 1994); and 3) the projected future impact of suicide with a rapidly aging population (Osgood, 1992).

Current knowledge in suicide inquiry has focused on the many separate factors related to suicide risk with little regard for how these factors interact to create the multifactorial phenomena of suicide. Furthermore, there is a stark absence of social inquiry into suicide. The limitations of our knowledge in the field of social perspectives of suicide have continued to restrict our understanding of the phenomena and hence our ability to positively impact suicide rates.

There is a dearth of research from the subjective perspective of the suicidal older adult. There is no information on the processes involved in decision-making. What is currently known about suicide is largely of a retrospective nature. Individual perspectives have been largely ignored, hence individual thoughts and feelings about wanting to die may be discounted or not addressed in the client-clinician interaction.

Theoretical Orientation

In this section, theoretical perspectives relevant to suicide will be presented. These are: life span development, a nursing theory of health as expanding consciousness,

the researcher's theoretical perspective, and major psychoanalytic and social perspectives of death.

Theoretical Perspectives

Theoretical perspectives of life span development, nursing theory and life span development, and the researcher's perspective are presented in this section to support the unique focus of this study.

Life Span Development

Many of the traditional theoretical perspectives on suicide do not address the variable of life span development. Developmental or life span considerations can contribute significantly to our understanding of suicide and therefore are important in this current study. Shneidman (1996) noted there is no youth suicide, adult suicide, or late-life suicide- just human suicide. At any time during the life span, an individual can engage in suicidal behavior, which may be viewed as crossing the threshold for adaptive coping. Psychache or emotional pain may be a common point on the pathway of life that increases suicide risk (King, 1998). Many earlier pathways may converge on this factor, but it is unclear just how pathways of childhood, adolescence, and adulthood contribute to psychache, suicidal intent, and suicide in late life. Exploration of these relationships was an anticipated outcome of this current study.

Some suicidologists have contended that a lifelong pattern of maladaptive coping characterizes many older suicide victims (McIntosh, 1995; Shneidman, 1985). Maris (1995) noted that suicide in the older adult is chronic in that "etiologies develop over

about 40 to 50 years" (pp. 173-174). He was the first to discuss the notion of "suicidal careers" and hypothesized that suicide was chronic in the sense that predisposing factors develop over the life span. Similarly, Moscicki (1995) discussed the accumulation of risk factors over the life span. He identified the following: 1) distal or predisposing risk factors that accumulate over the lifespan, and 2) proximal or precipitating risk factors which may cause the suicide event. Hence, an accumulation of events over the life span may predispose an individual to suicide and a new stressful event may precipitate the event.

Firestone (1997) noted human development from childhood through middle age portends emotional health and well-being in old age. Many suicide victims have in common a failure to master the developmental tasks of each life stage and have developmental stagnation (Maris, 1981). Examining suicide from a developmental perspective, focusing on life history may help specify direct and indirect causal pathways to the suicidal event. A transactional model of development emphasizes the constant interplay among influences in our lives over time. The focus is on individual differentiation in genetics and inherent vulnerabilities, life experiences and societal forces, caregiving environments, and the interplay among these rather than etiological factors and simple interactions between early childhood vulnerability and later stresses (King, 1998).

Failure of adaptation at any age or under a variety of circumstances can result in physical or mental illness. Optimal growth and adaptation can occur throughout the life

span when individual strengths and potentials are recognized, nurtured, and encouraged by the environment in which one lives. Old age requires unique developmental work just as youth requires mastery of early developmental tasks. The chief tasks during late life are to clarify, deepen, and incorporate a lifetime of learning and adapting (Butler, Lewis, & Sunderland, 1998).

Nursing Theory and Life Span Development

Several nursing theories support the significance of developmental processes in adult health and functioning. Historically, aging has been associated with decremental changes rather than with development. In a developmental perspective, human development is a process that can occur in later life despite obvious physical changes and deterioration associated with aging. Although growth refers to a physical change in size, development implies a qualitative change, a transformation rather than acquisition of knowledge. Development refers to a pattern of changes that are positive and functional for a living system. A life span focus is not restricted to theories that focus on a designated phases of maturation, such as adolescence, but instead on development that occurs throughout life (Reed, 1983).

In a contextual-dialectic paradigm, life span development indicates a developmental progression with regard to interaction between organismic and environmental factors. With age, there is an increasing ability to transform the current context with all its problems into energy for development. Furthermore, development involves a progression from general to more specialized organization and from less

organized to more integrated characteristics. It is important to note change can occur without development, however both are needed for developmental change (Reed, 1983). For example, despite the ability to grow from experience, many older adults who have experienced changes or losses in their lives may be unable to transform these experiences into energy for development. For many older adults with depression and suicidality, there may be an inability at a given time to transform loss into development.

Reed (1986) characterized human beings as being on a trajectory of increasing complexity and organization, integral with their environment, and capable of change throughout the life span. Furthermore, development is viewed as a process of trade-offs in which old behaviors and perceptions are traded for those more useful as contexts change with aging. This process results in developmental resources or assets that enhance mental health. It is an inability to exchange old behaviors and perceptions for new ones that places the older adult at risk for depression and suicide. For example, developmental events of late-life, such as retirement, loss of spouse or friends, change in residence, and declining physical health, may require restructuring of life. These events and other experiences of aging may contribute to depression, suicide, and other changes in mental health when an individual has problems in substituting less useful operations for resources more effective in one's current life context (Reed, 1986).

Rogers (1970) noted aging is a continuously innovative process with patterning evident in person-environment interactions. Newman (1979) was influenced by this basic tenet and developed her theory of health as expanding consciousness. Consciousness is a

manifestation of an evolving pattern of person-environment interaction. The concept of consciousness is defined as "the informational capacity of the system; the ability of the system to interact with the environment" (Newman, 1995, p.37). Health and disease are manifestations of the evolving pattern of an individual.

An individual is identified by his or her pattern, which is evolving. Bohm's (1980) theory of reality posited an unseen, underlying pattern as the primary order of reality. This implicate order is not made explicit all at once, rather it present in states of unfoldment and infoldment (Bohm, 1980). The pattern of interaction representing the current pattern of a person's life incorporates information enfolded from the past and information that will unfold in the future. For example, experiences of loss throughout the life span are influential in later life when losses may become more frequent. An inability to integrate or resolve previous experiences of loss may interrupt evolution. The pattern has new meaning when viewed in relation to previous patterns and presents an opportunity for action or transformation. This transformation can take place, but is not guaranteed.

Newman (1979) expanded on ideas from Young's theory of human evolution and Prigogine's (1977) theory of change to clarify health as expanding consciousness. An individual comes into being from consciousness and loses freedom as they are bound in time. The individual establishes personal territory in time and space and therefore movement may become restricted. When one becomes aware of these personal restrictions, they must seek to move beyond themselves (transformation) to return to the

ground of consciousness. For example, with the onset of a health problem an individual may recognize that the former skills they used in coping no longer work. At this point, the choice phase, s/he must then discover new rules to cope with the experience and move back into the freedom of time and space.

Newman (1995) defined health as an evolving pattern of consciousness. As such, health as expanding consciousness is a paradigm of evolving pattern of the whole. Whatever manifests itself in a person's life is an explication of the underlying pattern. Hence, illness or disease is a meaningful manifestation of the underlying pattern rather than something to be eradicated. The pattern that is manifested in disease may be a clue to what is going on in an individual's life and may represent something s/he can communicate in no another way. Illness may be the only way an individual's pattern can manifest itself. Illness may be an integrating factor for the individual in that it may accomplish for them what s/he was unable to do otherwise. The state of illness is health for that person at a given time (Newman, 1979; Newman, 1995). For example, depression may be a manifestation of underlying patterns of loss, isolation, and alienation in an older adult. Depression may be the only way the individual can express their state of health at that time. Pattern recognition is the key in the process of evolving to higher levels of consciousness. Nursing facilitates this process through authentic interactions between the nurse and client with a goal of assisting the client to illuminate their pattern and potential actions to achieve a higher level of organization (Newman, 1979; Newman, 1995). The evolving pattern of the whole emerges from the individual story. With suicidal older

adults, facilitating identification of patterns and potential actions to change current patterns may be the most helpful approach in resolving depressive symptoms.

The Researcher's Perspective

My perspective of late life suicide is informed by life span development, evolving patterning, and symbolic interactionism perspectives. Past experiences working as a nurse practitioner and more so recent experiences as a participant-observer in the VA Geri-Psychiatry Clinic have been instrumental in developing this perspective. As a bystander, I appreciated the importance of just listening to clients with no expectations of interaction or intervention. During this unique experience, an evolving pattern, as Newman (1979) has described, was often recognizable in individual histories across the course of the life span. Many were undergoing treatment for a reported first time depression, however life histories were reminiscent of similar depressed periods surrounding previous life experiences. These individuals had approached the stage of choice many times prior in their lives, but may not have been able to move beyond the choice point and transformation was not achieved. Related to Reed's (1986) perspective, these men were unable to trade older, less effective operations for more useful resources in coping with life events or problem solving. Subsequently, for many, depression in older years has ensued when many losses occurred and these individuals were unable to progress beyond the choice stage once again.

Suicide is not an individual phenomenon, rather it is a social one. Individuals construct meanings of suicide, however these meanings are informed by society and

social interactions with others. Evident in many histories are previous patterns of poor quality relationships, feelings of inadequacy, and a sense of alienation at earlier points. As such, patterning is seen in how individuals may have arrived at the current crossroad. Individuals were anticipated to illuminate patterns and meanings as they told their stories about suicidality in this inquiry.

Symbolic Interactionism

Decision-making surrounding suicidality in late life will be viewed from the theoretical perspective of symbolic interactionism. Symbolic interactionism is a sociological perspective that assumes that reality, society, and selves are socially created through the processes of interaction (Charmaz, 1980). Symbolic interactionism is based on the following assumptions: (1) humans act on the basis of the meaning they attach to physical objects and other individuals in their environment; (2) the meanings are derived from social interaction via communication between and among individuals; (3) it is through communications that symbols are created; and (4) meanings are discerned through an interpretive process, such as the individual ascribing meaning to his or her particular situation (Blumer, 1969). The researcher was designed to construct what the informants viewed as their social reality (Blumer, 1969), in this case informants' perspectives on decision-making surrounding suicidality.

The social context in which suicide occurs is significant in two principal ways. First, suicidal individuals draw on social values to understand, construct, and justify their feelings and actions. Second, relationships with others contribute to the process leading

to suicide (Charmaz, 1980). In the symbolic interactionism perspective, meanings of death arise out of the individual's experience as does the meaning of suicidal actions (Douglas, 1967). Furthermore, meanings and motivations are constructed out of collective social values.

An individual's view of suicide may be inextricably linked to an element of life review. There are differences in the degree to which older adults engage in life review. Some are able to actively integrate the remembered past and present into a coherent personal story, one that accommodates and facilitates personal understanding of life changes, including adversity or the expected developmental transitions, that occur over the life span (Duberstein, 1995). Others may be unable to engage in effective life review in terms of evaluating interpersonal relationships, accomplishments, unrealized expectations, satisfactions, and hardships throughout their lives. For older adults, life review is often a focus as the realization dawns that death is no longer a distant reality. A person may be reminded of mortality with the presence of physical illness, the changes that accompany aging, and the loss of family and friends. Meaning is attached to these life changes, which may be perceived positively or negatively (Duberstein, 1995). It is in these perceptions that decision-making lies.

In symbolic interactionism, suicidal individuals cannot be separated from the context of their experiences as has often been the case in extant analyses of suicide. The suicidal individual's interpretation of reality is crucial to understanding the situation (Charmaz, 1980). For example, focusing on depression and suicidality without focusing

on the social sources of both gives little insight into causation or potential therapeutic interventions. A typical perspective on suicide is that it is an individual problem. However, in order to understand suicide it must be placed in a social context. Inherent are dominant social values that reflect experiences of suicide and how it is viewed collectively. Charmaz (1980) asserted that at the core of these values is individualism, a product of the Protestant ethic, which continues to influence values. Individualism is exemplified by the themes of success and failure noted in American society. Individuals may judge themselves along these themes, which engenders self-blame and guilt in those who define themselves as "failures." The theme of personal failure is one repeated in suicide notes. The suicidal individual internalizes perceived failure as a symbolic marker in their definition of self (Leenaars, 1992).

Additional important themes that may be significant in understanding suicidality and suicide are: control over personal reality, "losing control" of the self, and taking control of the self through suicidality. Control over personal reality may be linked to achievement for some individuals. If unable to take control over their personal reality in the way they had expected, wished or planned, many individuals may perceive they have not been able to completely achieve their dreams and aspirations (Charmaz, 1980).

In symbolic interactionism, the loss of self may be progressive during the suicidal process. Social isolation is a process by which individuals become separated from their social world. The social world may become meaningless, since the individual no longer shares in it. Instead, the individual begins to rely more on a few significant others and

over-burden them with their problems (Charmaz, 1980). Jacobs (1971) contended most people, including those who later commit suicide, have internalized values viewing suicide as immoral and/or irrational. At some point, the suicidal individual transforms the "irrational" act into one that is a "reasonable choice." At the core of process is social isolation. When the individual no longer feels connected to the social world, the usual societal constraints against suicide do not apply to them and therefore suicide becomes a reasonable course of action.

Social isolation alone often does not describe the experience of the potential suicide decedent. Rather, emotional isolation describes the feelings and experiences of potential suicidal individuals who may be surrounded by others but lack meaningful sharing, mutual cooperation, and reciprocity in their relationships (Charmaz, 1980; Duberstein, 1995). Emotional isolation also underlies the conditions under which suicide becomes a reasonable course of action. Social and emotional isolation are not mutually exclusive. In either case, the suicidal individual comes to live in a separate reality. As problems increase, the prohibitions against suicide fall away. In many cases, relationships become more strained when losses increase. There is an intensification of emotional isolation when the individual is given either a real or symbolic invitation to die (Jourard, 1971). In either case, the more symbolic significance the extender of the invitation has to the individual, the more likely the hidden message will be understood. A consequence of the invitation to die is increased emotional and social isolation of suicidal individuals, reinforced by a sense of aloneness in the world and the feeling they have lost the status of

personhood among others. These feelings develop out of human interactions and relationships (Charmaz, 1980).

Those who are the most needful of social support may be the most likely to receive these invitations (Jourard, 1971). This is emphasized in cases of suicidal crises. Initially an individual is at the center of attention if the crisis is brief. However, if the crisis is sustained, the suicidal individual may be seen as a burden by others. This often engenders anger toward the individual who is causing the crisis. Significant others are not the only ones to extend the invitation to die to those in suicidal crisis. The response of health care personnel to suicidal individuals if hostile or indifferent may symbolically reaffirm their low self-worth and value (Charmaz, 1980). Welu (1973) studied the reactions of emergency room staff to those who attempted suicide and noted harsher modes of treatment were routinely employed with those who attempted suicide. In addition, medical staff was frequently resentful of those who attempted suicide and expressed their feelings to the individual unreservedly in negative comments. Additional theoretical perspectives on suicidality and suicide will be reviewed in the next section.

Traditional Theoretical Perspectives

Traditional theoretical perspectives have influenced images of suicide. Five perspectives will be briefly reviewed. These are: psychoanalytic, existential, Hillman's subjectivist, Durkheim's sociological, and suicide preventionist perspectives. These perspectives stand in contrast with the symbolic interactionist perspective, the perspective selected for this study.

Psychoanalytic

The psychoanalytic view of suicide emphasizes unconscious motivation and repression. Freud (1935) asserted that self-hatred is at the core of depression, which is a result of repressed anger towards another individual. When that anger cannot be consciously acknowledged, it is turned inward upon the self. In the psychoanalytic view, suicide is a form of self "murder" (Rushing, 1968). Menninger (1938) elaborated on the relationship between suicide and murder. He posited that suicide cannot occur unless an individual wishes to kill, be killed, or desires to die. Menninger also postulated that decedents of suicide are immature individuals who are fixated at earlier stages of development. In psychoanalytic perspectives, suicide has often been associated with mental illness. In reality, suicide is not restricted to mental illness (Davies & Janosik, 1991). This perspective is still taught and has its adherents.

Existentialist

The existentialist's perspective of suicide emphasizes the significance of the individual confronting death. Camus (1955) asserted suicide was the only serious philosophical question, since human life is without meaning. The emphasis is on an individual taking moral responsibility for life when they confront death. In contrast to other perspectives, death is not the enemy, rather living a life without moral courage is the more important issue. In existentialism, both life and death are viewed as lacking inherent meaning. Hence, the meaning of the suicidal experience can only be constructed by the individual (Charmaz, 1980). Existential theory has influenced many therapeutic

modalitites, including logo therapy (Frankl, 1959) and reality therapy (Glasser, 1965). These treatment approaches are still in use and emphasize self-determination and personal responsibility.

Subjectivist

Hillman (1964) is a Jungian psychologist whose approach to suicide melds existential and phenomenological perspectives into a subjectivist approach. He emphasized the subjective suicidal experience and the therapist's understanding of it. Several contributions are of note in Hillman's (1964) work. He asserted that suicidal persons have little understanding of their actions. Although death is within each human being, most individuals consciously separate themselves from it. The impulse to die may not be anti-life, but a wish for a fuller life that permits expression of individuality. Hillman (1964) emphasized the importance of the life of the soul rather than death by suicide. Further, death by suicide may be necessary to preserve the life of the soul.

In the subjectivist's view, death by suicide can be chosen. Since it can be chosen, suicidal behavior has meaning. These meanings can only be understood by getting inside the experience of the suicidal individual. This perspective is similar to symbolic interactionism in that death viewed from an objectivist's position limits understanding of it.

Durkheim's Sociological

Durkheim's (1951) study of suicide, which was originally published in 1897, has been viewed as the classic sociological perspective. He attempted to demonstrate that

social forces ultimately determine suicide. Durkheim (1951) asserted more integrated societies had a lower suicide rate for some types of suicide. Integration was defined as sharing a set of values, norms, and beliefs that govern behaviors. For example, Durkheim (1951) concluded that some religions, such as Catholicism, provided greater regulation and a source of social integration for its members. He contrasted this with Protestantism, which he viewed as sanctioning individualism by tolerating free inquiry.

Durkheim (1951) delineated three types of suicide: egoistic, altruistic, and anomic. All types are related to social integration. Egoistic suicide occurs when an individual is inadequately integrated into society. The ego affirms its own autonomy, but cannot cope with conflicting pressures. Thus, the individual frame of reference revolves around self-concern and the individual is less likely to be linked with social organizations (Charmaz, 1980).

The second type of suicide, altruistic, encompasses individuals who are overly integrated into society (Durkheim, 1951). The self is not individualized, but is blended into the structure of society. The socialization of these individuals prepares them to accept the group's goals even to the extreme of death. Kamikaze pilots of World War II exemplify altruistic suicide (Charmaz, 1980).

Lastly, anomic suicide involves a lack of regulation of the individual (Durkheim, 1951). The causes of anomic suicide are political and economic crises in which the individual no longer feels the moderating effect of collectivism. The norms that usually govern individuals' existence no longer control individuals' desires. An example of

anomic suicide is the businessman who dies by suicide when the stockmarket crashes. suicide in recent years. This perspective is in general use in practice and is the foundation for suicide crisis centers across the U.S. One of the most prominent proponents of this

Suicide Preventionist

The suicide preventionist perspective has dominated thinking and research about view is the suicidologist, Edwin Shneidman (1985). In sharp contrast to the existentialist's perspective, he emphasized the importance of analyzing suicide from outside the experience, using an objective party to describe individual motivation for suicide. To emphasize this, he identified the role an individual plays in his or her death. Of these roles, three are highlighted as major categories. These are intentioned, subintentioned, and unintentioned suicides. In intentioned death, the individual plays a direct role seeking or initiating death. In subintentional death, the suicidal individual takes an indirect action in precipitating death. The individual may not consciously perceive their actions to be contributing to their demise. According to Shneidman (1985), those with subintentional roles do not confront their desire for death, however they wish to die. Among this group are those who do not take care of themselves, including cardiac patients who continue to smoke and those who drive while drunk. Unintentional suicide is accidental, such as death from a heroin overdose when the individual had been abstinent for several weeks prior to taking a former usual dose to obtain a high.

Underlying the suicide preventionist's perspective is the belief that life has intrinsic value and it is therefore the right and obligation of the preventionist to intervene.

Decedents of suicide are viewed as having temporarily taken leave of their senses. All suicidal behavior is viewed as a cry for help with the suicidal person as ambivalent in that s/he wishes to die and be saved at the same time.

Summary

The theoretical orientation for this study was presented in this section: symbolic interactionism, Reed's framework on life span development and developmental resources, Newman's nursing theory, and the researcher's perspective. To provide background on suicide, the following traditional theoretical perspectives on suicide were summarized: psychoanalytic, existentialist, Hillman's subjectivist, Durkheim's sociological, and suicide preventionist. These perspectives have both influenced and reflected societal images of suicide. In the perspective of symbolic interaction, suicide is not viewed as an individual problem, but one that must be placed in the social context in order to be understood. Grounded theory, the method used in this study, was influenced by symbolic interactionism, a sociological perspective which assumes reality, society and the self is socially constructed through the processes of interaction (Charmaz, 1980).

Summary of Chapter One

Suicide in late life is a major public health issue. The demographics of suicide in late life were reviewed to underscore the magnitude of the problem. Current understandings of suicidality and suicide are restricted largely to retrospective examinations of suicide decedents, which offer little in the way of understanding motivation and the social context of suicide. Grounded theory, based on the theoretical

perspective of symbolic interactionism, can help in conceptualizing the reality of the suicidal older adult as s/he contemplates suicide. Grounded theory supports the development of nursing theory by generating theory that fits the data. With the development of substantive theory from the suicidal older adult's perspective, nurses will have a better understanding of the social context of suicide and how decision-making is influenced by this context. It is anticipated that this knowledge can be applied in assessment, prevention and intervention strategies in late life suicidality and suicide.

Additional theoretical perspectives were reviewed in this chapter, including life span development and nursing theory, to provide a broader perspective for understanding processes in suicidality. Traditional theoretical perspectives of psychoanalytic, existentialist, subjectivist, Durkheims's sociological, and suicide preventionist were summarized to provide background on how suicide and suicidality have been and continue to be viewed.

CHAPTER TWO

REVIEW OF THE LITERATURE

The review of the literature is presented in four major parts. First, risk factors in late life suicide are presented. Literature on the following risk factors are presented: biological, physical illness, psychological, cognitive, intrapersonal, social, gender, interpersonal, socioeconomic, and cultural. Second, self-disclosure and the older adult's ability to disclose sensitive information are presented. Third, issues of ageism and its implications for older adults are reviewed. Lastly, the topic of decision-making in late life is presented. All of these issues are viewed as inseparable for understanding why older adults contemplate suicide.

Risk Factors in Late Life Suicide

A comprehensive understanding of suicide requires an understanding of the multiple risk factors involved (Maris, Berman, & Maltsberger, 1992). Suicide is a multifactorial phenomenon (Shneidman, 1996). The risk factors to be reviewed are: biological, genetic, physical illness, psychological, cognitive, intrapersonal, social, and cultural. These risk factors may influence each other in multidirectional ways and are further influenced by developmental issues across the life span (Stillion & McDowell, 1996).

Biological and Genetic Risk Factors for Suicide

Both biological and genetic risk factors are implicated in suicide (Lester, 1988). It must be noted that knowledge of the biological underpinnings of suicide remains

incomplete. Research is often conflicting and at times confusing in this substantive area. Research on biological variables has focused primarily on neurochemical changes and abnormalities in brain structure. The older adult often has decreased levels of neurotransmitters, such as dopamine and serotonin, and a loss of neurotransmitter function in comparison to younger persons. These are both related to depression and suicide (Jones, Stanley, Mann, Frances, Guido, Traskman-Bendz, Winchel, Brown, & Stanley, 1990). Evidence for neurochemical changes is largely supported by postmortem examination of brain tissue. To date, the most compelling research in the area of neuroendocrinology is dysregulation of central nervous system serotonergic systems (Weiss & Coccaro, 1997). Neurotransmitter abnormalities have been found in the ventral prefrontal cortex of suicide decedents. This region of the brain, which is linked with impulsivity and aggression, plays a role in behavioral inhibition and dysregulation, hence may predispose to suicidal behavior (Arango, Underwood, & Mann, 1997).

Research supports that suicidal behavior is associated with a deficit in brain serotonin (5-HT) neurotransmission. The 5-HT metabolite, 5-hydroxyindoleacetic acid (5-HIAA), is also reduced in suicide attempters and has been more strongly associated with suicidal behavior than depression (Mann & Malone, 1997). Postmortem studies in suicide decedents provide support for abnormalities in the serotonergic system, however certain aspects of the research must be considered. Although postmortem examination permits direct examination of the brain with quantitative measurements, there are clinical limitations to such research. There are difficulties in obtaining accurate client information

concerning psychiatric medication history. Furthermore, subjective reports of client status, depressive symptoms, suicidality, and life circumstances are often unavailable for correlation with postmortem findings (Arango et al., 1997). Findings of altered serotonin levels in suicide decedents should also be interpreted critically as it is unknown whether the biochemical changes are precursors to suicidal behavior or if being suicidal causes the biochemical changes (Wheeler, 1996).

One of the major challenges in biological research in psychiatry is to develop techniques enabling valid correlation between central nervous system function and psychopathology. Many current techniques of examining neurotransmitter concentrations and receptor activity are limited as they do not reflect the dynamic function of neuroendocrine processes. Current mood may not be reflective of an individual's presuicidal state. Further, most suicide research is confounded by the coexistence of depression and suicidality. Separating neuroendocrine abnormalities related to severe depression from those more specific to suicide is currently not possible (Weiss & Coccaro, 1997). Despite these limitations, neuroendocrine pharmacochallenge techniques have offered a glimpse of how the central nervous system works in vivo. Pharmacochallenge involves administration of a small dose of psychoactive agent with subsequent monitoring of hormonal response over time. In vivo, it is possible to measure other markers indicative of serotonin levels in the blood, using the technique of pharmacochallenge (Weiss & Coccaro, 1997). Low serotonin levels were found in both

brain and blood samples of suicide decedents (Pandey, Pandey, Dwidvedi, Sharma, Janicak, & Davis, 1995).

Abnormalities in the brain structure have been identified and linked with both depression and cognitive decline in older adults. Both are significant risk factors in late life suicide. More cortical atrophy and ventricular changes were found in a sample of depressed individuals than in controls (Rabins, Pearlson, Aylward, Kumar, & Dowell, 1991). These findings have been replicated in several other studies using a control group of healthy older adults (Zubenko, Sullivan, Nelson, Belle, Huff, & Wolf, 1990; Lesser, Miller, Boone, Hill-Gutierrez, Mehringer, Wong, & Mena, 1991). Changes in the white matter of the brain have also been implicated in depression. White matter lesions identified by magnetic resonance imaging studies have been found in older depressed adults (Kapeller, Schmidt, Offenbacher, Payer, & Fazekas, 1996). It is unclear just how significant these lesions are in depression as similar lesions are found in other CNS disorders, including hydrocephalus, multi-infarct dementia, and multiple sclerosis (Englund, Brun, & Gustafson, 1989).

Researchers concentrating on genetics in psychiatric disorders of the affective type have sought evidence for an inherited risk factor in these disorders. A family history of both affective disorders and suicide significantly increased a younger individual's risk of suicide (Roy, 1992). Nearly 50% of 243 patients with a family history of suicide had attempted suicide themselves and nearly 57% of all patients who had attempted suicide had an affective disorder (bipolar or unipolar depression) (Roy, 1983). However, the

relationship of family history to suicide in the elderly is not as clear as in younger individuals (Lester, 1992).

In this section, the biological and genetic risks for suicide were reviewed. These risks included abnormalities in brain structure, neurochemical changes associated with aging, and the genetic factor in late life suicide. Closely associated with the biological changes of aging, physical illness is often implicated as a prominent risk factor in late life suicide.

Physical Illness as a Risk Factor

Physical illness and decline are often cited as factors influencing suicide in older adults (Stillion & McDowell, 1996). Draper (1996) assessed suicide risk factors in 69 elderly individuals and found 54% had chronic physical illnesses at the time of a suicide attempt. These included chronic respiratory disease with airway restriction, stroke, cardiac problems, and musculoskeletal diseases. Mellick and colleagues (1992) reported that men who left suicide notes indicated they were in considerable pain as a result of degenerative diseases.

By contrast, Tallmer (1994) noted the existence of a medical illness is not necessarily a precipitant factor in suicide. In a study of elderly psychiatric patients, Vogel and Wolfersdorf (1989) found that only 7.5% of the suicides were motivated by an acute illness and approximately 20% from a chronic illness. Similarly, a rate of 37% of elderly adults had either a chronic or terminal illness at the time of death. Whether this percentage constitutes a small or large percentage is open to interpretation. Interestingly,

Canetto (1995) noted older women have higher rates of physical illness and disability than men, however they are much less likely to die by suicide.

Despite the contention that chronic pain is associated with an increased risk of suicide, there are few studies to substantiate this assumption (Stenager & Stenager, 1998). In a study of suicidal behavior and chronic pain, there was a higher suicide rate in the chronic pain group (Fishbain, Goldberg, Meagher, Steele, & Rosomoff, 1986). However, the study has been criticized for several reasons, including no psychological autopsy to determine the actual precipitant factors in the suicides and a small reported incidence of suicide (three), which could have been incidental (Stenager & Stenager, 1998).

Among elderly men, chronic dyspnea has been found to contribute to suicide. It has been hypothesized that dyspneic states may increase suicidal risk through several mechanisms, including chronic breathing problems predisposing to depression, an increase in anxiety with dyspnea, and reduced oxygenation with consequent mental status changes. These alterations in baseline state are implicated in increased vulnerability for suicide (Horton-Deutsch, Clark, & Farran, 1992). Using psychological autopsy, 14 cases of suicide were identified in which the victims had a history of chronic dyspnea. The researchers found in all but one there was evidence of a major depression. Furthermore, all men had decreased functional status secondary to respiratory disease and many experienced other comorbid conditions with a recent decline in physical health. Study

findings must be carefully interpreted as information was obtained from third party informants and the study size was small.

Many neurological and medical diseases are notable for their depressive components, including Parkinson's disease (Kaszniak & Scogin, 1995; Klerman, 1987) and stroke (Klerman, 1987). However, in a study of Parkinsons's patients (N=485), the suicide rate was actually lower than in the general population (Stenager & Stenager, 1998). Depression is a common sequela of stroke- one that is often undertreated. Estimates of depression associated with stroke vary widely from 18-60% (House, Dennis, Mogridge, Warlow, Hawton, & Jones, 1991). The exact etiology of post-stroke depression (PSD) is unknown, however it is likely to be more complex than relating depression to the anatomic location of brain injury cited in extant studies (Gordon & Hibbard, 1997).

There is a dearth of research exploring the link between stroke and suicide. Of the few studies on stroke and suicide, many have found an increase in the incidence of post-stroke depression and have cited this as the precipitant for increased morbidity (Garden, Garrison, and Jain, 1990). In a recent epidemiological study on suicide after stroke, the authors found a suicide rate of 7.2% overall. The highest rate occurred in women 70 to 79 years in age and for men aged 50 to 59 years (Stenager, Madsen, Stenager, & Boldsen, 1998). The study results must be interpreted cautiously as only those admitted to hospital post-stroke were included, plus there was no consideration given to either functional status nor social circumstances associated with stroke.

In many cases physical illness has been linked to depression, which in turn is the strongest contributor to suicide (Reed, 1989; Richman, 1992). Badger (1993) found that there was an increased risk of depression in older persons with greater physical impairment. In another study, depressed older adults had more respiratory, gastrointestinal, and neurological problems, received more prescription medications, and had higher rates of hospitalization (Blixen, Wilkinson, & Shuring, 1994). In a study of 44 terminally ill persons, 34 never considered suicide, however the remaining ten who were diagnosed with severe depression had all contemplated suicide (Brown, Henteleff, Barakat, & Rowe, 1986).

Post mortem data has supported a link between diagnosis of carcinoma and suicide. Conwell, Caine, and Olsen (1990) used psychological autopsy to evaluate suicide deaths in 32 older adults and found that in eight selected cases the cause of the suicide was attributed to cancer. Of these cases, three of the four autopsies demonstrated no malignancy. Furthermore, of the eight individuals convinced they had cancer, five were diagnosed with major depression. Similarly, in another study of completed suicide, nine percent of older adults with new medical problems perceived they had a catastrophic illness although one had not been identified. One implication of these findings is that the perception of a terminal illness may increase suicide risk, rather than the illness itself (Conwell et. al, 1990).

In addition to physical illness contributing to discouragement and depression in some older adults, it may alternately be viewed as a loss for that individual. It may be that

perception of loss is more detrimental to one's decline and self-identity, rather than the presence of illness.

Physical illness as a risk factor for suicide was summarized in this section. Specific aspects of physical illness discussed were chronic pain, chronic disease, and neurological and medical diseases associated with depression, such as stroke, Parkinson's disease, and chronic dyspnea. The psychological component of suicide risk will be presented in the following section.

Psychological Risk Factors

Psychological risk factors are the focus in many models of suicidality. The psychological factors that contribute to suicide risk in older adults are cumulative, rather than singular (Maris, 1995). Lester (1997) noted depression may be a factor in suicide; however, alone it is not a sufficient predictor. Some common psychological risk factors of suicide among elders are: depression, psychological pain (psychache), vulnerability, coping, loneliness, isolation, and substance abuse. In general, higher suicide rates are found among older adults diagnosed with mental illness, especially major depressive disorders, bipolar affective disorder, and schizophrenia (Lester, 1997). The strongest predictor of late life suicide is depression (Kral & Safinofsky, 1994). It is estimated that two thirds of all suicide victims have a primary depressive illness (Black and Winokur, 1986). In one study, 87% percent of older individuals who attempted suicide were subsequently diagnosed with depression (Draper, 1994).

The most dominant cognitive theory of depression is Beck's (1967). The main tenet of this theory is the individual with depression processes information in negative ways. There is a resultant cognitive constriction in which the individual tends to view the self, world, and future negatively (Beck, Kovacs, & Wiseman, 1979). Depression is associated with a feeling of hopelessness in which individuals can see no solution to their problems and begin to regard suicide as a way out. Individuals experience a narrowing or tunneling of the focus of attention, which becomes directed towards escape. With increasing depression, individuals are unable to view their options realistically and finally believe that the only option is suicide (Beck, 1972; Shneidman, 1996).

Hopelessness is a major factor in many suicides (Aldridge, 1998). It is often related to loss. The loss of a significant other, one's health, or reputation are objective losses that are subjectively interpreted. Feelings of hopelessness result in suicidal behavior causing individuals to reinterpret their experiences. Hope is inextricably tied to meaning in life. As long as an individual has hope, s/he feels life has value and meaning. In other words, hope is maintained if an individual has symbolic images of their reasons for living (Charmaz, 1980).

The construct of hopelessness has been studied in depression and as a separate construct. Beck, Steer, Beck and Newman (1993) found that hopelessness was a better predictor of eventual suicide in a group of psychiatric patients than depression. These results have not been reproduced in studies with older adults. Hopelessness was found to be related to depression in older adults, however it has not been found to be a better

predictor of suicidality than depression (Trenteseau, Hyer, Verenes, & Warsaw, 1989; Uncapher, Gallagher-Thompson, Osgood, & Bongar, 1998).

Shneidman (1996) noted that despite suicide being a multifactorial event, "its essential nature is psychological" (p. 5). He further explained that it was the psychological pain or "psychache" which becomes unbearable and is ultimately the cause of suicide. The concept of unbearable pain is reiterated by Leenaars (1992) in his study of suicide notes left by older adults. A common theme was a long history of unbearable pain and despair, which included multiple losses, psychiatric problems, and alcoholism. These individuals were less ambivalent about dying and showed less confusion about self-identity than younger persons (Leenaars, 1992). Implicit in this information is the need to identify the point at which psychological pain becomes unbearable for an individual. This dissertation study was designed to elucidate some of the variables involved for individuals in identifying a point at which they think life is not worth living.

The focus on meaning in life is becoming more prominent in the sociological, psychological, and nursing literature (Burbank, 1992). This concept was explicated by Frankl (1984) and shares similarities with hopelessness. The concept of meaning in life is predicated on an individual's ability to define and discover his/her own meaning. If unable to find meaning, an individual may begin to focus on escape from life (Beck, 1967; Shneidman, 1985). In a phenomenological study of meaning of life, Moore (1997) found that long-term emotional suffering (psychache) in older individuals led to a perception of powerlessness, which they felt impotent to change and hence desired to

escape. Burbank (1992) explored meaning in life with a sample (N=81) of older adults people and found 87% stated their lives had meaning. Those who reported an absence of meaning were homebound and had poor physical health. The findings of these studies support how significant a meaningful life is for older adults during later years.

To summarize, psychological risk factors for late life suicide include depression, hopelessness, psychological pain, and absence of meaning in life. Of these, depression is the strongest psychological risk factor in late life suicide. Psychological risk factors in late life are inextricably intertwined with cognitive changes in many older adults.

Cognitive Risk Factors

The most common cognitive risk factors for suicide in the elderly are decline in fluid intelligence, emotional and intellectual acceptance of death, dementia, and alcohol abuse. With aging, there may be a decline in fluid intelligence for some. This may contribute to a decreased ability to solve problems and therefore may increase an individual's risk of depression and suicide (Stillion & McDowell, 1996). Older adults may become more accepting of death, intellectually and emotionally, which may increase lethality (Reker, Peacock & Wong, 1987). Researchers found death to be acceptable among a group of older adults. Suicide was often viewed both as a rational option when there was an accumulation of negative life events and acceptable as older adults did not have long to live anyway (Courage et al., 1993). Individual perspectives on suicidality and suicide will be explicated in this study. These findings will contribute to knowledge about rational suicide and coping with negative life events

With aging, the risk of developing cognitive impairment increases for those 65 years and older (Eaton, Dramer, Anthony, Dryman, Shapiro, & Locke, 1989). The most common cognitive impairment is dementia, which involves chronic deterioration in two or more areas of cognitive functioning, including language, judgment, personality, memory and abstract thinking (Bayles & Kaszniak, 1987). The average prevalence of severe dementia in extant studies was approximately 6% in those age 65 and older and an additional 10-15% with mild to moderate dementia (Cummings and Benson, 1992). The prevalence doubles approximately every five years after the age of 65 (Jorm, 1990). Alcohol abuse increases the risk of cognitive impairment in the elderly (Kaszniak, 1996), both in the short and long term. A lifetime of chronic alcohol abuse increases the risk of permanent, irreversible cognitive impairment. In turn, this heightens risk for depression, which is the major risk factor for suicide in older adults. Cognitive disorders can coexist with other medical illnesses creating a challenge for clinicians in evaluating the older adult for depression and suicide risk.

Alcohol abuse is recognized as contributory to both depression and suicide in older adults (Lester, 1997; Wheeler, 1996). According to Carraci and Miller (1991), alcohol abuse among the elderly is well above the single digit figures quoted in community surveys. The incidence of alcohol abuse has been shown to increase with age, with a sixfold increase in men age 75 and older compared to those aged 65-74 and a twofold increase for women in the 75 and older age group (Eaton, Dramer, Anthony, Dryman, Shapiro, & Locker, 1989). Many older adults use alcohol to raise their spirits

and ease their physical discomforts (Osgood, 1992). The sedating and depressant effects of alcohol may alone or in combination with prescription and over-the-counter drugs cause impairment in judgment and increase the likelihood of depression (Butler, Lewis, & Sunderland, 1998), therefore heightening risk for suicide. In association with depression, alcohol intoxication is an even stronger predictor of suicide than among those who do not drink (Morgan, 1994). A recent study found 54% of older adults had a positive toxicology for alcohol or a habituating substance at the time of their suicide (Purcell et al., 1999). In a study of older suicide attempters, Draper (1994) reported 19% had a secondary diagnosis of alcoholism. In summary, alcohol may serve as the predominant intoxicating agent, may potentiate other substances like anxiolytics, or may be taken as "Dutch courage" leading to disinhibition (Cattell, 1988). For this study, alcohol history was explored as part of the informant's background to expose associations with past and current use to life span issues, such as relationship problems, self-concept, and coping skills.

This section addressed cognitive risk factors for suicide in late life. With aging, the risk of cognitive impairment increases substantially. In combination with other risk factors, cognitive risk factors can enhance risk for suicidality in late life. The following cognitive risk factors were reviewed: decline in fluid intelligence, emotional and intellectual acceptance of death, dementia, and alcohol abuse. Next, intrapersonal risk factors in late life suicide will be presented.

Intrapersonal Risk Factors

This section will focus on the importance of intrapersonal factors and changes, which may enhance suicide risk in late life. The following risk factors will be briefly reviewed: cumulative losses, vulnerability, maladaptive coping, cognitive rigidity, and openness to experience.

The older years of the life span have often been recognized as a time of cumulative loss, in which individuals must cope with losses in succession without proper time to resolve the associated grief (Stillion & McDowell, 1996). These losses include, physical health, social relationships, self-esteem, youthful appearance and vigor, roles, finances, and memory (Osgood, 1992). Most adults develop coping mechanisms, social support, and other resources throughout the life span, which serve them well (Achte, 1988; Maris, 1992; Osgood, 1992). It is when these resources fail that older adults are the most vulnerable to depression and suicide (McIntosh, 1995; Miller, 1978).

Vulnerability signifies a weakness in coping ability, which allows a stressful life event to overwhelm the individual despite their efforts to cope (Clum & Lerner, 1990; Yufit & Bongar, 1992). Coping skills provide older persons with resiliency to withstand stress and loss. Weisman (1991) described growing older as a balance between coping and vulnerability with potential stressors surrounding family issues, financial issues, health, social, and existential questions. Those with maladaptive coping patterns are thought to be more vulnerable to stressors encountered in old age and are therefore at greater risk for suicide (Firestone, 1997).

In a seminal work on cognitive rigidity, Neuringer (1974) noted some individuals developed a rigid style of coping over the life span resulting in a diminished capacity for problem solving. Problem solving is "process of seeking solutions to specific problems" (Pollock & Williams, 1998). Although a number of studies address problem solving, there has not been a systematic approach. Deficits in problem solving may themselves increase the risk of suicidal behavior, or depression may be responsible for negatively affecting problem-solving ability (Pollock & Williams, 1998). Nezu (1986) suggested a reciprocal relationship between depression and ineffective problem solving. In his model, depression can be precipitated by the interaction of stressful events and/or problems and a deficit in problem solving.

In related research, Clark (1993) characterized older adults who commit suicide as having a "lifelong character fault" that interferes with the fundamental ability to adapt to the aging process. Key personality characteristics include behavioral rigidity, a fierce sense of independence, and the use of denial as a major coping strategy. With aging, the normal stressors of life begin to overwhelm some older adults resulting in a breakdown of their usual denial defenses, which eventually precipitates a suicidal crisis.

The idea of cognitive rigidity as a personality trait has been expanded on in recent research. Duberstein (1995) discussed openness to experience (OTE) as a risk factor in late life suicide. Those with low OTE are described as being constricted cognitively, affectively, and behaviorally. Cognitively, persons with low OTE are more likely to perceive problems and stressors in black-and-white or dichotomous terms. Affectively,

they are less likely to experience emotions as keenly as do those open to experience. For those low in OTE, behavior is also constricted and self-concept is narrowly defined. For these reasons, older adults low in OTE are at increased risk for suicide. Affective dampening, rigid behavior, and narrowly defined self-concept decrease the capacity to adapt both to loss and inevitable age-related changes in role, health, and function (Duberstein, 1995). For example, persons who define themselves and productivity in terms of occupational role are reminded everyday of their lack of productivity after retirement (Costa & McCrae, 1992).

Cumulative losses, vulnerability due to aging, maladaptive coping over the life span, cognitive rigidity as a personality trait, decreased openness to experience, and a failure to master the developmental tasks at each life stage may enhance suicide risk in late life. These intrapersonal factors and potential influences exerted by them were reviewed in this section.

Social Risk Factors

Durkheim (1951) was the first to focus on social variables in explaining suicide. The suicide rate was determined by the societal level of social integration, or group cohesion in social networks, and the degree of societal regulation of an individual's desires and emotions through societal norms. Suicide was most common in societies with either a low or a high degree of regulation (Durkheim, 1951). The most common American interpretation of Durkheim's (1951) work is that societal structure shapes social

interaction which determines social integration and social integration is what determines the frequency of suicide (Lester, 1997).

Behavior, microsuicidal attitudes, and self-destructive patterns mirror the broader pattern of society (Firestone, 1997). Through these values individuals structure their roles and their lives (Weisman, 1991). The elderly are expected to disengage, as in retirement and decreasing physical activities, which increases their isolation and their sense of stagnation (Firestone, 1997). Richman (1992) noted that commonly held social beliefs reinforce the perception of old age as a time of physical and mental decline, illness, and approaching death.

Gender as a Risk Factor

There is increasing support that variation in rates of suicidal behaviors in different social groups reflects variation in the perceived acceptability of suicidal behaviors (Lewis & Shepeard, 1992). Suicidal acts may be influenced by perceptions of their social meaning and appropriateness (Canetto, 1995). Gender likely plays a role in these perspectives. There is an association between suicide and masculinity in the U.S. (Canetto & Sakinofsky, 1998). Deluty (1989) studied age and gender of the suicide victim and the context (terminal, chronic, and psychiatric illness) by manipulating the variables to see how factors affected acceptability of the suicide. One of the principal findings was that suicide by women was rated as "weaker" and less "permissible" than suicide for men. Similarly, Lewis and Shepeard (1992) found that independent of context women who killed themselves were perceived as less well adjusted than men who killed

themselves. According to the researchers, older adults are devalued unless they have wealth and power, hence older women who are perceived as the most likely to lack wealth and power may merit the least sympathy for suicidal behavior.

Men and women have been found to have different attitudes toward suicidal behavior (Deluty, 1989). Women are generally less accepting of suicide than men and men are the most critical of those who survive suicide, particularly other men. In one study, Lewis and Shepeard (1992) found that men who killed themselves as a result of athletic achievement failure were rated as better adjusted that men who killed themselves as a result of relationship problems. Acceptability of death by suicide varies according to the context and assumed motivations of the suicidal person. Killing oneself is viewed as most acceptable when one is terminally ill, less acceptable in chronic illness, and the least acceptable in cases of psychiatric illness (Deluty, 1989)

Gender differences in suicidal mortality may reflect differences in coping. Women may just have better passive coping strategies than men throughout the life span, which may better insulate them from suicide (Breed & Huffine, 1979). Canetto (1992) has updated this version of coping theory to highlight the flexibility of women, rather than a focus on passive coping strategies. She has based her theory on evidence suggesting that older women are more resourceful, active, and independent in terms of personal self-care and social networking than older men. Also, the roles of women are usually more varied throughout the life span requiring adjustment, whereas the roles for men are likely to remain more constant.

Women may also be less likely to die by suicide because they are more likely to seek professional assistance for psychological problems then men (Canetto, 1992). Men may be less comfortable seeking help for psychological problems and hence focus on physical complaints when seeing a physician (Miller, 1978). For many older persons, admission of psychological problems is taboo and many reject proffered help rather than to be perceived as "sick" (Richman, 1992). Despite the lower rates of suicide for older women, widowhood can nonetheless bring marked lifestyle changes, including financial privation, loneliness, and change in social roles (Canetto, 1992; Stillion & McDowell, 1996). Gender based research has provided insights into risk factor identification for suicide, however there have been few studies exploring the relationship of extra-personal and interpersonal factors in suicidal behavior (Canetto, 1995).

In summary, Durkheim first explored social variables influencing suicide rates. Although his research has been critiqued by many modern theorists, it remains a classic contribution to sociology. Gender was discussed with respect to the their influence on societal perceptions of suicide. It is notable that older women have a markedly lower rate of suicide in the U.S., which is in part influenced by their adaptability to developmental experiences during the life span.

Interpersonal Risk Factors

Interpersonal relationships have emerged as a key contributory factor in both depression and suicide for older adults. For this study, it was anticipated that relationship

issues would arise during interviews. Patterning in relationships may be evident across the life span.

Relationship issues were not thought to be a significant factor in late life suicide in previous extant research. There is now current research substantiating poor interpersonal relationships as contributory factors in late life suicide. Draper (1994) noted family problems in 38 to 44% of persons who attempted suicide and marital discord in 45% of those who were married. Interpersonal factors were prospectively associated with suicidal behavior in older persons (Zweig and Hinrichsen, 1993). Strain in the relative-patient relationship, the number of difficulties related to the care of the depressed older person, and psychiatric symptoms in the spouse or adult child were all noted as salient factors in suicide attempts. Similarly, family issues were linked with poorer outcomes in depressed older adults (Hinrichsen & Hernandez, 1993). The mechanism by which interpersonal issues increase the risk for suicide is unknown, however it is hypothesized that a depressed person may perceive their depression has had a damaging effect on the emotional well being of a family member and on interpersonal relationships. This may be demoralizing for the depressed person who may perceive that their death would bring about personal relief and relief for family members. Another explanation may be that the presence of a poorly adjusted family member who is unable or unwilling to provide social support increases the suicide risk (Zweig & Hinrichsen, 1993).

Research on women suggests relationships are a key to understanding suicide. According to Canetto and Lester (1995), women have major affiliative needs. When these

needs remain unmet, suicide risk is enhanced. This contention was supported by a qualitative study of suicidal older women. There were several common themes over the life span, such as a history of non-nurturing families, a lack of close friends or a confidant, and unsuccessful marriages.

There is a link between interpersonal relationships and perceived social support in late life. A brief discussion of relationships and how they may influence suicide risk was presented in this section.

Social Support

Social support and its role in late life suicide have been extensively studied. Widowhood in the late years is a major source of social isolation, but appears to affect men to a greater extent than women (Canetto, 1992). Men often depend on their wives for socialization, emotional support, personal care, and domestic management. Thus when their wives die first, elderly men suffer an acute loss of personal stability and physical well being (Canetto, 1992; Szanto et al., 1997). Widowhood is a weaker predictor of suicide mortality in older women than in older men. One explanation may be that women are better prepared psychologically for widowhood, as it is a normative state for women. Women are often better prepared to manage their households independently than men because they are accustomed to daily domestic tasks (Canetto, 1995). One area in which women are often disadvantaged is in the management of economic resources. More to the point, in many households men were the sole or main financial provider in this older cohort. Therefore, death may take a permanent financial toll on women, but not men.

Interestingly, insufficient income does not appear to be a predictor of suicide for women despite the disadvantaged economic status of many.

The lack of a confidant has been emphasized as important to suicide, particularly for elderly men (Oxman, Berkman, Kasl, Freeman, & Barrett, 1990). Canetto (1995) noted women are more likely to name another woman as confidant than men. In fact, men are more likely to name their wife a sole confidant. In a study of social support on depression in older adults, an acute increase in depressive symptoms was associated with the loss of a confidant (Oxman et. al, 1990). In a classic study, there were almost three times as many suicides among men who did not have a confidant (usually a wife) (Miller, 1978). There is also an association between lack of a confidant and suicidality among women. In one study of suicidal older women, a lack of a confidant and a sense of disconnectedness to others throughout the life span were common themes (Haight & Hendrix, 1998).

The early period of bereavement, the first six months after the loss, is when the risk for depression and subsequent suicide is the highest in late life (Morgan, 1994). For men who had a history of depressive episodes prior to spousal loss, there was a higher incidence of depression with suicidal ideation (Szanto et al., 1997). In a study of older male suicide decedents, relationships for males were critical. Many described the loss of a spouse in a suicide note as "unbearable" (Leenaars, 1992, p. 73).

Bereavement is associated with a risk of suicide in both sexes, but women are less likely to choose suicide (Canetto, 1992). Women generally have larger social networks

than men and hence have more emotional support (Stillion & McDowell, 1996). The death of a spouse also brings role discontinuity for women, but possibly to a lesser extent, as they are accustomed to domestic management and maintaining emotional contacts. Canetto (1992) has suggested that living alone is a greater risk factor for suicidal behavior for men than for women. Although women are more likely to live alone, they are less likely to be suicidal than men. One explanation is that living alone for women does not necessarily mean being isolated. Women are more likely to maintain emotional connections with friends than older men (Canetto, 1995).

Social isolation has been disputed as a precipitant factor in late life suicide. In a study employing psychological autopsy, 34% of older adults who died by suicide were married and 54% were living with others at the time of their deaths (Clark, 1993). More than 60% of these individuals also had contacts with others outside their homes at least once a week. Perception of loneliness may be as significant when evaluating social circumstances in some older adults (Arve, Lauri, Lehtonen, & Tilvis, 1999). Furthermore, emotional isolation may be more pivotal than social isolation in late life for some. Issues of social support were addressed in a brief demographic profile for this study. Information about social support was further explored by informants during interviews.

In summary, this section presented extant research about the significance of social support in late life. Men are a higher risk for suicide than women after a spouse's death. Often times, a spouse is the only confidant and this loss may heighten suicide risk. Furthermore, the risk of suicide is greater during a bereavement period for men than

women. Research studies have not consistently found social isolation to be a factor in late life suicide. There is evidence that many individuals have spouses and other social support at the time of their deaths. This may lend support that perception of loneliness is a more important factor than the actual absence of significant others in their lives.

Socioeconomic Risk Factors

Poverty has been linked with suicide in older persons, although studies substantiating this are few. Older women are more likely to live in poverty, however the rate of suicide is much higher for men. Canetto (1992) has suggested limited financial resources may be a more common situation for women than men.

It is when resources decline for males, particularly at the time of retirement, that poverty becomes a factor. The loss of income was most acute for those men with marginal incomes before retirement, as they were unable to save for their retirement (Fillenbaum, George, & Palmore, 1985). Retirement for men is also associated with a change in social status and power, which may confound each other. Men who previously held high-level positions may experience depression upon retirement secondary to a loss of social and professional roles, such as status, and power (Stillion & McDowell, 1996). The concepts of independence and powerlessness are cited as contributors to suicide among older adults. In a study exploring suicidal ideation, a theme of powerlessness and lack of independence was found in a group of older adults (Moore, 1997). These adults felt powerless in all realms: in physical illness, lack of social support, and change in social roles.

The role of socioeconomic factors in late life suicide are not well substantiated. Decline in income is associated with personal and professional role loss in men. Some of the available information on poverty appears contradictory in that older women are more likely to live in poverty, but are the least likely to die by suicide.

Cultural Risk Factors

Cultural factors may explain some differences in suicide among older adults. As noted previously, the rate of suicide for white men is the highest with non-white men in second place, but at a much lower rate (U.S. Senate, 1996). In general, there is a lack of empirical findings addressing suicidal behavior in ethnic minority groups in the U.S. (Llorente, Eisdorfer, Loewenstein, & Zarate, 1996). Studies from other countries have suggested that intraethnic variables may be associated with suicide rates (Burvill, 1995; Ko & Kua, 1995), however definition of these variables is lacking. Much of the available information on suicide in minority groups focuses on theoretical perspectives that lack empirical support. Additional criticisms of available research on suicide in ethnic minorities include an ethnocentric perspective and dated theories (Chance, Kaslow, Summerville, & Wood, 1998).

African Americans. Suicide rates increase as white men age with the highest rates occurring in late life. In contrast, suicide is the third leading cause of death in young African American males aged 15-24 years (O'Donnell, 1995) with rates decreasing markedly with age. Although suicide rates remain relatively low in elderly African American males, rates are on the rise (U.S Bureau of Census, 1988). It is postulated that

this increase may be attributable in part to the increased life expectancy in this group (Chance et al., 1998). Previously, the number of African Americans reaching old age was low, lending support for the low rates of late life suicide. The current increase may reflect a lack of role models in this age group to facilitate adaptation to the aging process (Alston, Rankin, & Harris, 1995). Those who live to old age may be better prepared to cope with the stressors of aging after a life span of coping with many obstacles, such as poverty and racial discrimination (Cohen, 1993). Furthermore, many non-whites have less power, status and income throughout the life span, so in the late years any losses in these areas may be negligible in increasing suicide risk (Seiden, 1981).

Racial differences in family living arrangements may explain an apparent lower risk for suicide in part. The extended family is more common in many non-white cultures, whereas the nuclear family is the most common living arrangement for whites. The extended family may supply a support system by providing useful roles for older persons, such as childcare and domestic work, that is less common in a nuclear family structure (Garrison, 1992). This view has recently been challenged as some of the sociocultural variables that were previously identified as buffers against suicidality have changed as the social context for African Americans changes. There has been increasing disintegration of extended family networks, church and community organizations, increased poverty, and a paucity of role models, all of which may contribute to suicide across the life span (West, 1993). Suicide in late life suicide for African American women remains very low.

Other Ethnic Minority Groups

There is a paucity of information available on late life suicide in all other ethnic minority groups residing in the U.S. The diversity of the largest ethnic minority groups, Hispanics, Asians, and American Indians, complicates this inquiry, as well as, precludes generalizability of extant research findings. The information available on all of these minority groups reveals that suicide is male dominated throughout the life span and the rate of suicide decreases with age (Griffith, 1989).

Extant research has focused on comparing suicide rates in native countries of immigrants with the suicide rate for that minority group in the U.S. The results have been consistent in that suicide rates for Hispanic and Asian immigrants are higher than in their country of origin (Griffith, 1989).

Hispanic Americans. The two most frequently studied subgroups of Hispanic Americans are the Mexican Americans and the Puerto Rican Americans (Griffith, 1989). Much of this research is dated. In general, Puerto Ricans are more recent immigrants to the U.S. and Mexican Americans include both recent immigrants to U.S. and those residing here for many generations. Studies focusing on Puerto Rican immigrants support that suicide is a phenomenon of the young with those who have resided longer on the U.S. mainland being most at risk for suicide (Griffith, 1989). Mexican Americans are more a more diverse group. The rate of late life suicide in Mexican American men is increasing, however for women the rate continues to be far below Anglo American women. It is postulated the decline of the extended family together with acculturation are

contributory factors in late life suicide. Acculturation has led to a change in traditional family values, including decreased respect for elders and poverty, which may increase the view of elders as financial burdens to the family (Griffith, 1989).

A few recent studies have focused on late life suicide. In a recent study of older Cuban Americans in Dade County, the rate of suicide was 1.6 times higher than that for Anglo counterparts (Llorente et al., 1996). The groups did not differ with respect to number of medical illnesses, history of psychiatric illnesses, age, or recent physician visit. Declining health was the reason for suicide, according to relatives of the decedent, suicide notes, and direct statements made by the decedent prior to death (Llorente et al., 1996). Furthermore, it is hypothesized that older Cuban males suffer from economic and social losses, including a decreased socioeconomic class in the U.S. compared to their native Cuba and separation from extended family left behind in Cuba. There was a correlation between time lived in the U.S. and increased the risk of suicide. Those who had lived in the U.S. the longest were at lower risk than those who lived in the U.S. for a shorter period of time (Montgomery & Orozco, 1985).

Hispanics as a group tend to underutilize health care services in general and psychiatric services in particular (Alegria, Robles, Freeman, Jimenez, Rios, & Rios, 1991; Ruiz, 1985). Psychiatric care is stigmatized and depression is viewed as a character weakness rather than an illness. Furthermore, Cuban American males are expected culturally to be stoic, which may affect their decision to seek treatment. In the Dade County study, 50% of male suicide decedents were known to have depressive symptoms,

however tranquilizers rather than antidepressants were found on toxicology examination (Lorente et al, 1996).

American Indians. A preponderance of research with American Indians has focused on Alaska-Natives. There is a wide variation in suicide rates for American Indians due to the diversity in tribal culture, including acculturative experiences, general health, and prosperity (Griffith, 1989). For Alaska-Native elders, the suicide rate decreases after age 60 and is nonexistent after the age of 80. This has been attributed to increased cohesion among older adults that occurred as a result of cultural and economic changes. Alaska Native elders were respected for their knowledge of culture, tradition, and ability to maintain their society despite the rigors of their environment (Kettl, 1998). These same changes have instead distanced young persons from their traditions.

Asian Americans. The suicide rate for Asian Americans declines with age. Extant research has focused on Hawaii where a multitude of Asian ethnic groups reside. In a retrospective study, approximately 50% of Hawaiian deaths classified as suicides were Anglo (Purcell, Thrush, Blanchette, 1998). Other findings included: elderly males were the most likely decedents of suicide; nearly 50% of decedents had an active mental health problem of which depression was the most common; many had comorbid medical illnesses; and nearly 50% had seen a primary care physician within one to six months of their death. These findings corroborate those of many previous studies in late life suicide. However, a limitation of such studies is a lack of recorded statistics for specific ethnic groups.

In this section, culture was presented as a risk factor for late life suicide. There is a paucity of data for late life suicide in ethnic minorities in the U.S. Extant research is dated and often lacks an empirical basis, which diminishes the capacity to understand the cultural variable in suicide. In this dissertation, individuals of ethnic minority groups were recruited. Cultural beliefs and values may be implicit in data and possible links to suicidality were explored.

Self-Disclosure

Self-disclosure is a fundamental interpersonal process that is key in establishing and maintaining relationships. It involves revealing personal information about oneself to others (Jourard, 1971). It is through self-disclosure that one forms relationships with others, including friends and romantic partners. This interpersonal process is also significant in nurse-client relationships. In order to build trust between client and clinician, some level of self-disclosure is integral. This process is paramount in establishing a therapeutic relationship with depressed and suicidal older adults. The question may arise whether older adults are capable of sharing sensitive information with clinicians.

Some individuals easily disclose personal information, whereas others are more selective in choosing a confidant. The likelihood of self-disclosure is increased when certain conditions are met: a) the person is motivated to self-disclose, b) the person has the requisite social skills to self-disclose, and c) there is an opportunity for disclosure (Carpenter, 1987). However, these conditions may not apply in some cases. Many

individuals are not motivated to self-disclose, because they have been taught to be stoic and sharing personal revelations is a sign of weakness. For example, cohorts born after World War II have been socialized to express emotions more than their predecessors (Duberstein, Conwell, Seidlitz, Lyness, Cox, & Caine, 1999). In addition, many individuals lack a social support network or a confidant and have not developed the skill for self-disclosure. Finally, some may be motivated to disclose and have the opportunity, however perceive they lack social skills necessary for effective self-disclosure.

There are positive and negative consequences of self-disclosure. The positive effects include: beneficial catharsis, improved physical and psychological well-being, gaining insight into events that have occurred, validation of feelings, and development of personal relationships. Self-disclosure also has negative consequences. Revelations of personal information may result in negative effects for both the discloser and listener. The discloser may fear that negative or embarrassing thoughts will result in interpersonal rejection or ostracism by the listener. Even if the rejection is not perceived as overt, the individual may fear indirect rejection perceived through dismissal by the listener who changes the subject or offers unsolicited advice (Kowalski, 1999). Individuals may be reluctant to disclose for these other reasons: a fear of creating undesired impressions of themselves, a need to maintain personal boundaries through avoiding disclosure, and a need to keep some secrets from others to enhance feelings of uniqueness from others. Finally, feelings of regret may be overwhelming for individuals who have shared sensitive information with another (Harber & Pennebaker, 1992).

To the suicidal person, the negative consequences of self-disclosure may loom the largest. Unless s/he is able to develop a trusting relationship with their health care clinician, self-disclosure may not be possible. An individual's perception of another's suitability as a confidant is determined in part by the nature of the relationship between the discloser and the confidant (Kowalski, 1999). Individuals are more likely to self-disclose to those with whom they are more intimate. This feeling of psychological closeness to another person fluctuates, and so does the nature of disclosures (Goodstein & Reinecker, 1974).

Do the said criteria always apply to matters of self-disclosure? Unwillingness to disclose sensitive information is unlikely to explain all situations in which older adults fail to convey suicidal ideation or intent. Repression, denial and other psychological constructs have been proposed to explain the idea that people have feelings that remain unexpressed, not because they are unwilling to express them but because they are cognitively, affectively or linguistically unable (Duberstein, Conwell, Seidlitz, Lyness, Cox, & Caine, 1999).

Depression in late life may confound disclosure. In a recent study, older adults diagnosed by health care clinicians as having a severe depression requiring hospitalization were less likely to report suicidal ideation than their younger counterparts (Duberstein et al., 1999). This finding is relevant for many reasons. First, the prevalence of subsyndromal depression in older persons may lead to categorization of depression on the lower end of the diagnostic continuum, thereby de-emphasizing suicide risk. The risk

may not change, however the perception of risk may be diminished by the health care clinician (Duberstein et al., 1999). Secondly, there is an inverse relationship between suicidal ideation and completed suicide. Rates of suicidal ideation reportedly decrease throughout the life span (Moscicki, 1989), whereas rates of completed suicide increase. This finding suggests systematic underreporting of suicidal ideation by older adults. Again, this finding may be explained in part by uncharacteristic presentations of depression and the high rate of subsyndromatic depression in older adults. Finally, the absence of reported suicidal ideation may heighten suicide risk as those individuals who are most intent on dying may not reveal their plans for fear of intervention by the health care clinician (Duberstein et al., 1999). In this way, lack of self-disclosure may be associated with high lethality of suicide deaths of older adults.

Ageism

In symbolic interaction, selves and social structures are constructed through continuous interaction over time. These constructions are, in part, dependent on socialization. Age grading occurs in all societies as lifetime or biological time that is divided into socially relevant units. Age strata and age-status systems emerge in all societies. Duties, rights, and rewards are distributed to age groups, which themselves have been socially defined (Neugarten & Datan, 1973).

The age-grade system institutionalizes cultural values and forms a social system that shapes the life cycle. There are social expectations regarding age-appropriate behavior and these are internalized as the individual moves across the life span. For

example, there is an expected time to marry, raise children, retire, and die. There are social institutions and policies that support this structure, including the completion of high school education and age of legal majority. The system of age-grading is primarily consensual rather than formal (Neugarten & Datan, 1973). Individuals are aware of age norms and age expectations in relation to their own patterns of timing and can report whether a life event, such as marriage, occurred early, late or "on-time" (Neugarten & Datan, 1973, p.104).

Just as social structures support normative age-grading, they can also cause ageism. The basic idea of modernization and aging theory is that changes from preindustrial to an industrial societies cause declines in the prestige and status of elders (Cowgill, 1974). Several factors contribute to this devaluation including: a higher proportion of elders in the population, a decreased demand for elder workers due to increasing technology, increased retirement rate that lowers the income and social status of older adults, and rapid social change that creates obsolescence of knowledge that elders formerly passed down to younger generations (Palmore, 1999).

Elders continue to be subjected to ageism by both subtle and overt social and cultural messages. Stereotypes reinforce aging as negative. One such stereotype is all elders are depressed because they are sick, lonely, and miserable. In addition, elders are viewed as non-productive and therefore noncontributing members of society (Palmore, 1999). Hummert and colleagues (1995) demonstrated that most young, middle-aged, and older adults had similar views on both positive and negative stereotypes of older adults.

All groups thought the negative stereotypes presented were even more typical of older age and that positive stereotypes were associated with younger age groups.

Levin and Levin (1980) noted Americans generally expect and often encourage older adults to be unproductive, disengaged, and asexual. Many aspects of the American culture support and even perpetuate ageism. In fact ageism permeates our culture, although we may be unaware of it. It is through language, literature, television, and movies that stereotypes may be reinforced. Coupland, Coupland, and Giles (1991) noted that society marginalizes elders through conversation and social interaction. The effects of ageist language can accumulate over the entire life span. Equating chronological age with various negative characteristics used to depict elders is often ageist and sexist, such as biddy, hag, and old maid.

Depictions of elders in literature are often negative in content. One depiction is of elders who are helpless victims of neglect and indifference. Although there are more positive messages about elders viewed on television, many images tend to support ageistic attitudes. There are few older adults with starring roles in prime time programs. Women over the age of 65 are either rarely visible or seen as comic figures who are likely to be treated disrespectfully (Vasil & Wass, 1993)

The perception of conflicting values among the generations may reinforce ageistic attitudes for both younger and older adults. These ideas may be in contrast with the values older adults have internalized. This current cohort of elders was socialized during many major changes in national and world history, including the rise of Protestant ethic

that advocates success through hard work and self-sacrifice. Many elders continue to strive to maintain independence. Furthermore, they may berate themselves for not being able to work (Palmore, 1999).

Other values are due to aging and cohort effects. For example, older adults may de-emphasize the value of education because they do not have children of school age. In addition, older adults might value family ties more so than younger individuals because the older generation was socialized when family ties were considered more important than they are today. Younger individuals may perceive this as "old-fashioned", which reinforces this ageist stereotype (Palmore, 1999).

Meanings arise through interaction, however what is communicated often extends beyond the content of the words alone. Ageist attitudes are imparted through symbols and gestures. Since many elders do not have valued social roles or are not valued by others, they may receive continued messages that they are not wanted or useful. The concept of social death has been used to describe the final event in a sequence of declining social involvement. This phase begins for many at retirement when individuals are removed from the full involvement they once had. The process of social death is extended when older adults move to retirement communities (Mulkay, 1993). Although they voluntarily reside in retirement communities, many older adults receive this message and make the decision to move into a retirement community or home where they can reside with others like themselves. For others, the decision is made for them when they are placed in long term care and assisted care facilities. When the stigma of a wider society toward old age

is accepted and endorsed by older adults (Charmaz, 1980), they succumb to the majority and comply by segregating themselves.

Studies of health professionals' attitudes towards older adults support that they tend to have similar ageist attitudes as does the rest of society (Quinn, 1987). Medical students learn to see older adults as "vegetables" and "gomers" during their clinical practice (Butler, 1994). Despite extensive professional training, many physicians and nurses hold negative stereotypes about geriatric patients labeling them as inflexible, unproductive, and disengaged (Fineman, 1994). The reasons for this are complex, including little education about normal aging processes, fear of death, and biased experience with older adults. Many health professionals treat only sick, frail, or cognitively impaired elders and do not have the opportunity to see healthy older persons (Palmore, 1999).

Confronted with ageism, older adults may respond with acceptance, denial or avoidance. They may withdraw socially and disengage from activities in meet societal expectations. Others may choose to disengage reluctantly, but are not happy with the new role. In both cases, elders have internalized stereotypes about late life and accept them as they age (Palmore, 1999).

By contrast, denial of one's age is an adaptive response to ageism. Palmore (1999) noted that denial of "old" as a self-concept may actually be a denial of negative age stereotypes rather than a denial of chronological age. It has become commonplace for older adults to deny their age. Social construction of identity is used to construct and

maintain positive identities. Matthews (1979) noted women attempt to present themselves in a positive light by being productive so as not to be viewed as useless. In addition, they suppress their age by not disclosing it or lying about it and avoiding situations that make them feel old.

Some elders react to ageism with avoidance through isolation, alcoholism, drug addiction, and mental illness, including suicide. Many older adults prefer segregation from younger persons as they fear victimization and discrimination from them. The move to retirement facilities may serve as a protective factor from discrimination, but also the individual is not constantly reminded of the differences between themselves and others when they live among neighbors their own age. Alcoholism and drug abuse may be used to avoid the reality of aging. Both practices help one to deal with role loss, status, and the prejudice among elders, however can contribute to declines in physical and mental health. Ageism contributes to the stresses that are cumulative in mental illness. As elders age, there are significant role losses for many. These may translate to social isolation, feelings of inferiority, and a sense of feeling non-contributory. The resultant accumulation of stresses may culminate in depression for many elders and place some at high risk for suicide (Palmore, 1999).

Decision-Making

At some point, suicide may become a viable option for older adults. This process is not well understood. Decision-making has been explored in certain contexts, such as

end-of life, however, there is no extant research related specifically to decision-making in suicidality. This is the key question to be explored in this dissertation.

Some researchers have explored end-of-life decision-making, although not specifically in older adults. Instead, research has focused on the decision-making capacity of older adults with respect to making legal judgments, specifically in determining competency (Buchanan & Brock, 1989). Rationality in decision-making is often the focus in the case of the older suicidal adult. There is a presumption of incompetence in these cases as those with a desire to die are assumed to be mentally ill, hence incompetent (Sullivan, 1998). This thinking has been similarly applied to individuals with depression. Depression is thought to compromise individual autonomy. The influence of mild to moderate depression may be overestimated by clinicians when evaluating preference for life-sustaining treatments. In one study, mild to moderately depressed older adults selected less aggressive treatment in hypothetical scenarios, however depression accounted for only 5% of variance of the responses (Lee & Ganzini, 1992). It remains unclear how much depression impacts decision-making.

As individuals age, issues of competency regarding legal decisions and judgments concerning the capability of older adults to care for themselves and manage their own affairs become paramount (Appelbaum & Grisso, 1998). This has been the focus of extant literature addressing decision-making in older adults. End-of-life decision-making, in particular, has been in the forefront in recent years. There is a dearth of research on

decision-making in the suicidal older adult and the results of this research were anticipated to contribute to the goal of furthering nursing knowledge in this field.

Decision theories provide important background information regarding the process of decision-making. Decision-making is defined as the ability to make a reasoned choice (Smyer, 1993). Rational choice models have dominated decision-making theory during the past two decades. These models have been applied to economics, as well as, social sciences. One of the most prominent rational choice models was authored by Janis and Mann (1977). They listed seven stages of the decision-making process: 1) canvass a wide range of alternative courses of action; 2) consider the full range of objectives to be fulfilled and the values implicit in the choice; 3) weigh the risks of negative consequences and the positive consequences which could result from each alternative; 4) search for new information relevant to the evaluation of alternatives; 5) assimilate any new information or expert judgment even when the information does not support the course of action initially preferred; 6) reexamine both the positive and negative alternatives, including those originally rejected as unacceptable before making a final choice; and 7) make plans for the implementation of the chosen course of action including contingency plans if known risks were to appear. These stages occur sequentially and are built upon the relationships among the stages (Janis & Mann, 1977).

This model of decision-making includes, influences of individual perception, social status, self-esteem, and stress. Stress is thought to be the most relevant factor influencing complex decision-making (Janis and Mann, 1977). A new opportunity and

the need to make a decision create stress. The greater the stress, the greater the effect on decisions that are dependent on one's values, personal responses, and social influences. In serious decisional conflict, each alternative is viewed as a threat. A loss of hope in finding a solution accompanies the threat. For older adults contemplating suicide, deciding to die may be seen as a threat as the desire to die and the decision to act on this thought compete with each other. On the one hand, there are reasons that may support the desire to die, but on the other hand there are barriers and consequences in making this final choice. If a threat is perceived as severe, the decision-maker perceives little time to consider alternatives. In this case, a state of hypervigilance ensues which disrupts thought processes. In the case of a weak or moderated threat, the decision-maker is prompted to carefully consider alternatives and decide on a satisfactory resolution to the threat (Janis & Mann, 1977). For example, the threat of suicide likely prompts an individual to consider alternatives and whether their current situation warrants action at the given time.

Environmental influences and personality factors form an integrated system in which a decision is formulated. The environmental influences that impact on the individual are health status, finances, and living situation. Environmental influences may or may not be under the control of the individual (Janis & Mann, 1977). Personality factors are defined as coping mechanisms chosen by the individual to maintain the sense of self in the decision-making process (Salthouse, 1996). According to Willis and Schaie (1993), the external environment is composed of situations in which older adults must

respond. The influence of both the physical and social environment on individual competence is an important consideration in decision-making.

The primary interest in decision-making is how close the decision-making is to optimal. Salthouse (1996) noted reasoning and comprehension are fundamental to effective decision-making. Reasoning is "the ability to evaluate and integrate information" (Salthouse, 1996, p. 30). Reasoning is important because most decisions involve the selection of an alternative based on different pieces of information that need to be evaluated and integrated. Comprehension is the ability to understand and assimilate information" (Salthouse, 1996, p. 30). It is key to decision-making because an informed decision requires an understanding of relevant aspects of the situation, including the risks and benefits of all alternatives.

The decision-making capacity of older adults has received attention largely with respect to saliency in making legal judgments. More specifically, determination of competency has been the focus of interest for researchers. Buchanan and Brock (1989) noted competence is a legal term denoting adequate mental capacity to make informed decisions. All adults are assumed to be competent, unless otherwise demonstrated. These authors make a distinction between competence and decision-making capacity. The latter is used to describe varying degrees of mental ability ranging from none to excellent, whereas the former is all or none. Some individuals with impaired decision-making capacity are judged competent, while others who retain some capacity are judged incompetent. When applied to medical treatment, competency to refuse or accept medical

treatment is decision specific and must be evaluated with respect to that decision (Buchanan & Brock, 1989).

Buchanan and Brock (1989) have identified three types of mental attributes requisite for optimal decision-making: understanding and communication, reasoning and deliberation, and a stable set of values. Understanding includes the abilities to receive, process, and use information relevant to making a particular decision. An individual must be able to communicate his/her concerns, questions, and decisions. For example, expressive aphasia might be a situation in which the individual is incompetent, whereas a mechanically ventilated individual although unable to speak could communicate through writing. The ability to reason and deliberate requires the individual to make inferences about the consequences of a certain choice and compare alternatives and the impact of possible outcomes (Buchanan & Brock, 1989). Appelbaum and Grisso (1998) noted the importance of rationality in evaluating treatment alternatives. This refers to "the ability to reach conclusions that are logically consistent with the starting premises" (Appelbaum, 1998, p.1636). These authors emphasized that deciding what is rational and what is not is not an entirely objective process as an individual's choice may be viewed as irrational if the clinician does not agree with it.

With respect to older adults, competence can be defined broadly to encompass the ability of the individual to perform certain tasks of self-care and manage property on a daily basis (Willis & Schaie, 1993). Willis and Schaie (1993) identified five components involved in decision-making related to tasks of daily living. The latter authors cite similar

components essential to decision-making, however additional emphasis is given to components relative to functionality in the older adult. These components are: mental abilities; domain–specific knowledge; understanding personal circumstances and the interpersonal context; attitudes, beliefs, and preferences; and integration of decision-making components. Different constellations of these mental abilities and processes may be required to solve practical problems of varying difficulty. Decision-making requires an ability to integrate mental abilities, domain-specific knowledge, understanding personal circumstances, individual attitudes, and values and beliefs. Integration of multiple components is necessary for identifying solution alternatives, excluding options when inappropriate for one's individual circumstances, and prioritizing the remaining options (Willis & Schaie, 1993).

The final attribute reported to be necessary for optimal decision-making is a set of values that are consistent and affirmed as one's own. Although values can change over time, sufficient value stability is such that a decision can be "stated and adhered to over the course of its discussion, initiation, and implementation" (Buchanan & Brock, 1989, p. 25). Understanding one's personal circumstances reflects certain attitudes, beliefs and values. For example, locus-of-control and self-efficacy beliefs influence decision-making regarding health care (Forbes & Hoffart, 1998). Beliefs concerning aging focus on changes in independence, financial concerns, responsibility and beliefs concerning nursing homes. For many elderly persons, as functional status declines a perceived decrease in control over life occurs (Forbes & Hoffart, 1998). Personal values are

standards that guide conduct in a variety of ways. Personal values are standards that guide an individual in rationalizing beliefs, attitudes, and actions so that one will develop feelings of morality and competence. These values influence perspectives on suicide, hence are likely to influence the decision to take action on suicidal thoughts or not.

Rationality in decision-making is the focus in the case of suicidal individuals. For individuals who report suicidal plans, the desire to die is considered evidence of mental disorder and impaired capacity to make decisions concerning the need for psychiatric treatment (Sullivan, 1998). Rights to treatment refusal are not upheld among the actively suicidal. Historically, this has been based on the rates of treatable mental illness among decedents of suicide (Pokorny, 1983). Justification is based on a temporary presumption of incompetence.

Similarly, this thinking has been applied to individuals with depression. It is thought severe depression compromises individual autonomy (Sullivan, 1998). However, Appelbaum and Roth (1981) noted depression as a cause for treatment refusal was particularly difficult to evaluate. Depression is often difficult to recognize and the depressed individual is often able to offer "rational" explanations for the choices made (Applebaum & Roth, 1981). Research with the terminally ill has often supported suicidality to be linked to a mental disorder, specifically depression. In this case, depression may impair the ability to make a competent choice. But in many cases, individuals with a terminal illness may have a rational desire to die or to hasten death rather than prolong their death. There is evidence the impact of mild to moderate

depression on preference for life-sustaining treatments may be overestimated by clinicians (Sullivan, 1998). In one study, mild to moderately depressed older adults selected less aggressive treatment in hypothetical scenarios, however depression accounted for only 5% of the variance in responses (Lee & Ganzini, 1992). Other research supports the finding that depression is a poor predictor of preferences concerning life-sustaining treatment in medically ill older adults (Michelson, Mulvihill, & Hsu, 1991).

Just as those with terminal illness may choose to die rather than continue with life-extending treatment, many older adults may decide to choose suicide when illness becomes overwhelming or terminal. The idea of choice when death is perceived as near may also take precedence for many. In the preliminary exploration of this study, the question of choice in time of death was broached by one man with multiple medical problems (Bell, 1998). He contended that hastening his own death should be his choice, especially since he had no quality of life in his current circumstances. Despite the issue of personal choice, consideration of significant others in decision-making was evident in the data. As much as the individual desired to die and stated reasons for dying, significant others served as a restraint in decision-making. Other factors that may affect decision-making were the intensity of depressive symptoms, fluctuation in health problems, emotional distress, and contextual factors, such as inability to perform physical tasks.

In this section, decision-making in late life was reviewed. The majority of extant research on decision-making in late life has focused on end-of-life decision-making and

the requisite mental attributes. A discussion of competency in decision-making reviewed salient issues. The rational choice decision theory has guided research related to medical decision-making. The most prominent of these by Janis and Mann (1977) was reviewed and the role of stress, social status, self-esteem, and individual perceptions were illustrated. Willis and Schaie (1993) stressed the importance of decision-making related to activities of daily living for older adults. The importance of self-disclosure in sucidality is clear. An inability or unwillingness to disclose may heighten risk. A discussion of ageist attitudes and how they influence older adults in areas of self-identity, self-worth, and sense of belonging was presented. Risk factors, ageism, self-disclosure, and decision-making are seen as intertwined for older adults contemplating suicide.

Summary of Chapter Two

Chapter Two reviewed the literature related to: risk factors, self-disclosure, ageism, and decision-making in late life suicidality. First, risk factors for late life suicide were summarized in the following areas: biological and genetic, physical illness, psychological, cognitive, intrapersonal, social, and cultural. It is clear that multiple factors contribute to suicide risk and completed suicide.

Second, self-disclosure was reviewed as fundamental in the process of interpersonal communications. Individuals have different inherent abilities to disclose themselves to others. Older adults may not self-disclose in suicidality, which may heighten risk for suicide. On the other hand, they are capable of describing their histories and their thoughts about suicidality. Socialization contributes to ideas of ageism, as do

social and cultural factors. Ageist attitudes can shape an older adult's perception of self and their place in the world. The result may be a negative view of the self, which may encourage withdrawal from society and serve as an additional stressor in late life. These ideas were reviewed in the third section.

Fourth, the process of decision-making was addressed. Any decision-making process is individualistic, however a set of progressive decision-making stages may be applicable. In cases of depression and suicidality, decision-making may be altered however the impact of a mental illness on decision-making has not been clarified.

CHAPTER THREE

METHODOLOGY

The methods for the study are presented in this chapter. The methods will be described in three parts: background of grounded theory, a description of the procedures, and criteria for trustworthiness. The background will include a discussion of the usefulness of the grounded theory method for illuminating nursing phenomena, the foundations of grounded theory, and the process. The procedure section will include: ongoing literature review, data collection, study criteria, theoretical sampling, data management, and data analysis including substantive and theoretical coding. The third part of this chapter will present criteria for addressing trustworthiness in this study.

Background on Grounded Theory

The grounded theory approach was used for this research. The goal of grounded theory is to generate theory that is grounded in empirical data in order to account "for a pattern of behavior which is relevant and problematic for those involved" (Glaser, 1978, p. 93). These patterns, or basic social processes, are fundamental "in the organization of social behaviors which occur over time and go on irrespective of the conditional variation of place" (Glaser, 1978, p. 100). Grounded theory illuminates these basic social processes with the goal of developing theory. Grounded theory is directly related to the symbolic interactionism. In symbolic interactionism theory, it is believed that individuals construct their social reality through the process of interaction. Humans attach symbols to

other individuals and their physical environment and act on the basis of these meanings. It is through communication that symbols are created (Blumer, 1969)

Usefulness of Grounded Theory Method

Qualitative research is effectively used to explore phenomena for which little information exists or to gain a fresh perspective regarding a familiar phenomena or setting (Stern, 1980). The researcher studies a phenomena in its natural setting "attempting to make sense of or interpret, phenomena in terms of the meaning people bring to them" (Denzin & Lincoln, 1994, p. 2). Grounded theory is a useful research method for studying complex nursing phenomena in a naturalistic setting, such as how older adults view suicide, how suicide becomes an option for them, and factors triggering suicidal ideation. This method explores the richness and diversity in the human experience while contributing to the development of nursing theory (Streubert & Carpenter, 1999). If there is to be any understanding of why individuals choose suicide, the questions must be asked of the suicidal individual. Furthermore, an emphasis on social interaction and the social reality of the suicidal individual is a topic that has been missing in extant research. In this study, the goal was to gain some insight into decision-making surrounding suicidality and the processes involved at the time when the older adult begins to consider suicide as an option.

The Grounded Theory Process

The grounded theory method includes the following steps: 1) simultaneous data collection, coding, analysis, and categorization, 2) development and integration of

categories using the constant comparative method, 3) data reduction, theoretical sampling, and identifying a core categories, and 5) theory construction, including explicating emergent basic social processes (Glaser, 1978).

Grounded theory is unique for its characteristics, including constant comparative analysis, core categories, and basic social processes (BSPs). Constant comparative analysis guides theory generation. Glaser (1978) described the process of comparison involved in generating theory. First, there is constant comparison of incident to incident for the purpose of establishing the underlying uniformity and its varying conditions. Second, incidents are compared to concepts to generate new theoretical properties of the concept and additional hypotheses. Lastly, while the first two comparisons continue, concepts are compared to concepts for the purpose of establishing the best fit with a set of indicators. Constant comparisons generate categories that are verified for fit with other categories and the core variables.

One or more categories emerge as central variables in the study. Theory is generated surrounding the core category, as it is this category that accounts for most of the variation in pattern of behavior. As most other categories are related to it, a primary function of a core category is integrating the theory. A core category reoccurs frequently in the data and becomes more and more related to other variables. For these reasons, it takes more time to saturate a core category as it is related to more categories and is recurrent. Core categories can be any kind of theoretical code, including a process, a condition, or a consequence (Glaser, 1978).

Basic social processes (BSPs) are "fundamental, patterned processes in the organization of social behaviors" (Glaser, 1978, p.100). Glaser (1978) defined two types of BSPs: basic social psychological process (BSPP) and basic social structural process (BSSP). A BSPP refers to a basic social psychological process, such as becoming. There are distinctions between a BSP and a core category. Basic social processes are one type of core category, but not all core categories are BSPs. While a core category is always present in a grounded theory research study, a BSP may not be. A BSP is more likely to be generated during the process of fieldwork which continues over time and with subsequent research studies, rather than in one individual study (Glaser, 1978).

Grounded theory is a scientific method that employs both inductive and deductive strategies to generate theory from data (Glaser & Strauss, 1967). From the inductive phase, theory emerges from the data and observations made by the researcher. The theory is then tested empirically to generate hypotheses about the phenomena under study (Streubert & Carpenter, 1999). With deductive work, codes are derived from data and these conceptual codes guide direct sampling of more data to derive hypotheses and generate theory. Deduction is a method to enhance further induction. Grounded theory is for discovering concepts and hypotheses, not for testing or replicating them (Glaser, 1978).

Theoretical sensitivity is requisite to the outcome of grounded theory. Theoretical sensitivity refers to the researcher's knowledge, understanding, insight, creativity, and skill in generating categories and hypotheses according to the emergent theory. It is a

personal attribute of the researcher to be able to give conceptual insight and meaning to the data. Without it, the result is a preconceived conceptual description rather than grounded theory. In each stage of grounded theory, there are techniques built in to encourage creativity (Glaser, 1978; Glaser, 1992). For example, writing memos allows the researcher to develop theoretical musings during the process. The researcher must be open to emergent theory, therefore s/he should approach the process with a open mind. Preconceived ideas are held in abeyance during theory development, so that the researcher can remain as unbiased as possible. Also, minimizing the literature review prior to beginning qualitative research will not bias the researcher's efforts to generate categories and theoretical codes that emerge from the data. The literature is again reviewed after data are collected, analyzed, and the theory is generated and grounded (Glaser, 1978; Glaser, 1992).

In grounded theory, theory generation and methods are tightly integrated. Theoretical sampling is the process of data collection for generating theory by simultaneously collecting, coding, analyzing data, and deciding what data to collect in order to develop the theory. The process of theoretical sampling is recursive as the research proceeds. Data are coded using the constant comparative method. The comparison of codes is ongoing as the data are analyzed first line by line and later selectively. After categories are generated with open coding, data are reduced as core variables emerge and the data are selectively sampled to further develop core concepts. Theory then continues to be constructed around a core category (Glaser, 1978). This

process of data collection and analysis provides checks within the method to ensure that emergent theory represents the data. The codes that emerge are further developed theoretically until saturated. Theoretical sampling continues until code saturation occurs or when no new conceptualizations emerge from the data (Glaser, 1978).

Procedures

In this section, the procedures for this study are presented along with the research process for grounded theory. The procedures are presented in the following sections: ongoing literature review, data collection, study criteria, theoretical sampling, informant demographics with a description of each, screening instruments, and the interview process.

Ongoing Literature Review

In grounded theory, data should be collected in the field first. When the theory seems sufficiently grounded and developed, the literature in the particular field is then reviewed and the theory is related to an integration of ideas from the literature (Glaser, 1978). This permits the researcher to approach the area of inquiry without preconceived ideas during theory generation. For this study, it was necessary to review the literature in the field for both theoretical context and previous research regarding risk factors for suicide. This did result in heightened awareness in this field of inquiry, however in this case the largely empirical research available did not reflect the importance of individual perception when viewing decision-making in suicidality. The grounded theory approach was used to identify salient variables to older adults in this particular situation.

After the data were analyzed and a theoretical framework evolved, reading of the literature resumed. Literature from nursing, psychology, sociology, and material related to the substantive area were read. One such reading was a personal account of living with bipolar disease. In retrospect, this reading enhanced my theoretical sensitivity as my own research developed. Once the theory was generated from the data, ideas from the literature were compared with research findings to generate more ideas for the development of theory about suicidality. Integrative connections were discovered as to the fit of the generated theory with other research. Glaser (1992) emphasized reviewing the literature to generate ideas and to integrate the emerging theory to show its contribution, not to seek verification of hypotheses or findings.

Data Collection

Procedures for data collection will be presented in this section. These are: a description of participant observation, study criteria, human subjects, theoretical sampling, description of study informants, screening instruments, and the interview process.

Data collection was conducted in two phases: phases one and two (Table 3.1). During phase one, four elderly male veterans were interviewed at VAMC (July, 1998) about depression and suicidal ideation. In phase one, depression was a focal point of the interview rather then suicidality. Nine additional veterans were interviewed for the second phase (May through August, 2000). During the second phase, additional data were collected as a participant observer in the Geri-Psychiatry Clinic at the VAMC.

Table 3.1. Timeline of Study

Date	Phase	Method
Summer 1998	Phase One n=4	Open-ended Interviews
Fall 1999-Summer 2000	Phase Two	Participant Observation
Summer 2000	Phase Two n=9	Open-ended Interviews

Participant Observation

The researcher gained entry into the Geri-Psychiatry Clinic at the VAMC through an affiliation with a psychiatric-mental health nurse practitioner. The nurse practitioner worked closely with her since October, 1999. The researcher spent an average of 12 to 15 hours per week in the Geri-Psychiatry Clinic for one year.

My role in the clinic was as a participant observer. Participant observation refers to the researcher having an established role in the scene studied (Atkinson & Hammersley, 1994). Adler and Adler (1994) noted the role of the researcher in a naturalistic setting may be either covert or overt. In a covert role, the researcher interacts with group members closely enough to establish an insider's identity without participating in member activities. Whereas in an overt role, the researcher becomes involved in central activities of the group without committing to group values and goals (Atkinson & Hammersley, 1994). The researcher became a participant observer at the Geri-Psychiatry Clinic at the Tucson VAMC assuming both overt and covert roles. The researcher assumed an overt role while conducting new client evaluations, posing questions, or offering input during the interview. Some of these individuals were later

invited to participate in the study. In a covert role, the researcher observed during evaluation and therapy sessions. During the evaluations, the researcher made mental notes concerning the client's affect, presentation, and impressions of their disclosures. These mental notes became field notes and memos, which are data that were merged with data from the formal interview.

Study Criteria

Criteria for study participation were established to ensure a sampling of individuals who could address the phenomenon of suicidal ideation. The study criteria were:

1) age 65 years or older living independently in the community;

2) English speaking;

3) a suicidal ideator at the time of the study;

4) receiving ongoing outpatient mental health care for suicidality;

5) may have had a previous suicide attempt anytime prior to this study;

6) a score of 16 or higher on the Geriatric Depression Scale and 25 or higher on the Mini-Mental State Exam; and

7) no previous diagnosis of psychosis, schizophrenia, or dementia. The operational definition of suicidal ideator is one who has thoughts about self-harm or self-destruction (Stillion & McDowell, 1996).

Screening Instruments

Prior to formal interviews, a brief semi-structured questionnaire was used to obtain background information on participants (Appendix A). The questions were used to establish rapport in addition to providing background and included: age, marital status, number of children and current relationship with the participant, medications, physical health problems, activity restrictions and cause, and alcohol use. Two instruments were used to screen for dementia and depression in the study sample. The instruments were given to the participant to complete after written consent for study participation was obtained. Those with cognitive impairment as evaluated by the Mini-Mental State Exam (Appendix B) (score less than 25) were excluded from the study All individuals who were invited to participate had been previously evaluated for dementia in the VAMC Geri-Psychiatry Clinic, but considerable time may have elapsed since the assessment. For this study, those with a score of less than 25 were excluded from the study to assure that participants were cognitively intact and not marginal for mild cognitive impairment. The scores ranged from 26 to 30 with nine participants scoring 30 (Appendix C). No participants were excluded based on MMSE scores. The Geriatric Depression Scale was used to rate depressive symptoms at the time of the interview (Appendix D).

Mini-Mental Status Examination. The Mini-Mental State Examination (MMSE) (Folstein, Folstein, & McHugh, 1975) is a commonly used instrument to screen cognitive functioning in both community based older adults and nursing home residents (Appendix D). The MMSE has a high test-retest reliability for both 24 hour or 28-day testing

performed by single or multiple examiners. The Pearson correlation coefficient was high in both cases, for 24-hour test-retest (r=.89) and 28 day retest (r=.83) in persons with dementia. Those with a score of 20 or less were found in those with dementia, schizophrenia or affective disorder, and not in normal elderly (Folstein et. al, 1975). Concurrent validity was assessed by comparing the test scores to the Wechsler Adult Intelligence Scale. For the verbal performance, the Pearson correlation was .78 ($p<.0001$) and for mental status/performance .66, ($p<.001$) (Folstein et al., 1975). A score of 20 or less was found only in individuals with dementia, an affective disorder, delerium and schizophrenia.

Geriatric Depression Scale. The Geriatric Depression Scale (GDS) is a reliable and valid instrument to assess depression in the elderly. The GDS was used in this study to gauge depressive symptoms at the time of interview. A score of zero to nine is normal, ten to 19 indicates mild depression, and a score above 19 indicates a severe depression. Cronbach's alpha for internal consistency reliabilty was reported at .94. Test-retest reliability at one week apart was .85 ($p<.001$). Those subjects who were classified as normal attained lower scores on the GDS compared to the mildly and severely depressed groups by paired t-tests (Yesavage, Brink, Rose, Lum, Huang, Adey, & Leirer, 1983).

Human Subjects

Detailed information about the study was provided to all the potential informants. Informants were asked to sign a consent form (Appendix E), which explained the benefits and risks and assurances of confidentiality and anonymity. Data were initially identified

by informants initials, then each was given a pseudonym after transcription. Consents were kept in a locked drawer separate from study data. Approval from the Committee for the Protection of Human Subjects at the University of Arizona (Appendix F) and the internal review board at the VAMC in Tucson (Appendix G) were obtained prior to recruitment.

Theoretical Sampling

In order to elucidate the processes involved in suicidality, individuals with suicidal ideation were selected to reflect on their suicidal thoughts. Thereafter, data collection was guided by the emerging theory. The sample for this study was selected from older adults who had been referred to the Geri-Psychiatry Clinic or the Mental Health Clinic for a mental health evaluation and treatment at the Tucson VAMC. A nurse practitioner colleague in Geri-Psychiatry assisted with participant recruitment. The participant's were selected for their ability to share information about the phenomenon of suicidal ideation. Individuals were selected to include a range of individuals, including those with atypical experiences, to obtain a complete range of phenomena (Morse, 1991).

The researcher sought to purposively include women and minorities, however the older cohort of veterans consisted largely of white men. Furthermore, white men at this VAMC were more likely to be seen in the Geri-Psychiatry Clinic. The number of older women seeking mental health care at the VAMC was very small. Of the few women enrolled in Geri-Psychiatry Clinic, most were undergoing treatment for depression associated with dementia. Similarly, of men belonging to ethnic minorities, most had

dementia or were not suicidal. For these reasons, the participants were all older white men. Since older white men are at highest risk for suicide in late life, this study had substantial merit. The information gained may highlight issues pertinent to other older veterans and to the larger male cohort.

During phase one, all four informants were referred by a nurse practitioner colleague who had an ongoing therapeutic relationship with them. They were contacted by the investigator via telephone to describe the study and ascertain interest in their participation. During phase two, the researcher met all informants through her work as a participant observer in the Geri-Psychiatry Clinic or the Mental Health Clinic prior to scheduling interviews. Ten men were approached to participate in the current phase of the study. Nine consented and one declined after some consideration. This man had end stage chronic obstructive airway disease and his health was poor. After initially agreeing to participate, he declined stating that with further consideration he was uncomfortable discussing his suicidal thoughts. Five participants had received ongoing care for months to years in the Geri-Psychiatry Clinic and continued to receive treatment for depression. The sixth received ongoing care in the Mental Health Clinic. The remaining three were recent referrals for evaluation and treatment of suspected depression.

After two to three clinic encounters, the researcher invited individuals who met study criteria to participate in the proposed research study. Prior to the scheduled interview, the researcher and subject had not met. Some reluctance and discomfort was noted during the interviews because the topic was so sensitive. To facilitate trust building

and increasing participant comfort and self-disclosure, recruitment for phase two of the study was changed. After two visits, informants who met the study criteria were approached for interviews. The quality of the current interviews confirmed this decision to be a good one. Theoretical saturation occurred by the ninth interview and sampling ended. Data from three preliminary interviews were selectively sampled to saturate core categories.

Description of Study Informants. In this section, confidentiality issues and brief descriptions of the informants are presented. Informant confidentiality was maintained by keeping consent forms separate from transcripts and by identifying each person only by a pseudonym.

Thirteen interviews were conducted in the two phases of the study. All participants were white men, aged 67 to 83. All had been diagnosed with depression and were receiving ongoing treatment with antidepressants and individual psychotherapy. Three men reported a history of depressive illness prior to late life and two additional had a history of depression documented in their medical record. Six men were married and two had significant others. For the six informants with known educational levels, three were high school graduates and three held graduate degrees.

Ralph

Ralph was age 83. He was a retired geology teacher, who continued to be active writing articles for publication and giving seminars. He also served on several boards of director for diverse companies and had no plans to retire. Ralph was diagnosed with

depression approximately one year before when his wife of nearly 60 years died suddenly of a brain aneurysm. He remained on antidepressant therapy and had shown considerable improvement moving through his grief and depression. Ralph was healthy physically. He had two sons and reportedly had good relationships with them. They resided in other states. He also had several close friends he saw frequently and considered his support system to be good.

Rick

Rick was 76 years of age. He had been retired for many years. His last occupation was construction. Rick was the primary caregiver for his wife for two years before she died in 1994. At that time, she refused to continue dialysis and he supported her decision. His relationships with his family, including two daughters and two grandsons that he and his wife raised, were reportedly poor. His wife's death led to his estrangement from his family altogether. Rick sold his home and lived alone in a condominium. He knew some of his neighbors, although had isolated himself from them and discontinued activities in the community. He had been receiving antidepressant therapy and psychotherapy since February, 2000. Rick rated his physical health as good.

Leo

Leo was 74 years of age. He and his wife had been married for 52 years. They had no children and reportedly had a good relationship. His wife scheduled social activities for both of them, which reportedly improved his moods. He saw other friends occasionally, but this had decreased since he was no longer able to golf. Leo had both

severe osteoarthritis and chronic nasal congestion from an obstruction that was inoperable. Both conditions had restricted his mobility a great deal, reportedly interfering with his quality of life. Leo retired early at age 58 from a managerial job because his wife retired. He reportedly had a difficult time adjusting to retirement.

Carl

Carl was age 69. He was divorced and lived alone in a low-income apartment complex. His daughter also resided in the building. Carl did not have other close friends or family. His occupation was in maintenance and he had retired two years prior to the interview. He had a history of bipolar disease that was controlled on medications. He had a history of heavy alcohol use in the past and had been abstinent for three years. Carl rated his physical health as good.

Jack

Jack was 80 year of age. He retired as a greens keeper, but his previous career included being a sociology teacher at the university level. He had a master's degree. Jack was divorced with two children residing out-of-state. He continued to be in touch with them regularly. He resided in an independent living retirement complex where he had friends he interacted with regularly. Jack had advanced chronic obstructive pulmonary disease and was largely dependent on oxygen. This had prompted him to think of end-of-life decisions, including a planned suicide. Despite this, he viewed his illness as "irritating," not debilitating.

Jay

Jay was 67 years of age. Jay was married for the second time. He had four children and two resided in Tucson. His relationships with family members were good. Jay was diagnosed with depression and continued to receive psychotherapy, but was not on antidepressants because they reportedly gave him intolerable side effects. His occupation was in computer technology including the development of computer software and computer consultation prior to retiring a few years prior to the study. He continued to do volunteer work through his church visiting other older adults who were alone and required assistance. Jay had a history of frequent chronic migraine headaches that were incapacitating. One major concern for him was his decline in memory that was exacerbated in certain situations. There was no diagnosis of memory impairment.

Sid

Sid was age 77. He and his wife had been married for 54 years and had one son. His relationship with his wife and son was close. Sid was living at home with his wife as his caregiver. He was disabled and in a wheelchair due to a chronic back condition that became inoperable. He had back and knee pain that medications did not alleviate. Sid had cardiovascular disease and had been receiving treatment for depression for 20 years. He may have had previous treatment for depression when he was in his 40s, but his history was not clear. His work history included being a locksmith and a business owner. Sid was formerly very active socially and professionally. He had a history of suicide attempts (none in past two years).

Don

Don was 73 years of age. He lived with his second wife on a rural property. They had three children, all who resided out-of-state. He described their relationships as close. Don had no other close friends or acquaintances as he noted all his friends had died. He reported having no confidant except his therapist. Don retired as a bar owner in 1995. His previous occupations included being a farmer and a construction worker. He continued to keep active by renovating his property. Don reported chronic pain due to arthritis, which worsened with physical labor. Pain medications were effective for pain relief. He had a history of heavy alcohol use earlier in his life.

Jake

Jake was age 80. He had been married three times and had two daughters who lived in Tucson. His third wife was deceased. His relationships with his daughters were not close. Jake resided with his dog in an apartment. He had no close friends as they had died. He had a history of heavy alcohol use at the time of data collection. He described his health as failing, with visual changes, hernias, and tremors. Despite these, he drove and cared for himself. Jake had a history of bipolar disease and was controlled on medications.

Gerry

Gerry was 75 years old. He was married and lived with his wife in a mobile home. They had two daughters, one died in infancy. Gerry had reported a close relationship with his daughter and was in the process of relocating to live next door to her. He rated his

health as good. He had been receiving antidepressant therapy since a suicide attempt in 1981. For the prior year, Gerry had been taking antidepressants less regularly, as he was no longer able to afford to see a community mental health provider. He had resumed regular antidepressant therapy one month prior to the interview. Many years before the interview, Gerry retired after a short-term disability from the post office. He expressed regret over this early retirement. Gerry did some volunteer work with his church, but his involvement had decreased in recent years.

Carroll

Carroll was age 79. He was married to his second wife and they lived in a small city east of Tucson. Carroll had a close relationship with his wife and she planned activities for them to do together. He had two children living in other states. He had frequent contact with other family members. Carroll had completed a master's degrees and had been a music teacher. He enjoyed teaching and regretted his early retirement. Carroll retired when his first wife retired and encouraged him to travel with her. She suffered a fatal heart attack approximately one year after retirement. Carroll was diagnosed with inoperable prostate cancer and was receiving injections of chemotherapy. He had a ongoing problems of cardiovascular disease and congestive heart failure. Due to medical illness, chemotherapy, and depression, his energy was low and he had no desire to be active. Carroll was diagnosed with depression earlier in 2000, although he did not think he was depressed.

Roger

Roger was 81 years old. He was divorced and lived alone in an apartment. His two children lived out-of-state and he considered his relationship to be especially close with his youngest daughter. Roger had acquaintances, but no close friends. His therapist was his only confidant. He remained active using his computer daily and going out to the park. As a younger man, he ran the family furniture business for many years before selling it and moving to California. He had a history of heavy alcohol use in the past. Roger considered his physical health to be good, despite inoperable prostate cancer. He had a history of past depression and suicidal ideation, but no suicide attempts.

Pete

Pete was 76 years old and lived alone. He was divorced, but regularly spent time with a woman companion. He described this relationship as "rocky." Pete had seven children from two marriages, but was not in touch with the three younger ones. His relationships were not close with the older children due to disputes over money. Pete was a successful businessman prior to retirement in 1985. He was attempting to reestablish himself in business, but was having financial difficulties. Aside from his significant other, he had no friends. He was involved in volunteer work and had future expectations for gainful employment again. Pete was physically healthy. He viewed his therapist as his only confidant.

The Interview

All interviews were arranged at a mutually convenient time during VAMC clinic hours and were conducted in a private clinic office at VAMC. Due to the sensitivity of the topic, conducting interviews in the clinical setting was anticipated to provide a safe environment for both informant and researcher. Immediate psychiatric referral was available for clients who were assessed to be in crisis with active suicidality. No adverse events occurred with any of the study informants. Prior to beginning the interview, the researcher discussed the nature of the research study, the informant's rights concerning the study, and written consent was obtained. A copy of the signed consent was given to those who desired one.

One interview was scheduled with each informant. Interviews lasted from 35 to 90 minutes and they were audio taped in entirety. The interview began with the semi-structured demographic questionnaire to put the participant at ease and build rapport before discussing the topic of suicide. The selected screening instruments, the GDS and the MMSE, were then administered. The interview was initiated with a reflection on the informant's history of suicidality and a broad data-generating question was asked to elicit the informant's story concerning suicidality. The data-generating question for the phase one of the study was "tell me about your depression." Some individuals gave a very detailed history of their depression and it was sometimes difficult to redirect them to include reflections on suicidality. For the second phase, the researcher adopted a participant-observer role in order to meet study participants in the clinic setting first to

promote trust building and disclosure. As Goodstein & Reinecker (1974) noted, individuals generally self-disclose to those with whom they are more intimate. Building rapport prior to the interviews had a positive effect on disclosure during the subsequent remaining interviews.

For the second phase of data collection, the data-generating question was "tell me about your suicidal thoughts." During data collection, the researcher listened to the informant's story and prompted the participant to ensure appropriate interpretation of the informant's words and to minimize investigator bias. The process was guided by the emerging theory as informed by ongoing data collection, theoretical coding, and data analysis. For example, after the first three current interviews, religious beliefs emerged as a category. The researcher then asked of subsequent informants what role religious beliefs had in their contemplation of suicide.

During data collection, the researcher remained attentive and discretely recorded field notes only when necessary, such as when the informant said something before and after the audiotape was turned off. Otherwise, field notes concerning body language, mood, impressions, and other notable occurrences were written immediately after the interview. The interview audio tapes were transcribed verbatim by a professional transcriptionist. The researcher then reviewed each audiotape for accuracy and made corrections, and added nuances not recorded by the transcriptionist. The audio tapes were retained for future analysis. Each participant was identified by a pseudonym to ensure confidentiality.

Immediately after the interview, the researcher debriefed the participants through inquiry into how they were feeling after sharing intimate feelings. At this time, the individual was assessed for mood changes following the interview. None of the informants admitted to feeling distressed, nor did they appear to be after the interview.

Data Management Procedures

In this section, data management procedures will be described. Scrupulous attention was given to record keeping with the goal of producing an audit trail. Field notes and theoretical memos facilitated data collection and analysis and will be discussed individually.

Record Keeping

During data analysis, open, selective, and theoretical coding was done on the individual interview. When coding for one transcript was completed, core categories were compiled and typed into a Microsoft word document for legibility. This procedure was followed by category reduction in each interview, then across all interviews. Memos were generated as the data were coded and these were also recorded in a Microsoft document. Core categories and properties were generated and recorded. In addition, the core categories in each interview were placed into a schematic that depicted the story being told in each interview. Later, when core categories were merged into theory, the concepts were placed into the emerging theoretical framework. Schematics were revised as new insights developed and during discussions with faculty advisors. Copies of all

these materials and one audio tape were given to Dr. Badger, the faculty auditor, for review.

To facilitate data collection in grounded theory, the researcher relies on the use of field notes to prompt recollection of events and ideas that have occurred while in the

Field Notes

Recording field notes assists in generating properties of categories (Glaser, 1978). naturalistic setting. When it is not possible to record observations in the field, making notes as soon as possible after the encounter serves to prompt details of the encounter or interview.

During participant-observation in the VA Geri-Psychiatry Clinic, observations were recorded as were statements thought to be significant in understanding each individual story. Notes included statements by potential study informants about their histories, past experiences, and thoughts about depression and current life circumstances. Many informants were very articulate in describing their feelings. Capturing these thoughts increased the density of the data. The formal interview was audio taped and observations and impressions during earlier encounters with participants in the Geri-Psychiatry Clinic were consigned to field notes.

Theoretical Memos

Memos are "the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding" (Glaser, 1978, p. 81). Memoing is an ongoing process that begins with initial coding of data and continues through joint data collection,

coding, and data analysis and continues on through to the writing of the final draft. There are four basic goals in memoing: 1) to theoretically develop ideas, 2) to record ideas with freedom, 3) to develop a rich fund of memos, and 4) to create a fund of memos (Glaser, 1978). Constant comparative analysis, or comparing indicator to indicator and indicator to concept, was the principal source of memos at the onset of a study. Thereafter, additional memos were generated by existing memos, sorting of memos, and conceptualization. Ongoing memoing gives direction for theoretical sampling, focuses reasoning through category verification, integration and fit, and clarifies the emerging theoretical framework (Glaser, 1978).

For this study, memos were kept separate from data and referenced to field notes from where they originated, so the researcher could check grounding and give illustrations as needed. They were generated as ideas that occurred during data analysis so impressions were not lost. Memos assisted in theory development as core concepts emerged from the data.

Data Analysis

In the grounded theory approach, data are analyzed using two types of codes. These are substantive and theoretical coding. Substantive coding conceptualizes the empirical substance of the research. Theoretical codes conceptualized how the substantive codes may relate to each other as hypotheses. Selective coding is a technique for delimiting the data to be coded after substantive codes have emerged. Substantive

coding is then restricted to core concepts in an effort to focus on theory being generated. All will be discussed in this section.

Substantive and Selective Coding

After interviews were transcribed, data were coded using two coding procedures, substantive and selective coding. Substantive codes are the conceptual meanings of the generated categories and their properties and are the result of open coding. The data were fractured through the process of open coding in which the data are examined line by line to identify category and category properties (Glaser, 1978). A substantive code was assigned to the data bits to convey the substance of the data. Through the process of constant comparative analysis, data were compared with other data and assigned to categories or clusters according to their fit. This process was ongoing. Open coding is intended to saturate individual codes and stimulates ideas concerning the data. The concepts are emergent in this process (Glaser, 1978). Coding continued until core categories, such as loss, hopelessness, and alienation, were identified. After this occurred, the researcher began selectively coding for these core categories in subsequent interviews. At this point, open coding ceased and analysis continued with selective coding of core categories in the interviews. Selective coding refers to coding done only for those categories relating to the core categories as theory is developed. These core concepts then became a guide for further data collection and theoretical sampling.

Theoretical Coding

"Theoretical codes conceptualize how substantive codes relate to each other as hypotheses to be integrated into the theory" (Glaser, 1978, p. 55). For example, theoretical codes show how the categories of loss and depression may relate to each other and how they relate to theory (Glaser, 1978). Theoretical codes are emergent like substantive codes as categories are compared with properties for the best conceptual fit. They enable the researcher to see the research, data, and concepts in new ways to be used for generating theory. Theoretical codes weave the story back together after it is fractured in substantive coding. Using both types of coding results in grounded theory that fits the data (Glaser, 1992).

Trustworthiness in Qualitative Research

Lincoln and Guba (1985) set forth criteria for evaluating trustworthiness in qualitative research. The criteria were proposed to specifically address the issue of rigor in qualitative research, rather than apply the traditional criteria of internal and external validity and reliability used to evaluate rigor in a positivist paradigm.

The following aspects for assuring trustworthiness were employed in this study: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985).

Credibility

Credibility is concerned with the truth value and believability of research findings (Lincoln & Guba, 1985). This parallels internal validity in a quantitative paradigm where the underlying assumption is that a single reality exists and the study findings display an

isomorphism, or a one-to-one relationship with that reality. In qualitative inquiries, there is no assumption of a single reality. Instead, "reality" is a multiple set of mental constructions made by human beings. The principle of isomorphism is impossible to apply as there is no ultimate benchmark for reference (Lincoln & Guba, 1985). Instead, truth value lies in the discovery of human experiences as they are lived and perceived by the individuals involved (Sandelowski, 1993). A qualitative study is credible when the researcher has represented the multiple constructions and reconstructions faithfully and these are recognizable to the constructors of the original multiple realities (Lincoln & Guba, 1985). Two techniques were employed to enhance the credibility of data interpretation and research findings of this study. These were: prolonged engagement and peer debriefing.

Prolonged Engagement. Prolonged engagement is the investment of sufficient time to learn the culture, test for misinformation that may be introduced through distortion by the researcher or the respondents, and to build trust between the researcher and the respondents (Lincoln & Guba, 1985). Schwartz and Ogilvy (1979) noted that objects and behaviors take their meaning from their contexts. Without prolonged engagement, both personal distortion and distortions by the respondents may occur. Unintended distortions include misinformation due to misinterpretation of the researcher's questions, a desire to please the investigator, and a lack of motivation to address the investigator's concerns (Lincoln & Guba, 1985). Indeed, building trust is a developmental process, which occurs over time.

For this study, the researcher became a participant-observer in the Geri-Psychiatry Clinic at the VAMC. In part, this role was selected because I wanted to learn more about depression and cognitive changes in older adults. Secondarily, it seemed appropriate to meet potential study informants in a setting that was familiar for them. As an observer, I could also begin establishing rapport, learn about their history, and observe interactions with their therapist. My role remained largely that of a participant-observer. I conducted initial intakes on new mental health clients, however these were in conjunction with my nurse practitioner colleague. She then conducted follow-up sessions and psychotherapy and my role reverted to that of an observer.

The process of prolonged engagement includes, pledges of confidentiality to the respondents, honoring respondent input into the inquiry process, reassurances that respondent confidences will not be used against them, and reassurance that no hidden agendas are being served (Lincoln & Guba, 1985). Due to the sensitivity of this research topic, prolonged engagement was conjectured to enhance client disclosure if trust and rapport were given time to develop. As a participant observer, my intention was to build rapport and trust through several meetings during regular clinic visits prior to subject recruitment for this study. This was accomplished and the results were positive. All informants were assured of confidentiality during this study. They were assured that their agreement to interview with the researcher was independent from their relationship with their health care provider.

Peer Debriefing. Peer debriefing is the second technique for enhancing credibility of research findings. In this process, the researcher exposes him or herself to an uninvolved peer for the purpose of exploring aspects of an inquiry which may other wise remain implicit in the researcher's mind (Lincoln & Guba, 1985). The debriefing serves multiple purposes, including: to keep the researcher honest through rigorous questioning; to provide an opportunity to test working hypotheses; to provide an opportunity to develop and test steps in an emerging theory design; to assure hypotheses are reasonable and that all interpretations of the data have been considered; and to provide an opportunity for catharsis or emotional release which may clarify judgment (Lincoln & Guba, 1985).

Peer debriefing was done at regular intervals with my major faculty adviser. During these sessions, data were presented beginning with open coding, reduction of categories, development of hypotheses, and subsequent theory development. At the final stage, discussions with the methodology advisor, were helpful for exchanges and generating new perspectives of how to view the data. As suggested by Guba and Lincoln (1981), both faculty advisors have expertise in the substantive area and in methodology. Peer debriefing was essential to the development of this research study.

Transferability

Transferability addresses the extent to which research findings have applicability to other contexts with other respondents. The qualitative researcher does not seek to produce generalizations. Instead, the goal is to provide in-depth understandings and

knowledge of a particular phenomena that are linked to time and context (Leininger, 1994). It is not the qualitative researcher's task to provide an index of transferability, rather it is the provision of detailed information that allows other researchers to determine whether study findings may be transferable to another similar context (Lincoln & Guba, 1985).

The hallmark of transferability is the thick or dense description. Denzin (1989) noted that a thick description "presents detail, context, emotion and the webs of social relationships that join persons to one another" (p.83). In order to accomplish this, the researcher provided a thick or in-depth description of informants' backgrounds, context of inquiry, and procedures followed in this study so other researchers who look at the information can make comparisons. A thick, rich description is ensured when the informant's words are used to support the interpretation. Interviews with informants were audio taped in entirety in order to ensure that the essence of their individual stories were captured.

Data saturation contributes to thick description. Saturation is achieved through theoretical sampling in which the researcher has completed an exhaustive exploration of the phenomena under study through multiple descriptions by informants and no new conceptualizations, descriptions, or explanations are forthcoming (Leininger, 1994). In grounded theory, sampling is theory-driven and is conducted until the point of saturation (Glaser, 1978). Theoretical and purposive sampling enhances transferability of the findings to other groups (Lincoln & Guba, 1985). This study focused on veterans who

had a current history of suicidal ideation. The findings identified core concepts inherent in a process of decision-making in suicidality.

Dependability and Confirmability

Strategies for enhancing dependability and confirmability dovetail and hence will be discussed together. Dependability addresses consistency of study findings. In a quantitative design, dependability is referenced as "reliability" or whether study findings can be replicated with the same or similar subjects in the same or similar context (Lincoln & Guba, 1985). Reliability as such is not applicable to qualitative research. Qualitative research emphasizes understanding the uniqueness of human experience, which may not necessarily be accessible to validation in the usual sense (Sandelowski, 1994). A goal of qualitative research is to produce "coherent and illuminating" (Schofield, 1990, p.203) description of a phenomenon or situation that is based on and is consistent with the detailed study of that situation. Guba and Lincoln (1981) proposed that auditability rather than reliability be the criterion of rigor relating to consistency in qualitative findings.

Auditability refers to the ability of another researcher to follow the procedures and decisions of the inquiry (Guba & Lincoln, 1981). In the confirmability audit, the auditor has two tasks. The first is to examine the inquiry process to ensure fairness of the representation. The acceptability to the auditor results in the affirmation of the dependability of the inquiry. The second task is to examine the products including the data, findings, interpretations, and recommendations of the inquiry. The auditor certifies

that both the process of the inquiry and the products are acceptable according to professional, legal, and ethical limits (Lincoln & Guba, 1985).

To enhance confirmability of research findings, the criteria for a confirmability audit was followed (Lincoln & Guba, 1985). The primary faculty advisor was asked to serve as the process auditor. She was asked to examine the data, findings, interpretations, and theory to ensure that the research product was supported by the data. This process was ongoing from the beginning of data analysis. The following information was reviewed by the faculty auditor on an ongoing basis: 1) raw data including the researcher's theoretical notes, and memos; 2) data reduction and analysis products, including field notes, summaries, theoretical notes, working hypotheses, and hunches; 3) data reconstruction and synthesis products, including structure of categories, findings and conclusions, and the final report noting connections to the existing literature; 4) process notes, including methodological notes and audit trail notes; 5) materials relating to intentions, including personal notes, the inquiry proposal and expectations (predictions) (Halpern 1983 as cited in Lincoln & Guba, 1985). Dr. Badger was given copies of transcripts, coded data, category generation and reduction, and schematics depicting core categories. The audio tapes were also made available for the audit trail. This process was followed to assure objectivity of the research (Lincoln & Guba, 1985).

Summary of Chapter Three

This chapter described the methodology. Grounded theory is a process that can contribute to the development of nursing knowledge through theory grounded in the data.

The usefulness of grounded theory for this study in late life suicide was discussed. The second section presented procedures followed in the study, including a description of the literature review, data collection, theoretical sampling, data analysis, and data management. Lastly, criteria used to establish trustworthiness were presented. These included, credibility, transferability, dependability, and confirmability.

CHAPTER FOUR

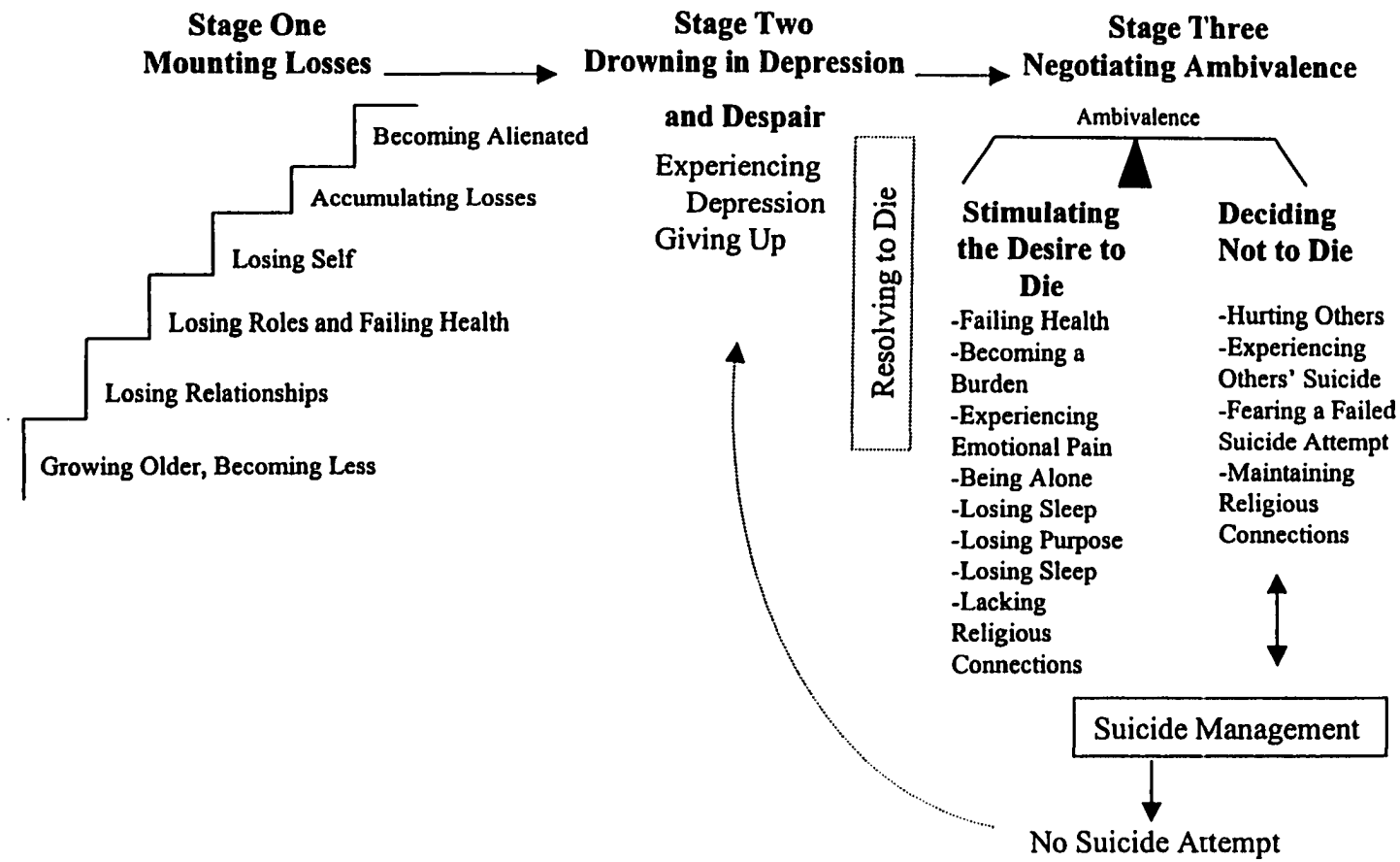
RESULTS

The results of the data analysis from participant observation and interviews with older adults contemplating suicide are presented. The informants were asked to discuss their suicidal thoughts. From this data, a process was identified that theorized how the individual moved away from being the person they were or wanted to be before the depression and became the person they were at the time of inquiry. A model of the processes is depicted in Figure 4.1. Following the model, a brief explanation of the model is presented. Each variable and stage of the model are then defined and illustrated by examples from the data. The core concept identified in the data is the process of *Losing Connections*, as the older adult descends into depression and remains in the balance between wanting to die and not acting on that desire. All of the variables in the model are related to the category, *Losing Connections*. The research question that guided this study and that will be answered in this chapter is:

> What are the processes involved in decision-making surrounding suicidality for older white men?

Decision-making processes will be discussed as the basic social psychological process (BSPP), *Losing Connections*, is presented in three stages. What emerged from the data and participant observation were processes of loss occurring in each informant's life that led up to contemplation of suicide. From this process, a state of disengagement or depression/despair ensued when the individual began to have suicidal ideation. The first

Figure 4.1 Basic Social Psychological Process:
Losing Connections



two stages of the BSPP focus on precipitant factors for suicidality moved the older man to the decision point of Stage Three. At the decision point, there was a balance of triggers and barriers that modulated suicidality in a given context. As long as ambivalence was present, the suicidal man was likely to conclude he was not ready to die and he reordered his thinking to move on until the next decision point. This process was cyclical.

The Basic Social Psychological Process: *Losing Connections*

Figure 4.1 depicts the processes surrounding suicidality in older men. The BSPP of *Losing Connections* was identified from the data. The process refers to factors involved as the man contemplates suicide and makes a decision to postpone a suicide attempt. The following three stages in suicidality were identified by the research: *Mounting Losses, Drowning in Depression and Despair, and Negotiating Ambivalence.* An overview of the model is presented and a description of each stage follows.

Overview

A BSPP was identified in which older men experienced loss, depression, despair, and suicidality. In Stage One, *Mounting Losses*, loss was the main theme. Losses for informants included, relationships, health, and role losses that were professional, social, and personal in nature. With each loss, the older man moved further away from the person he once was. In Stage Two, there was a transition from the processes involving loss to a stage of depression and despair during which the individual contemplated suicide. During this stage, the older man considered whether he should depart from this

life. Stage Three was characterized by the desire to die and deciding whether to die. Triggers, such as emotional upset and chronic pain, moved the individual toward suicide, while barriers forestalled the process. Barriers included, consequences of suicide to significant others and maintaining religious connections. Triggers and barriers were modulated by ambivalence, which affected the outcome of suicidal ideation. Management of suicidal thoughts, such as diversional activities, were used to interrupt suicidal ideation. The model will be presented in stages in the next section.

Stage One: *Mounting Losses*

The initial stage, *Mounting Losses,* was characterized by an accumulation of losses. The following types of loss were identified: losses of aging; role loss, including self, professional, personal, social; loss of relationships; and loss of health. These losses usually were interwoven and not discrete. Thus, separating each out detracts from a wholistic understanding of loss.

As a result of these losses, an older adult may realize he was no longer the person he used to be or the person he wanted to be. The duration of this stage was variable, spanning months to years. Contextual factors and an accumulation of losses culminated in a profound change during which he sought advice from a health care professional. The changes may have included sleep disturbances, fatigue, or a notable change in mood. For some, the encounter with the health care professional led to an assessment of depression. The physical symptoms noted by the individual were a manifestation of processes involving loss.

Loss occurred over the life span for all individuals. Most were able to process loss using appropriate coping mechanisms. However, some men had not coped with loss effectively at the time of the event and the loss remained unresolved. As losses accumulated, these individuals were not able to exchange old behaviors and perceptions for those that were useful in their current context of development. For many individuals, the onset of Stage One was protracted over the life span. Many were aware of changes occurring in their lives, however could not articulate the changes nor explain the feelings evoked by these changes.

Loss emerged as a core concept or BSPP of this research. It was not confined to one stage, but instead was integral at all stages. Loss could have begun as a discrete event, however it became enmeshed and more pervasive as the individual sank into depression and considered ending his life. Loss sometimes served as a trigger for suicidality. Loss was the key factor of Stage One. For some informants, there was a proximate loss, such as loss of a spouse, that preceded the depression and then a downward spiral ensued. For others, there appeared to be a constellation of losses over years, which precipitated a more gradual descent into depression and sometimes despair. Also, for one man there was both a proximate and cumulative loss pattern evident. Depressive symptoms brought all these men to the attention of health care professionals.

Types of loss will be discussed individually in the next sections, but will also be integrated to represent the connectedness among losses.

Growing Older and Becoming Less

For many informants, aging signaled loss. It represented the passage of time and for many, a loss of youth. Many began to experience tangible losses, such as major and minor health problems with aging. As family members and friends died, many informants became more aware of their mortality. Aging issues were apparent in most of the interviews. Some informants simply made reference to being old. However, others viewed their aging in derogatory, self-deprecating terms.

Negative view of Aging. Two men compared themselves to old cars that no longer worked or had outlasted their usefulness. Jay made this reference twice during the first part of the interview stating,

...if you had an old car would you decide to put a new engine in it? ... or would you just dump it and go buy another car? A new car? (Jay, 9-13)

Later he returned to the same theme noting,

...the idea is that if I were an old car I'd certainly take me down and have it scrunched up and gotten rid of (Jay, 32-34).

Jack made a similar analogy about aging. He stated,

...in terms of ideal of what human potential...a good healthy human being would be like you and various other people around- fully functioning people...I have a lot of admiration for that. And the further I get from that more and more decrepit- can't get up, can't hardly get out of chair...like the wheels coming off my used car or something (Jack, 34-42).

Jack inferred that old age and decreased quality of life were synonymous. He noted,

And the further I get away from the quality of life- well the less I want to hang around. Especially at 80 years old. You know if I'm 40 that's a whole different bag, but I recognize old age as terminal anyway. (Jack, 194-199).

Roger conveyed a stereotypical picture of aging when describing himself in the following terms,

...my cup of happiness doesn't have much in it these days. I'm an old man. I'm living alone. All my old friends are dead. I don't get to see my children very often. So it can't be said that I have a very fulfilling life (Roger, 340-345).

Unlike several others, Ralph continued to be active and engaged in life. He stated,

*...the funny thing... is that when you live with someone for as long as B. and I lived together- at what day did they start looking old? You don't wake up suddenly some day and look and say "my God, she's old". Nor do you look at your face in the mirror and say the same thing (*Ralph, 438-443).

Instead of denying aging, he acknowledged his age and the likelihood that illness could have intervened at any time. However, he dreaded a disease that would impair his mind or his capability for self-expression. Ralph stated,

And the fact is that I know how old I am. Even though I'm healthy today while we are talking I could drop over with a stroke. Then can you imagine locked in that body? (Ralph, 550-553)

With aging, there was a realization for informants that they were no longer the person they used to be or wanted to become. Furthermore, there was a sense they were someone they did not want to be. They were unable to accept themselves as they aged. With aging and loss, individuals viewed themselves as growing older, but becoming less.

Losing Relationships

The loss of a relationship connoted the loss of a significant other(s) through death or separation. Two informants had suffered the loss of a spouse and a long-term relationship. The circumstances surrounding the deaths were dissimilar, however both felt the loss acutely.

Losing a Spouse. The death of Ralph's wife was sudden, whereas Rick's wife died after a lengthy terminal illness during which he was her caregiver. Reflection on their loss evoked suicidal ideation. Ralph noted,

So we were pretty close and it's a loss I can't comprehend. ... you are so distraught, so terribly distraught you can't focus on analyzing it scientifically (Ralph, 364-365; 571-573).

For Rick, the actual moment of death remains acute in his memory.

When she took her last breath I just went crazy... I ran into my bedroom and tried to hurt myself (Rick, 218-222).

The memories of the spouse and their enduring relationships evoked powerful feelings, sometimes negative ruminations. Ralph recounted a situation, which triggered emotional upset.

One day I just was in the closet and picked up one of her hairs. I knew it was her hair and then I broke up, of course. I carried it around clutching it for hours and hours and hours (Ralph, 575-580).

By contrast, both men also found comfort in memories of their wives. Ralph noted,

I've got another beautiful copper vase and then I picked a lot of roses and put that on a table so I had some other pictures, so that makes me happy (Ralph, 41-45).

Rick noted,

Sitting in my living room and looking at my wife's picture. Everything was going through my mind you know- what we did, have a good time.... I couldn't understand how one person could have that much talent...she was always special like that (Rick, 67-70; 75-76; 78).

Rick suffered the loss of other relationships in his life during his wife's illness and subsequent death. Both of his daughters and his two grandsons, who he and his wife raised, broke connections with him because they did not agree with the discontinuance of hemodialysis. He continued to regret the loss of these relationships, as well.

For these two men who lost their wives to death, there was also a loss of a long-term role as husband. Part of them died with their spouse.

Rick noted,

All my good times and my best life have left me when my wife went away (Rick, 14-15).

Ralph focused on the specialness of the relationship with his wife and the deep feelings he continued to have for her.

You see I think we did have a special relationship (104-105). *I think this thing bears on what we're talking about- the deepness of my feeling for her* (Ralph, 180-181). To summarize their relationship, Ralph quoted Shakespeare:

"Loves alters not but brief hours or weeks but bears out even to the edge of doom" (Ralph, 161-162).

Losing Friends. For other informants, loss of friends was significant. Leo stated,

Being around people because I like being around people... I would go out and spend time with friends and... be around them you know (71-72; 74-76). *I haven't been able to play golf anymore and so forth, it just takes away a lot of the fun of life* (Leo, 69-71).

For Jake, thinking about old friends stimulated memories of his youth. Jake stated,

My own movies make me happy. I look at my old friends and half or two thirds are dead. It takes me back- memories in my own neighborhood. My own surroundings. That was when the good people were living (Jake, 30-35).

Roger reflected on both past losses and future losses. He stated,

All my old friends are dead (342-343). *Sometimes I get out and see a couple of old acquaintances there in the park, but they're getting so damn close to death they aren't going to be around long* (Roger, 355-358).

The loss of relationships was significant for some. Normal grieving had extended into depression for both men who suffered the loss of a spouse. Although most men talked about loss of spouse, other losses of family and friends contributed to losing relationships.

Losing Roles and Failing Health

Role loss was also a dominant theme in Stage One. Of these, the most commonly addressed by the veterans was professional role loss. For some, role loss appeared to be inextricably linked with failing health. Furthermore, there were losses of social relationships and social roles with retirement, as well. These losses will be discussed in this section.

Losing Professional Roles. For five men, retirement signaled the end of a professional role and relationships with peers. It was a decision all regretted. They all expressed the importance of a strong work ethic and being a contributing member of society. Most men defined themselves by being productive and decreased productivity subsequently precipitated feelings of uselessness, inactivity, and a loss of purpose. With professional role loss, there was also loss of social roles. For these men, socialization was often conducted through professional associations, and with retirement, both roles were lost.

Two men retired primarily to comply with their wife's desires, not because of their readiness to do so. Leo retired at age 58 because his wife was retiring and they decided to travel. His initial expectations were not met. Leo stated,

And the first eight or nine months of my retirement I just was uncomfortable. And talking to myself about it until I said one day you know what I miss is nobody comes to me anymore for me... with something to guide them on or... I'm not important anymore (Leo, 93-99).

Similarly, Carroll retired because his wife retired and wanted him to travel with her. He began to have suicidal thoughts after her death. Carroll stated,

...she lasted one year with a heart attack and I was alone. And I still wish I had never retired (160-162). I had some more good years left to teach (Carroll, 174-175). *...while I was busy and teaching all those years I didn't have these thoughts* (SI) (18-20). *And I enjoyed teaching. The only job that I ever had that I looked forward to going to everyday* (Carroll, 21-23).

Pete retired voluntarily because he had financial stability. He stated,

I just felt as though I'd contributed all that society expected me to contribute. I had been successful and so now I'm useless. No one needs me (Pete, 748-751).

Failing Health. Other veterans retired due to disabilities. All had developed health problems and were unable to continue working in the same profession. Jay was a computer specialist who owned a business. He sold the business when he developed depression and subsequent memory lapses. Lack of productivity had moved into other areas of his life leaving him feeling demoralized. He noted,

I'm not functional. I don't have anything that I do that's productive or useful or whatever... I sit there to do the email and I can't remember how to get the computer to do

it. (151-153). *Then finally I just walk away* (Jay, 155-156).

Subsequent to a cardiac arrest with resultant memory problems and disability, Sid was forcibly retired. He reflected on this time in his life stating the following,

I lost my memory completely. And these were blows that really hurt me. I was told that I couldn't work in my profession or at anything. I was 100% disabled. That was depressing. (Sid, 293-297)

His 30-year history of chronic health problems continued to take a toll.

...I'm bothered with that and physical illnesses and disabilities always get in the way if I want to do something to enjoy. I can't do them (Sid, 217-220).

His professional role loss signaled the beginning of further role losses. He noted,

...I was successful in what I was doing and I enjoyed what I was doing (137-139). *I've led a very good and fruitful life until I died...* (Sid, 144-145).

Furthermore, he was cognizant of role loss and stated,

Even going out in the sun is proscribed. So that is the reason that I feel worthless. I have no role to fulfill, just wander aimlessly (Sid, 249-252).

Losing Social Roles. In addition to professional role loss, there was evidence of social losses with aging. Some experienced social losses with retirement. Carroll enjoyed teaching and stated,

The only job (teaching) *that I ever had that I looked forward to- going to everyday. Had some great kids and some real nice people to work with you know* (Carroll, 21-25).

Others lost social roles as they experienced depression. Rick noted,

I belong to the American Legion and there is a lot of things that I could participate in there... you know with them. But it doesn't seem... it all seems ridiculous and silly to me you know (Rick, 25-29).

Gerry had discontinued church work he was formerly involved with. He had been involved with others and previously believed he was capable of meeting with other people. However, this had changed. He stated,

...I was that way but... things are always changing and I knew that I wasn't doing as good. I wasn't even... when I was conducting the Watchtower which I did for a number of years Ah even then I was dropping off in field service. And I felt well maybe it's my age and my wife's age and we're not able... (Gerry, 778-785).

With the accumulated losses of roles and failing health, individuals appeared to experience a loss of the self.

Losing the Self

A loss of self was integrated with other losses. With each loss, there was some loss of self. For example, there was a loss of self when professions, health, and relationships were lost. Nearly all informants conveyed in words or expressions that they were no longer the person they used to be. A loss of self was integral to a sense of alienation.

For Jay, professional role loss had overflowed into other life roles. He was experiencing loss of self, including a loss of self-concept. Previous life experiences had

instilled in him a sense of competence. Now he felt his was declining, as his memory problems progressed. In the following passage, Jay acknowledged his decline.

I begin to realize how incompetent I am mentally some days. ...and today I feel rather you know articulate and sharp and my mind is working and all that stuff. But there's so many days when my mind just can't remember (Jay, 85-91).

Loss of health precipitated subsequent multiple losses for these informants. Leo had decreased his social involvement due to chronic arthritis pain. He was an avid golfer and greatly missed this pastime. Leo stated,

I haven't been able to play golf anymore and so forth. It just takes away a lot of the fun of life (69-71) ...so I miss that aspect of life. I don't feel like I'm contributing a lot anymore (Leo, 77-78) .

Similarly, Jake made the following observation:

You have a lot of problems when you get to be 80 years old (61-62). I feel like everything is dropping out from under me (Jake, 72-73).

Pete noted profound changes in himself just prior to being diagnosed with depression.

...when I started before, after World War II, I was very successful in the business world. Had a lot of energy. Enjoyed meeting with people and overcoming a challenge. Enjoyed competing and winning. And I was a different person then (42-46). In retrospect I can't even believe it was me (Pete, 49-50).

The loss of self was integral to other losses. For some informants, there was a theme of loss over the life span.

Accumulating Losses over the Life Span

In addition to loss that was proximate to depression and suicidal ideation, there were cumulative losses over the life span that influenced the informant's current circumstances. In addition to mounting losses in later life, there was a theme of previously unresolved losses that may have compounded more recent losses. For example, one man experienced the loss of his father as a child. His father left the family resulting in a life of poverty for his wife and children. When Sid sought out his father as a young adult, he was rejected. He again experienced rejection in the military when he received a medical discharge. Sid stated,

I sank down into a hopeless world. Nobody would hire me. I was then... one of the first veterans of the war and nobody would give me a job. Nobody wanted to help me (Sid, 492-496).

Sid linked the onset of many subsequent episodes of depression with this incident. Similarly, earlier life experiences were a focal point for Gerry, who reminisced about these experiences. He noted,

...in the family I was- kinda felt like an outcast. I don't know what it was (176-177) *...I guess the others* (siblings) *thought that there was something wrong with me or something* (Gerry, 227-229).

This appeared to have affected his relationships with family members. After he joined the military, he seldom went home to see them. He stated,

I didn't go see my family all that much because I didn't have a very good job. Anyway didn't have to deal with them much, so I didn't (Gerry, 249-252).

Similarly, Carroll made references to a lifetime of disappointments, which had shaped self-concept and roles. He reflected on previous disappointments in the following passage:

I think I should have been more successful in life... I spent four and a half years (in the service*) in what I would consider what would have been my productive years* (38-39; 41-43). *I've always thought that the world just passed me by... or I let it go* (Carroll, 46-47).

Roger vividly recounted negative experiences in the military. This took a toll on his mental health and he was hospitalized for a mental health problem (unknown diagnosis) then given an honorable discharge. He recounted this life changing experience in words choked with emotion:

I came home and after this terrible, traumatic experience and I was so ashamed and I was so scared and still put down. I was terribly put down and embarrassed (Roger, 188-191).

The data suggested a pattern of unresolved losses over the life span for some informants. It appeared that many were unable to continue growing and developing as they aged.

Becoming Alienated

As the individual experienced mounting losses, the internalized values that once gave them a sense of belonging seemed to now separate them from the community. The sense of connectedness appeared to become loosened leaving many older men with fewer and fewer reasons to live.

Sid reflected on his alienation. He stated,

...whatever I was doing, it (the world) *needed me and I was an integral part of the world. But, I've lost that connection. I think that is what is at the root of this whole thing is finally that connection is eroded to the point where it doesn't exist anymore. Stop the world... I want to get off* (Sid, 395-401).

More often, alienation was implicit in the individual story rather than explicit. There was a lack of connection woven into the narrative. In many cases, there was a sense of losing connections throughout the life span. For Gerry, there was an early experience of alienation from his nuclear family. He stated,

...in the family I was kinda felt like an outcast (Gerry, 176-177).

Interestingly, he had nightmares surrounding conflict with his brothers when all were young and about his job insecurities at the post office. These appeared to reflect experiences of alienation throughout his life.

Gerry noted,

There must be something in there that makes me feel a little inferior and it doesn't take much to hurt my feelings (Gerry, 412-414).

Several informants conveyed their sense of alienation from community and world. Three informants focused on changing values and the decay of the world around them. For them, the world used to be a better place. Jay stated,

...It's unfortunate you didn't have a chance to see life in the old days. But you take it from old codgers like me that there was a better world and that... (492-495) *...the values aren't there in society that we had when I grew up and I- I still have a lot of those imbedded in there and... they're not going to go away probably* (Jay, 502-507).

Similarly, Jack stated,

I'm living in a vicious society. I'm beginning to feel that way- like I can be done with it. In a globe that is being ecologically destroyed and environmentally really badly messed up (Jake, 179-182).

Jake also expressed similar thoughts about a changing world.

That's when the good people were living. That's when the movies were good and the world... this country wasn't as sorry as it is now. As a matter of fact, the whole world. People were nicer. We didn't lock no doors or nothing. Nowadays there's violence (Jake, 34-41).

Furthermore, he saw these changes reflected in his personal world.

I had a grandson and he died in January on dope. He was 39 years old. Have another grandson in jail, speeding and stole my car for one thing. It goes on steady (Jake, 41-45).

With mounting losses, the informants seemed to become more alienated from the community and society as suggested by the BSPP, *Losing Connections*.

Summary

This section presented loss as a precipitant factor in the processes of *Losing Connections*. Mounting losses, including relationships, health, professional and social roles, self, and losses of aging, were interwoven to move informants forward to the next stage. Both proximate and distal losses were identified and appeared to contribute to the informant's current circumstances. For many, distal losses or those incurred previously in the life span appeared to be related to their present losses and depression.

Personal value systems were recognizable in many of the individual narratives. The most prominent values communicated were religious beliefs. Lack of religious connections were apparent for many of these men. Since the investigator believed these values strongly influenced the decision stage, they will be discussed under Stage Three. Other values, such as the importance of a traditional work ethic, being productive and a sense of collectivism were also apparent. These values shaped self-concept and identity throughout the life span. They also defined a sense of belonging to the greater community. Value systems are hypothesized to affect the process of *Losing Connections* at all three stages of the model. As each stage is presented, pertinent values will be discussed to enhance understanding of their importance in contemplations of suicide.

Stage Two: *Drowning in Depression and Despair*

Drowning in Depression and Despair was characterized by the transition from Stage One to Stage Two in which older men lost connections with the self, others, and society culminating in a disconnectedness- residing in a place of depression and despair. In Stages Two, individuals began seriously to contemplate suicide. In Stage One, the informant perceived they were no longer the man they once were or never became the man they wanted to be. The older man had made an assessment of his life to that point and seemed to have concluded he had failed to achieve expectations for themselves and others. These conclusions seemed to be the impetus that pushed them into Stage Two. For informants who had transitioned into Stage Two, themes of low self-esteem, devaluation of self, depression, despair, and alienation were apparent.

Experiencing Depression

The term, "depression" was used by some of the informants to describe the constellation of symptoms they were experiencing. However, others simply described what are commonly known as depressive symptoms without labeling them. Low self-esteem and devaluation of the self are inherent in depression, therefore they will be addressed collectively.

Ralph quoted Shakespeare to convey his experience of depression in the following passage.

Cans't thou not administer to a mind disease? Plucked from the memory a rooted sorrow? Raise out the written troubles of the brain and with a serious and oblivious

*antidote cleanse the troubled bosom of the perilous thoughts that weigh heavy on your heart" (59-65). I have a rooted sorrow and there is no question about that (*Ralph, 68-69).

For Sid depression was always present. He stated,

"it's always present. It's with me like- it's worse than a shadow. You might even say it was an alter ego (Sid, 104; 106-108).

There was a sense that sadness was always present, but at times it intensified as reflected in this passage.

But at times the depression gets so great that I don't want to live anymore (Sid, 370-372).

Similarly, Rick described depression as an ever-present sadness. He stated,

I'm sick and tired of being sad all the time (163-164). *I've been feeling ready to get rid of this sad feeling that comes over me and I can't get rid of it. It's with me all the time* (Rick, 314-316).

For many informants, depression was described as cyclical. All had some good days when the depression seemed less encompassing and bad days when symptoms intensified. Two men were particularly eloquent in their descriptions. Sid described his experience in this passage.

Depression is just like a wave and the surf- if you see the wave move out of the wave and it overcomes you for the moment and withdraws and then comes back again and you have to learn to live with that. The wave coming in and surviving while the wave

is tumbling you about (Sid, 302-308).

Pete stated,

...it was like fording and wading in a stream and I waded in and it got worse and worse and worse and when I reached the deepest part about the center of the stream I started toward the other side and it got less and less and less and I still haven't reach the bank yet...(Pete, 24-30).

Furthermore, he noted when he had reached the lowest point in his experience of depression. He gave the following description,

It's just like I'd fallen in lake and I was going down for the third time. I didn't care (Pete, 743-744).

For Jay, depression was not acknowledged, but his story was descriptive of how his moods varied which also demonstrated a cyclical pattern. He noted,

The sun is shining now I'm all doing great. But then the sun goes behind the clouds and the gloom comes in (Jay, 47-50).

Later in his narrative he stated,

Then these things (memory lapses) *compound and sometimes they'll start and the first day it'll be a little bit of that and the second day is more and by the third day it's rather intense and it kind of just deadens your whole world and you can't think and you're frustrated...* (Jay, 128-134).

Lastly, stressors influenced the cycle of depression.

Well when a lot of problems come to a head. When a lot of problems show up then naturally the depression is worse. But if things are going easy and I haven't got a lot of places to go and do or things that I haven't done that grabs me and it closes in on me and naturally it's worse (Jake, 93-98).

Descriptions of how depressive symptoms were evidenced in daily life were commonplace. Don focused on being productive and noted when depression interfered with his ability to complete a project. He made the following statements.

You get a worthless feeling. Just like you're- you're not needed and when you are just worthless like you're already used up (6-8). *That is when depression really gets you* (when you have responsibilities). *It makes you a slow starter or impossible starter* (Don, 25-27).

Carroll reported complaints of fatigue so severe he could do little except lie around. Although he did not acknowledge he had depression, he pinpointed a time two years prior to the interview when his life had changed. He stated,

I can remember definitely it's like you... just closed the door on the times I could do a lot of things (Carroll, 303-306).

Although many informants discussed depression, others described their despair. There was a sense of hopelessness in their stories, an overarching sense of giving up.

Giving Up

A theme of giving up was conveyed by many of the informants. They used the term despair with hopelessness. Despair is defined as being overcome by a sense of futility or defeat (Burube, 1982, p. 386). Many informants conveyed a sense of hopelessness noting that living seemed futile. Similarly, these men had no expectations for the future.

Sid distinguished between depression and despair. He had a longstanding history of depression and decided he had crossed the line between depression and despair when he was told he could no longer work. Sid stated,

So I went through depressions quite a bit. And this is giving up of life. This is despair. This is not depression (Sid, 298-300).

He added,

Depression goes to despair (388). *But the end of the road is despair and I think I'm at the end of the road* (Sid, 390-392).

Leo noted that at times it did not seem worth continuing to live. The times when these thoughts were most prominent were when his chronic arthritis pain was most severe and usual activities were most limited. He stated,

...sometimes the pain you know it's so bad and it's every day... then there is the downside that keeps from doing things like golf that I'd like to do... it will pop into my mind what's it worth going on for (Leo, 16-19; 22-23).

With chronic headaches and associated memory changes, Jay described the frustrations of being locked into a cycle of forgetfulness and feeling out of control as a result. He reflected,

...when you get into this then these things compound each other and this whole part of feeling... like out of control like the roller coaster falling off or something. But, what really it is it's like you... it seems like you're on a way out... (Jay, 96-103).

Protracted feelings of incompetence resulted from these cycles. These thoughts served to further reinforce self-doubt and demoralization resulting in despair and culminating in suicidal ideation. Jay stated,

...I guess despair or something is one of the words that...might come to mind and so then you say to yourself...I can't go on like this (Jay, 108-110).

Later, he restated his feelings,

And that's the real problem you have in life and desperation is a word that comes to mind there where you feel like you know the world is closing in on me and what are my options (Jay, 524-528).

Lack of Expectations. A lack of expectations for the future was recognized as integral to despair for some individuals. For Rick, the loss of his wife had changed his perspective on life. He had disengaged from activities, including a men's club, sports, and socializing with others. Rick stated,

...there is nothing ahead for me. All my good times and my best life have left me when my wife went away (13-15). I've given up (Rick, 25).

Similarly, Sid had no future expectations for recovery from depression or recovery from health problems. He stated,

Nothing but despair. So what the hell is the use of living? Can't fix anything. Can't make anything better and I can't go in a different direction because everything I do is based on what I have now. I don't have any assets, I have heavy deficits (Sid, 528-534).

Finally, there was an expression of defeat,

I'm older, more tired, more spent and more of the opinion that there is nothing there... further along in my life that means that I should stay alive (Sid, 90-93). Resolving to die was driven by the depression and/or despair in Stage Two.

Resolving to Die

An exploration of what suicide meant to these informants may aid in understanding the decision phase. Most informants who stated a reason why suicide was an option, viewed it as an escape from existing conditions. A few viewed it as solution to a perceived problem or a way to control the time of death. In this sense, failing health or terminal illness provided the rationale for the suicidal act. The reasons for suicide were also triggers for suicide for some individuals. Suicide was viewed as solution to the pain of loss. Ralph stated,

...my antidote is easy- to end it. That's all there is to it (Ralph, 73-74).

Rick noted reminiscence of painful thoughts about his wife, especially arguments, precipitated suicidal ideation. He noted,

I'd sit there and remember those things and being married you have good and bad days you know where you argue and you walk out mad and say things you really wish you could bite your tongue off for saying and wish you could take them back right now. That is my biggest problem... (78-85). When that stuff goes through my mind I think well... I'm not going to think about this anymore. And there is no other way I can do it except just stick my gun in my mouth and pull the trigger (Rick, 91-95).

Furthermore, death was viewed as a solution to perceived problems. Sid has multiple health problems, a trigger for his suicidal ideation. He stated,

It's the ultimate solution. Let's put it that way to anybody's problems. You're dead, you have no problems. And that is where I want to be, with no problems (Sid, 574-577).

Similarly, the focal point of suicidal ideation for Gerry and Carroll was perceived problems. Gerry stated,

...you don't have much patience and you don't uh... feel like dealing with what you see coming you know. And you think, "well if I wasn't here then I wouldn't have any of these problems". So maybe that would be one way to go (Gerry, 12-17).

Similarly, Carroll noted,

I thought that (suicide) *as a way out you know. And I wouldn't have to worry about things anymore* (Carroll, 74-76).

Informants who viewed suicide as a rational choice held similar views. They had defined when life was no longer worth living or when ambivalence would be gone. Roger was diagnosed with prostate cancer previously and was given a prognosis of one to two years. He saw his father suffer and die from cancer many years before and had made the decision at that time not to die in the same way. Roger stated,

I planned for years to commit suicide rather than go into a hospital ward and die from cancer (411-413). *I got a little weed patch out there that I would lay down in and I'd stick that gun in my mouth and just pull the trigger. As far as I'm concerned that would be the end of all my worries* (Roger, 418-422).

Similarly, Jack had a terminal respiratory condition and had noted his progressive decline. He planned to commit suicide when his breathing became more problematic and he felt useless. Jack stated,

If I get into a dehumanized state and I mean by human uh ... where I can walk and talk and think and move around in what I call a normal context of the general public out

there (Jack, 143-147) ... *if I become totally useless then I might use that gun* (Jack, 17-18).

For some informants, death was viewed as a welcome deliverance, a comfort. Jack noted,

Dying is goodness...a nice sleep. You don't have to worry about that crap any more (183-185). *The comfort of the dying and beyond death- death and beyond. Death as*

the big curtain so to speak I, I eliminate all that stuff. All these little aggravations and troubles and worrying... (Jack, 171-175).

Sid had experienced a cardiac arrest at an earlier point, which was the onset of his health problems. He reflected on this experience,

Until I died that time. So death was no a stranger anymore. It was a cessation and all the pain was gone. All worry, even my memory got wiped out. So I began to think of it as an ally, not any enemy (Sid, 568-572).

Some informants declared they did not fear death. These informants also had a lack of religious connections, which likely influenced their perspectives. Ralph shared some of his beliefs in the following passages.

I know there is something greater than us but I think we are just quarks and electrons and a few things like that and when we go, we're gone. That's it. The world will go on. There is something greater than us but were are like little parameciums... (389-395). *So I'm not afraid that by...I'm not afraid of death. If I die. I die and that is all there is to it. So I'm not afraid of it. Anything that holds me back had nothing to do with that* (Ralph, 399-402).

Roger shared these beliefs.

...I don't believe in heaven or hell. I don't believe they exist so I have no problem with that. I could lay down on the ground and plug myself with a gun and I would have no compunction about worrying about where I'm going. I think when I die I'll be dead as a door nail (Roger, 242-249).

Suicide became an option because it was viewed as a solution to problems, a comfort, and an escape from existing conditions. Fear of death was not a barrier for some. Identifying properties of suicidal ideation may provide some understanding of suicidal behavior and how it occurs.

Stage Two was characterized by depression and despair as the older men were overwhelmed by the losses of Stage One. Loss did not stop in this second stage, but instead compounded the depression. When the informant descended into depression and despair, he began to contemplate suicide. They had weighed all the information from Stages One and Two and had concluded from this information that their life was in some areas unsatisfactory or a failure. Informants were contemplating whether to die or not. As the older man moved to Stage Three, he began to negotiate ambivalence.

Stage Three: *Negotiating Ambivalence*

Stage Three, the decision point, was the critical juncture that was characterized by the struggle between the desire to die and deciding not to die. The struggle was defined by an interaction between triggers and barriers. Triggers were events or situations that prompted the individual to think about suicide, such as feelings of missing a deceased spouse. Barriers to suicide were reasons for not acting on suicidal thoughts or impulses, such as the consequences for significant others. Ambivalence moderated the struggle and how the individual negotiated ambivalence determined the outcome. It appeared a balance needed to be maintained between triggers and barriers to stop progression across the suicidal continuum or that barriers outweighed triggers. Ambivalence may reflect that

not all conditions for acting on suicidal ideation (SI) had been met. If a balance between triggers and barriers was maintained, the individual moved away from the decision point by reordering his thoughts with the help of SI management strategies. This movement away from the decision point reset the cycle of the decision phase. Stage Three was not conceptualized as occurring in isolation from Stages One and Two. It was viewed as a trajectory, a dynamic process with ebb and flow.

Properties of Suicidal Ideation

Prior to discussing triggers for suicidal ideation, examining the nature and properties of suicidal ideation may provide some understanding of how older men resolved not to commit suicide. Properties of SI may have been part of decision-making for suicide. Informants identified suicidal ideation as sudden in onset, variable in frequency, and rational in nature. Suicidal thoughts were described as fleeting for some and most reported management strategies to interrupt the process before acting on the thoughts. For the informants who viewed suicide as a rational decision, there was a sense that SI involved careful consideration, whereas for the others it was impulsive.

The following properties of suicidal ideation were identified.

1. Sudden in onset. Suicidal ideation was most often described as sudden in nature. The thoughts struck the informant precipitously and demanded a response. Ralph described SI as sudden at times and impulsive at other times. He noted SI was,

Very sudden. It won't be something that I'll think about all day long... now I do admit this that I've planned and I've thought when I'm calm of different things (468-471).

...most of the time it's nothing but an impulse, an overwhelming impulse to say the hell with it (Ralph, 159-162).

Similarly, Rick described SI as sudden.

I wouldn't be thinking about anything special or doing anything special. Just coming out of nowhere (SI) you know. Then I start really saying, "The hell with this" (Rick, 159-162).

Gerry stated,

It does seem like it comes pretty quick anymore and I can't get to the bed fast enough and lie down and go to sleep (Gerry, 685-688).

Lastly, Carroll described SI in similar terms,

They were only momentary. Kind of random thoughts (10-12) ...fleeting thoughts (Carroll, 84).

The sudden onset of SI exemplified the struggle at the decision point of Stage Three. It may also stimulate ambivalence, particularly since the SI will pass.

2. Variable Frequency.

Suicidal ideation was characteristically variable in frequency. It was often associated with feeling sad or a cycle of sad moods. Two informants described specific cycles of sad moods that precipitated SI. Leo stated,

Well, when I get into this mood it probably is on a daily basis for awhile which is not good either because that just keeps you- you know feeling down all the time (Leo, 179-183).

Jay noted a similar cyclical quality in the following passage.

These thoughts are not obsessive to me. ...I have those thoughts on a recurring basis. I don't have them over you know... they don't normally last over... ah two or three days. They actually come in a cycle between... ah the times when I feel better and ... ah there is some times that life gets up to almost a euphoria (Jay, 41-47).

Similarly, Carl stated,

...I'd say it don't hang with me the whole day just, just for a period of time. I'll have that thought (Carl, 12-14).

For some individuals, SI was persistent, rather than cyclical. The thoughts never left, but could be ignored when engaged in activities. Two of the informants described SI as persistent, always present. Sid stated,

It's always there. It doesn't stop and start again. It's always there. I eat with it. Do everything. I go to sleep with it and I wake up with it. Because my life is worthless (20-23) *...it's worse than a shadow. You might even say it was an alter ego* (Sid, 106-108).

Similarly, Don described SI as persistent in nature.

Well I had little bitty thoughts peeking out... (374). *Little bitty thoughts peeking out quite often, but I've been able to shove them back. They are still there* (Don, 377-378).

He used a very descriptive metaphor to describe the suicidal thoughts.

It's like mice climbing up a table leg and looking over the top of the table. Little and... most people hate mice because they are dirty. Well, I hate mice too but scare them or if the table has wobbling leg-s well wobble it over against the wall and that is the way those thoughts are. They are always there (Don, 389-395; 396).

Suicidal ideation had both persistent and cyclical qualities.

3. Rational.

Suicide was described by some informants as rational. For example, some informants had planned to commit suicide when their health markedly declined. Failing health provided the reason for resolving to die. Jake believed suicide was a rational decision and discussed suicidal thoughts in an intellectual context.

Generally it's the context of, of somebody bringing it up (71-72). In my kind of context, intellectual context. It's like talking about it. It's a dimension of the fulfillment of the life is how you are going to terminate it. How are you going to exit? (Jack, 79-83). Similarly, Roger had prostate cancer and was making end-of-life decisions. He stated,

...now my PSA has gone up and I'm under the threat of death from... cancer (228-230) ...after watching my dad die a terrible six-month bout of cancer I decided than that I would never permit myself to die that way. That I would commit suicide. Now, I'm up to the time when... I'm probably going to die of cancer (Roger, 233-235; 237-238).

These properties of suicidal ideation were helpful in describing how SI may occur.

Ambivalence

Ambivalence moderated the balance between triggers and barriers at the decision point in Stage Three. Ambivalence about suicide seemed to protect the informants from moving from SI to a suicide attempt to completion of suicide. Ambivalence was noted explicitly in some of the interviews. Although the individual may have felt he wanted to die, ambivalence intervened and he did act on the desire. If the balance between triggers and barriers were maintained, the action did not occur.

Most informants expressed ambivalence, however it was often indirectly or contextual in nature. For example, Roger had been certain he would shoot himself when his cancer was at the terminal phase. Instead, as the event drew nearer he was reconsidering. Interestingly, both Ralph and Rick hid their weapons to restrict easy access. Both noted it gave them time for a critical moment to pass and for them to reconsider. Indications of ambivalence were stated explicitly. Leo specified on one occasion when he had SI that he realized he was not ready to act on the thoughts.

Well, I mean things were not bad enough for me to actually want to go through with it and to do something (Leo, 30-32).

Lacking Religious Beliefs/Maintaining Religious Connections

Religious beliefs were personal values affecting Stage Three. Religion refers to an organized system of beliefs, practices, or forms of worship (Emblen, 1992). They were

internalized values that could affect an individual throughout the life span. For some informants, religious beliefs were a barrier to suicide and for others they were neutral or irrelevant to decision-making. The majority of men either eschewed religious beliefs or had an animosity towards religion. Of the ten informants who addressed religious beliefs in the interview, two noted it was a barrier to acting on SI.

Jay noted that there was accountability beyond this for those who chose suicide.

Religion has a big factor in that too, because I firmly believe in God and –and the fact that we are all a spiritual person within a human body and that spiritual person doesn't die. You jump off that bridge and that spiritual person still has to deal with the problem (Jay, 389-395).

For Gerry, religion was also a barrier.

...I think I love Jehovah too much to do it. He's been too good to me... (Gerry, 745-746).

Jake acknowledged the prohibition of religion on suicide, but noted his beliefs had changed with advancing age. His viewpoint was changing as he expressed a desire to control the time of death to avoid suffering.

My mother brought me up with the Bible and not to kill myself. I can even think back there. I can even think that far back. I struggled but like I said as times progresses and my age is progressing and it depends on what is coming unbeknownst to everything and I have to plan accordingly. I don't want to go through all these tubes hooked up on me. I don't want to just suffer completely, bad suffer (Jake, *8-16).*

For others, there was a similar view that planning the time of death as one aged was crucial to avoiding life support, suffering, and a lingering death. There was a stark absence of religious connections among these individuals. Roger noted,

...I don't... ah believe in heaven or hell. I don't believe they exist so I have no problem with that (suicide) *(242-245). So I have to decide, am I going to spend six months in the hospital ward on dope or to plug myself* (Roger, 251-253).

Rick and Leo grew up with religion and both considered themselves religious. This changed after Leo entered the military. He noted that seeing the effects of war changed his beliefs. He considered himself a non-believer at the time of the interview.

I'm not a religious person and never have been. Well, yes I was. I grew up a religious person. Through my teens and going into the military I was very religious. In fact the minister there thought of talking to me about going into the ministry. But then as I went off to war and began seeing a lot of questions in my mind and so forth. I went through a lot of years as more or less and agnostic I guess (Leo, 41-51).

Rick stated,

...I don't consider myself an atheist or anything like that. I don't go to church everyday or every Sunday or anything like that. I did when I was younger. I was in a men and boy' s choir- St. Stevens. ...so I had an opportunity to hear what Christians need to know. I also I don't have any delusions about meeting my wife on the other side or anything like that you know (Rick, 226-231; 233-237).

Three informants did not subscribe to religious beliefs. Religion appeared to be irrelevant to their decision-making. Furthermore, these informants expressed animosity toward organized religion. Ralph stated,

...I never was (religious) *and my beliefs have been informed at least by the religious people that I've met and by the history that I've read, but the terrible things that religions have done to other people like through the Inquisition, throughout everything* (Ralph, 384-389).

Jack noted,

It's like these Roman Catholics who go to Roman Catholic schools... not Roman Catholics but Mormons and others who are indoctrinated from birth (211-214). *Then and then they start talking about death and suicide is a sin and you won't go to heaven and they go into all this hocus pocus stuff and it disgusts me* (Jack, 218-221).

Similarly, Sid denied having religious beliefs.

I don't believe in the hereafter. I don't believe in any of the so-called spiritual stuff that is being passed around. Because that has done more harm to man then anything else I know that has caused man more pain and anguish and brought out the worst in man. Killing in the name of God (Sid, 401-407).

In general, religious beliefs were not a barrier for suicide in this study. It is noteworthy that a lack of religious beliefs did not indicate an absence of spirituality and other beliefs that may have insulated the individual from suicide. For some individuals,

prior religious beliefs had fallen away leaving them free to move on through the decision point without being influenced by their previous beliefs.

Rational Suicide

Rational suicide is based on lucid reasoning. Rational suicide was a consideration in Stage Three of the model. At first glance, it would appear to be a trigger for SI, however this was not supported. Two of three informants with a rational decision viewpoint had specific criteria for time of death. Of the three, Roger and Jack had reported that SI was precipitated when a third party inquired about it. Roger noted that when the decision point arrived he would decide whether to enter hospice or kill himself. However, Jack had COPD and SI was also affected by increased dyspnea in addition to third party inquiries. Jack was the only informant without expressed barriers to suicide. He reportedly had discussed his decision with his two children. Jay expressed a rational decision view, but for him SI surrounded feelings of incompetence and worthlessness. Furthermore, for Jay there were admitted religious and family barriers to suicide. Roger admitted that concern for his daughter may prohibit a future suicide attempt. From the data, it appeared that ambivalence continued to prohibit a suicide attempt for this group of informants.

Stimulating the Desire: Triggers

Triggers for suicidal ideation were situations and/or events and thoughts that stimulated the desire. Triggers for suicidal ideation were contextual. There was a connection between losses incurred in Stage One and triggers for SI in Stage Three. Loss

was enmeshed in the process of *Losing Connections*. As such, the accumulation of losses in itself may have acted as a trigger for SI. This was conveyed in the data.

Failing Health. One common trigger for suicidality was health problems, either living with chronic illness or symptoms of a chronic illness, such as pain. Most often, chronic illness interfered with the individual's ability to maintain the former level of function to which they were accustomed. This led to decreased socialization and increased isolation.

For Leo, pain interfered with his enjoyment of life, such as hobbies and socialization. He stated,

...the pain you know it's so bad and it's everyday... and then there is the downside that keeps me from doing things like golf that I'd like to do... (Leo, 16-19). Due to a mechanical breathing obstruction, Leo also had sleep disturbances that left him feeling tired and drained. Both of these problems triggered thoughts of worthlessness and subsequent SI.

Jack had end stage chronic obstructive pulmonary disease. When his dyspnea worsened, SI was prompted. He stated,

It (SI) *may impact on a depressed time or a time when I've been having particular trouble with my breathing or health or functionality as a human* (Jack, 104-107). Don had arthritis and physical labor, which he enjoyed doing, precipitated a cycle of pain and discouragement. When he was not productive, he felt useless and began to contemplate suicide. Don noted,

But I get angry at myself because I can't do anything. I know how to do things but it hurts. Physically it hurts (295-297). *When I get to feeling, "Ah the hell with it. What's the use of going on?"* (Don, 290-291)

Only one informant, Sid, had multiple health problems and was in a wheelchair secondary to disabilities. His illness burden was the focal point of his narrative. Health problems had overwhelmed his life, appearing to create a web in which he lived. Sid stated,

...physical disabilities always get in the way if I want to do something to enjoy. I can't do them. I can't stand. I can't sit too long or my ankles swell up like crazy and they hurt (Sid, 218-222).

For Sid there was also a component of emotional pain to SI. In fact, there was an identifiable process of SI, which he described.

These feelings are triggered by thought more than pain. The thought is triggered by the pain and situations that occur like this last main one (altercation with spouse)... (33-35; 37). *I was more vulnerable at this time because the intensity of all of this varies from day to day and moment to moment. Some days I can deal with by setting it aside and saying, "Well this is more important to work with now." Sometimes it's just overriding and I have to battle with it mentally* (Sid, 38-44).

Becoming a Burden. Two informants noted they had suicidal thoughts when they perceived themselves to be a burden to their spouses. Sid noted,

She is 80 years old. She has her own problems that have come and she doesn't

need me as a problem to deal with (Sid, 239-241).

His wife was his caregiver and he felt responsible, in part, for contributing to her depression. Despite the concern he was a burden, he felt she still needed him. Sid noted,

And I didn't want to be a drag in her life yet I know that she, living with her all this time, I know that she needs me... (Sid, 53-56).

Jay had memory problems that interfered with his ability to remember simple details at times. He relied on his wife to remind him of appointments and obligations, but he thought he was a burden to her when his memory lapses were more frequent than usual. This was one factor in a constellation that prompted suicidal thinking. Jay stated,

...she's more tolerant than any woman I could ever imagine putting up with me but this is the way I feel that I am a drag on her (Jay, 143-146).

Experiencing Emotional Pain. For the two informants who suffered loss of a spouse, thoughts and reminders of that person were triggers for SI. It was the emotional pain and deep sadness that precipitated SI. Ralph noted,

... anything that precipitates thinking about B. upsets me (Ralph, 36-37).

He later qualified this stating he had many good memories of his wife that were pleasurable, but there were times of great sadness. He stated,

But there will be things that will precipitate a very deep sadness and I really don't know what causes it (47-49). *I have a rooted sorrow ...and my antidote is easy. To end it* (Ralph, 68; 73-74).

Rick was often reminded how meaningless his life was without his wife. He could appreciate memories of their pleasant times together, however his thoughts remained focused on missing her and guilt for the times he spoke harsh words. Rick stated,

Every place I looked and everything I touched was hers you know or she had liked it or bought it or something like that... (Rick, 102-105).

One notable difference between these two men was Ralph continued to be active and involved professionally after his wife's death, whereas Rick who was his wife's primary caregiver, had no professional or social obligations to return to.

Being Alone. Solitude was a powerful precipitant for suicidal thinking. Five informants referred to this as a trigger for suicidal ideation. The presumption was that rumination was more likely to take place when the mind was not otherwise occupied. Both informants who lost their wives were prone to thinking about suicide when left alone with their thoughts. Also, Carroll noted he had SI at previous points in his life, but more prominently after his first wife died. He stated,

...I have them (SI) *occasionally... when I was living alone* (Carroll, 29-30).

Losing Sleep. There was a link between sleep disturbances and suicidal ideation for some informants. Sleep deprivation was a powerful trigger for SI. Carl noted,

I guess when things are catching up with me where I think of uh ... things that have happened you know where I'm at today. Seems hopeless at times. Particularly when I go to bed and just toss and turn (Carl, 8-12).

Don stated,

Another thing that you have is an inability to sleep. I don't know if that caused from pain or caused from depression except I know that one pill I take seems to let me sleep (Don, 15-19).

Leo had a nasal obstruction that interfered with his sleep. He stated,

The last couple of years just getting any sleep is very difficult. Laying down. Now I can get up and sit in the chair and fall asleep. But it would just be so wonderful to lay down... It leaves you so tired you know and worthless and you feel worthless... So that's the worst part of my life (Leo, 140-148).

Losing Purpose. Suicidal ideation for some informants involved a constellation of factors, including their inability to feel productive and contributory. "Useless" and "worthless" were frequently used by informants to indicate a sense of purposelessness. Without a sense of purpose, many questioned their reason for living. There was a loss of connection with the world as social roles fell away. An accumulation of role losses also served as triggers for SI.

Jay noted,

The longer it goes and the less active I am or able to be the less active I am able to be and I feel like my health is the big restraint on it... You know my evaluation of myself and my usefulness to the world gets diminished (Jay, 66-71).

Jack stated,

...in terms of ideal of what ...a good health human being would be like you and various other people...fully functioning people...I have a lot of admiration for that. The further I get from that more and more decrepit can't get up, can't hardly get out of a chair, this and that problem you know (Jack, 32-36).

Don valued being productive, which was a validation that he was a contributing member of society. He noted,

One thing that makes me feel useless is not being able to do anything anymore physically (354-355). I've got to see material things. I've got to be able to look back at the end of the day and that I've accomplished something (Don, 358-361).

Similarly, feeling worthless triggered SI for Leo.

It's going through a period where I kind of feel worthless you know. I feel you know what am I contributing to life you know and that sort of thing (Leo, 115-119).

Feeling Stressed. Situational stressors were common triggers for SI for the informants. Gerry described situational frustrations with his medical provider that caused angry moods and SI. Emotional upsets were a key trigger for him.

Ah if-so I get my feelings hurt and that's what I think about well I'm just going to end it or just find some way to get out of this (418-421). *That's I guess the other thing that bothers me. If things don't go along pretty good without much change. I got to get upset I guess* (Gerry, 633-635).

Similarly, emotional upset was a trigger for SI for Rick.

Well, if something comes up that upsets me or I think it's going to be a problem that I can't handle. Then at that time I say, "oh what's the use of going through all this? I might as well just end it now because I'm getting up to advanced age now...I don't see anybody's going to miss me ... (42-49). *I don't really see any reason for staying alive* (Rick, 55-56).

For Carl, emotional upset and anxiety was triggered by frustrations, especially related to social interactions.

Uh... I was getting a bunch of them (suicidal thoughts) *when I as dealing with Social Security. Just going down there- the thought would get to me. When I'm dealing with the government and not making any headway* (Carl, 17-20; 21-23).

Triggers for SI were emotional pain, chronic pain, solitude, situational stressors, and a sense of worthlessness. Loss was integral to the processes involved in precipitating SI, hence in itself served as a trigger for SI.

Deciding not to: Barriers

Barriers forestalled the decision not to die. Informants identified the following barriers: consequences of suicide for significant others, experiencing another's suicide, and fearing a failed suicide attempt.

Hurting Others. For seven of eight older men who addressed reasons for not attempting suicide, consequences to significant others were the major barrier. Spouses and children were the significant others identified. Leo stated,

The thing that has probably kept me from doing something is my love for my wife and what it would do to her so... (Leo, 13-15).

Similarly, Ralph noted,

There is really only thing that really holds me... and that was the consequences. And the consequence of course to the family (76-80). *The sole thing that has held me back several times is my older son, the younger son can take it. My older son couldn't...* (Ralph, 403-405).

For Carroll, family members were also a foremost consideration in making a decision.

I wouldn't actually wouldn't want to leave my three kids and my grandchildren (109-110). *I'd worry about leaving them. And now that I married J. and she is in a real difficult financial situation* (122-123). *Yeah I think she and my grandkids would keep me from doing something like that* (suicide) (Carroll, 129-131).

Sid added,

What keeps me from doing it is this constant struggle between my wanting to do it and my realizing the effects that it will have on the people that I love. And so I'm in a bind just between those two forces. I suffer (Sid, 96-100).

Roger viewed suicide as a rational decision to be made when his cancer was terminal. The current struggle he faced was whether to act on his desires and hurt his daughter by the act or to die in hospice and face prolonged pain and suffering.

Now my problem is I have my youngest daughter, the very religious girl and if I commit suicide it'll break her heart because she wants to see me in heaven (238-242) ...I do know if I commit suicide it will crush my daughter (Roger, 249-250).

Experiencing Another's Suicide. Jay had seen the aftermath of suicide for others and this served as a barrier to suicide for him. One incident involved a business associate whose wife killed herself and their two children. Jay recounted how he identified the bodies, notified his associate about the tragedy, and assisted his partner to make funeral arrangements. He was reminded of this and similar situations in which he was involved when he contemplated suicide. He noted,

...then you do an inventory of what effect that has you know. In other words there goes my wife and my family and all of those people who really care about me and then what effect does that have on them? (Jay, 323-326)

Similarly, Rick was acquainted with a neighbor who committed suicide, but his response was more impersonal. He saw the aftermath of suicide for others and did not want this to be world's last impression of him. He recalled this incident in the following passage.

Just seemed like to me a bad, horrible thing to have someone come in and clean up after your- after you'd done way with yourself (Rick, 147-150).

Fearing a Failed Suicide Attempt. Another barrier for three informants was a fear of surviving a suicide attempt. Two informants had previous suicide attempts. Sid wanted the assistance of a health professional the next time to ensure the attempt would culminate in death. Sid stated,

...I really want somebody who would make sure that nothing went wrong because there is no perfect way of doing it. As long as man is involved in it there is always more of a probability than a possibility of something going wrong (Sid, 117-122).

Gerry was hospitalized in the past for a suicide attempt and reflected on that experience.

...that experience was pretty bad and I don't really want to go through that again (Gerry, 649-650).

Jay couched this fear of failure of a suicidal attempt in humorous terms. He stated,

...I haven't found a bridge tall enough yet because I always think that I'm going to just fall and splatter and I'm not going to just do the job right. And there is one thing you don't want to be is half dead (Jay, 297-301).

Despite all the losses, these men still had connections with others. Many feared a failed suicide attempt or had seen the aftermath of suicide for others. All of these barriers continued to restrain their decision to commit suicide.

In this section, barriers were reasons for deciding not to die. The following barriers were reviewed: consequences to others or hurting others, experiencing another's suicide, and fearing a failed suicide attempt.

Managing Suicidal Ideation

The management of SI appeared to be crucial to preventing a suicide attempt for these informants. These were strategies used by informants to interrupt SI, so as not to act on their thoughts. Interestingly, many informants seemed to have a fear they would

progress to a suicide attempt and therefore took precautions to avoid this step. In a sense, the management of SI became a barrier in itself to suicide.

Several suicide management strategies were identified from the data, including diversion, social interaction, separation/avoidance of the situation, pushing away suicidal thoughts, and hiding weapons.

Diversion. Diversions, such as music, productivity, and social interaction were the most common management strategies. One informant noted he pushed suicidal thoughts out of his mind indicating this was effective for him. Rick stated,

I like music so I have music going in my house you know all the time. It gets quiet and that is when I start to think really strong... (165-169) ...it helps me to get my mind off of what I don't want to think about (Rick, 174-176).

Social Interaction. Two of the informants used social interaction to divert their attention. Ralph had difficulty being alone in the house without his wife in the evenings. He called friends or went out to visit them.

...I called and said, "G. I've got to come over". Because I know I had to do something because I knew that if I had stayed in that house I'd probably not be here (Ralph, 415-418).

...she (wife) *probably reads the way I'm thinking by my dead eyes and so forth at times and the way I look. So I know she does because there are times when she makes plans for us to do something* (Leo, 209-213).

Ralph also phoned friends to manage SI. He noted,

...I had to do something because I knew that if I had of stayed in that house I'd probably not be here (Ralph, 416-418).

This same informant kept busy to avoid suicidal thinking.

I've been so professionally involved all my life that it is something that I've trained myself right back into work again (450-453). ...I've kept this past year because I knew I'd better keep as busy as I could this last year (Ralph, 461-463).

Separation/Avoidance. Separating themselves from the situation in which SI occurred was a useful strategy for some. Gerry escaped the situation and laid down when he was upset and contemplating suicide.

It (SI) *does seem like it comes pretty quick anymore and can't get to the bed fast enough and lie down and try to go to sleep you know (685-689). But if I can get away from the situation then it'll go away. I'll calm down* (Gerry, 688-691).

Similarly, Carl avoided his neighbors whom he saw as likely to trigger his SI.

I'll go down a different entrance. Or get a different time (Carl, 263-264).

Pushing away Suicidal Thoughts. Don noted he shoved the suicidal thoughts out of his mind and therefore could control them, despite the persistence of SI.

...and that is the way those thoughts are. If you don't let them get the best of you can shove them out (394-397) ...you control them but they are always there... hiding back there and trying to slip out (Don, *399-400).*

Hiding Weapons. Two informants who owned guns, kept them out of reach so they were not immediately accessible.

Now I don't leave them out handy because I'd have to give more than a passing thought (Ralph, 531-533). Rick stated,

Well, I always keep my gun loaded in the house though. And I've had a habit of hiding it in a place where only I knew where it was.... I still have a habit of doing that. So I just can't put my hand on it immediately and you know and take a little bit of time and then I don't know what stopped me- several times (Rick, 117-125).

Management of SI was critical in preventing a suicide attempt for the study informants. The majority used diversional tactics, such as music, socialization or productivity to deflect their thoughts and from acting on an impulse, rather than making a thoughtful decision about suicide.

Summary

In Stage Three, management strategies were employed by the informants to interrupt SI and a suicide attempt after deciding he was not ready to die. If management strategies were effective, the decision point passed. Thought processes were reordered and the individual resumed living until the next trigger for SI occurred. At the time of the next trigger, the decision point was again confronted. Triggers were evaluated together with barriers and ambivalence weighted the scale towards deciding that this was not the time to die. This process was cyclical. When the informant decided not to attempt suicide, life continued until the next decision point was reached.

In Stage Three, factors in *Negotiating Ambivalence* were presented. The decision phase in suicidality was characterized by triggers for the desire to die and barriers to not dying. Ambivalence moderated the process and determines the outcome of suicidality. Suicide management strategies were used at the decision point to prevent acting on SI. Clues to how suicide became an option were found in individual reasons for considering suicide and properties of SI.

Summary of Chapter Four

Results for this qualitative study were presented in this chapter. The BSPP, *Losing Connections*, was explained in three stages. In Stage One, *Mounting Losses*, loss was identified as the key theme. Relationship, health, and role losses were identified in the data and examples of each were given. Of these losses, professional role loss was the most common. For many, it was the initiation of Stage One. It may or may not have been followed by other losses before entering stage two. Stage Two, *Drowning in Depression and Despair*, was characterized by depression and despair. Other themes were devaluation and low self-esteem. Stage Two culminated in a decision phase moving the individual to Stage Three or *Negotiating Ambivalence*. During this phase, there was a struggle between wanting to die and deciding to die. The struggle involved a balance of triggers and barriers, which were moderated by ambivalence. The individual perceived they had reasons to die, but struggled with deciding to die. Triggers for suicide were contextual, including thoughts of a dead spouse, emotional pain and upset, hopelessness, uselessness, and health problems. Barriers were consequences to family members and

fear of a failed suicide attempt. Religion provided few barriers to suicide for these informants. Lastly, the decision point culminated in the decision that the individual was not ready to die. That decision appeared to be reached with the assistance of suicide management strategies. Effective management strategies inhibited the individual from making an attempt.

CHAPTER FIVE

DISCUSSION AND RECOMMENDATIONS

The findings presented in Chapter Four described how informants with depression began to engage in suicidal thinking and decision-making surrounding suicidality. A basic social psychological process was identified where the older individual incurred losses in Stage One, transitioned to depression and despair in Stage Two, and moved into a decision phase in Stage Three where triggers and barriers modulated suicidal ideation. In this chapter, interpretations of study results and integration with the literature will be presented. Implications for nursing theory, research, and practice are also discussed.

Overview

The basic social psychological process (BSPP), *Losing Connections*, was presented in three stages in Chapter Four. Older adults recognized they were no longer the person they used to be or may never have become the person they had hoped to be. In Stage One, *Mounting Losses*, loss was identified as an overarching theme in a current episode of depression with subsequent suicidal ideation (SI). With each loss, the individual drifted further away from the person they once were. Connections among the self, others, and world began or continued to loosen. Furthermore, losses become intertwined, often defying recognition. The losses for informants included, relationships, health, and role losses that were professional, social, and personal in nature. Of these, professional role loss signaled by retirement was especially significant. There was an apparent lack of readiness for retirement and subsequent disappointment ensued. This

disappointment yielded feelings of uselessness and a sense of alienation. Relationship losses were significant for some. Two informants suffered the loss of a spouse and others lost family and friends. For some informants, there was a constellation of losses over the life span, such as loss of a parent or poor quality interpersonal relationships. Personal value systems affected the process of *Losing Connections* at all stages. A strong work ethic and sense of being productive were important to maintenance of self-concept and feeling like a contributing member of society. Without connections to others and the world, a sense of alienation developed. This was a recurrent theme that was often implicit in the narratives, rather than explicit. Progressive alienation over the life span was evident for some, whereas others have more recently become alienated with processes of aging and loss.

In Stage Two, there was a transition from processes involving loss to a stage of depression and despair culminating in suicidality. This stage, *Drowning in Depression and Despair*, was characterized by low self-esteem, demoralization, and devaluation. Many characteristics of depression, such as sad moods and sleep disturbances, were common complaints expressed as reasons for not being productive and feeling discouraged. There was a cyclical quality of depression that contributed to "bad" days or periods when the individual was particularly gloomy and likely to have SI. For many, feelings of despair more aptly captured the processes of Stage Two. Those with health problems were likely to express despair and no expectations for the future. Health problems were assessed to be beyond cure and made the informants' situations untenable.

With depression and despair, connections continued to loosen accompanied by feelings of hopelessness and alienation.

Stage Three was characterized by the struggle between wanting to die and deciding not to die in *Negotiating Ambivalence*. At this decision point, there was a desire to escape this life and its problems and a paucity of reasons to live. The major reason for suicide was to solve perceived problems and end emotional pain. Death was perceived to be the "ultimate solution" for some. Stimulating the desire (triggers) and deciding not to die (barriers) surrounded the struggle. Triggers are thoughts or events that precipitate SI and barriers are restraining factors or reasons for not committing suicide. While triggers may move the individual forward across the trajectory of suicide, barriers forestalled this progress. Triggers for SI in this study were thoughts of a deceased spouse, health problems, solitude, and emotional upset and/or emotional pain. The most dominant barrier to suicide in this group was consequences to significant others. Secondarily, a failed suicide attempt was a barrier for some. The balance of triggers and barriers was moderated by ambivalence. For some, ambivalence appeared to be a barrier in itself. By a few, death was viewed as a comfort, a welcome deliverance from this life of pain and unhappiness.

In Stage Three, there was an absence of religious connections among the informants. In fact, the data were notable for both a lack of religious convictions and an animosity towards religion voiced by some. It was expected that religious beliefs would serve as a barrier to suicide, however there were few informants with strong religious

beliefs to support this hypothesis. Of those who noted religion was a barrier to suicide, all made statements leaving an impression of uncertainty. This may indicate that even those who expressed beliefs prohibiting suicide may have been experiencing a loss of connection with former religious beliefs. In other words, as other connections were breaking, religious bonds were also. For two men, religious connections had fallen away earlier in life.

Individuals employed management strategies or skills to interrupt SI. Of these, diversion, such as listening to music, social interaction, and being productive was common. The diversions engaged them, so the suicidal impulse or thought passed. In all of these cases, the individual removed themselves from the context of SI. Other strategies such as pushing back suicidal thoughts and using humor with sad moods were mentioned. A fear of acting on SI served as a management strategy in that both men who owned guns hid them noting they did not want to act on impulse and wanted the time to reconsider.

An overview of the BSPP, *Losing Connections*, was summarized in this section. The next section will focus on a discussion of the research findings and their integration with the literature.

Integration with the Literature

A process had emerged from this study that described a sequence of loss, becoming depressed, and culminating in suicidal thinking in informants. The findings for this study will be reviewed concurrently with the literature to note intersections and

dissimilarities. As the researcher returned to the literature, some intersections with the dissertation research were apparent.

Risk Factors in Late Life Suicide

The literature reviewed for chapters one through three provided a useful background on information in suicide and suicidality. There is a plethora of research focusing on risk factors for suicidality and suicide in older adults. Common risk factors for late life suicide included: situational factors, such as loss, stressful life events, and social isolation; a family history of mental illness; psychological factors, such as depression; exposure to suicidal behavior; and biological factors, such as low neurotransmitter levels in the brain (Moscicki, 1995; Stillion & McDowell, 1996).

Frequently described risk factors of physical health, depression, retirement, and the social factors of spousal loss were identified in this study as risks for sucidality. However, there was an absence of descriptive processes that occur in suicidality, particularly in viewing the process of how loss affected older individuals and contributed to depression and subsequent SI.

The processes of loss, depression, and suicidality were interwoven and more complex than previous research on risk factors would suggest. A compilation of risk factors may indeed give a profile of elders at the highest risk for suicide, but ignores the process of moving from being at risk to reaching a decision point. The dissertation study findings began to explore this process.

The literature on risk factors focused on classifying or grouping factors as separate entities, such as psychological, social, and biological, rather than a composite of the many variables. Although risk factors may be defined as being cumulative, the process of how they all fit together is not described. Furthermore, illness and disability, retirement, social factors, and aging are seldom described in terms of loss. Instead, they are discrete factors of a biological, social, and psychological nature that occur as individuals' age. In this study, it was apparent that these entities were experienced as losses for the informants.

Conceptualizing Risk Factors as Losses

Old age has been described as the season of losses (Osgood, 1985). The losses incurred for informants in this study were essentially physical, social, psychological, and emotional in nature. There was a loss of physical health, including chronic health problems. Health problems were associated with chronic pain, disability, and terminal illness. Social losses identified were retirement, community involvement, and loss of relationships. Loss of a relationship was both social and emotional in character. Psychological losses of self-concept, self-confidence, and competence were prominent, however most often were implicit.

Physical illness and decline have been associated with increased suicide risk in extant research. This association may be mediated by depression (Richman, 1992), which is in turn the strongest contributor to suicide. Chronic pain has been associated with an increased risk of suicide in some studies, however this has not been a consistent finding.

Stroke, Parkinson's disease (Kaszniak & Scogin, 1995), and respiratory diseases with chronic dyspnea (Horton-Deutsch, Clark, & Farran, 1992) have all been associated with an increased rate of depression in older adults. Some informants had chronic diseases they identified as important to feeling well both physically and mentally. Chronic arthritis pain was a continual challenge for three men and appeared to mediate moods and hence suicidality. Other chronic illnesses were terminal in nature, such as COPD and prostate cancer. Interestingly, those with terminal prognoses were those who reported a rational view of suicide.

Illness affects an individual in less perceptible ways, as well. Physical illness poses threats to integrity, life, self-concept, emotional equilibrium, and to the fulfillment of customary social roles and activities in work, family, and community (Cohen & Lazarus, 1979). It influences self-image negatively, as many older adults have difficulty incorporating a personal image of infirmity. Illness is a constant reminder of one's frailty and threatens permanent dependency. It is also a reminder of one's mortality, that death is nearer than ever. Illness affected informants in these more subtle ways.

The constellation of losses identified in this study translated into the loss of multiple roles with aging. Rosnow (1973) noted that the loss of roles excludes individuals from social participation and devalues them. Role loss deprives individuals from roles that validate self-esteem, self-worth and self-concept, hence they become marginalized and alienated from a larger society. This culture does not provide older adults with meaningful norms; therefore individuals are left to construct the "aged" role for

themselves. For several men in this study, retirement appeared to be the initial role lost. This may have served as a tangible reminder of their entrance into old age. It appears also to have triggered other role losses, such as discontinuance of active social involvement. For others, retirement was enforced due to health problems. All retirements, including the two men who elected to retire, were off time in nature. There was a lack of adequate preparation and consideration for this event.

Role theory may be helpful in understanding role losses in late life. Role theory is a related sociological perspective that contends individuals develop identity through social roles (Lopata, 1973). For older men of this cohort, the occupational role was foremost during the life span. It has had the greatest impact on self-identity of all roles. The loss of social roles may result in subsequent losses of self-concept, self-esteem, and a sense of meaningless in life. Similarly, Miller (1965) in a classic theory of identity crisis of retirement noted that other work roles and leisure roles would not be adequate substitutes for that of the lost work role. Hence, productivity of another type cannot fill the requirement. This was evident for many of the informants.

Old age is the first stage of life associated with systematic status loss. Other stages are marked by acquisition, such as attaining success, prestige, and increasing financial rewards. However, passage into late life is marked by decrements for most. There is no longer the possibility for attaining previous goals set in younger years, instead the skills to accomplish this dwindle (Rosnow, 1973). For study informants, there was the realization that they were not the people they used to be and never would be.

According to symbolic interactionists, the image of self is formed by taking into account perceptions of significant others. In relationships where a spouse or significant other has taken on roles seen an extension of oneself, the loss of that relationship is in some ways a loss of the self (Lopata, 1973). Study findings supported this view. For two men who had suffered the loss of spouse, there was sadness and loneliness. The spouse with whom they shared so much and whom they needed and were needed by was gone-leaving them with a resultant feeling of a loss of themselves. The loss engendered a feeling that life was meaningless and not worth living.

An accumulation of psychological factors are hypothesized to contribute to suicide risk in late life (Maris, 1995). Depression is the most common, but other factors, such as loss, emotional pain, loneliness, hopelessness, vulnerability, and ability to cope are similarly linked to suicide risk. Hope is inextricably tied to meaning in life and as such gives value and meaning to life (Aldridge, 1998). Without hope, an individual may lose his/her symbolic reasons for living (Charmaz, 1980). Schneidman (1996) described psychache or extreme psychological pain as the ultimate cause of suicide, as the individual seeks an escape from this state. For some study informants, the pain of loss and sadness was something they desired to escape. Death was viewed as a comfort, a place to find solace.

Loss in the social realm is connected to loss in the psychological realm (Durkheim, 1951). As such, it has a role in bringing about depression. This is seen after the death of a significant other when a normal grief response extends into depression.

Loss was supported in the literature as a factor in depression. Cumulative loss is thought to heighten the risk of depression and subsequent SI and suicide. For those with depression, growing old may bring a negative evaluation of self and subsequent low self-esteem. This was apparent for many of the study informants. Individuals are faced with the task of explaining to themselves and others that they are not the person they used to be, but they are unable to accept or explain the new old self and therefore lose their earlier identity (Kastenbaum, 1964). When there is such dissonance, older adults begin to loathe themselves, further increasing a sense of alienation. A lack of acceptance of the new self and self-loathing was evident for some. One man with late stage chronic obstructive pulmonary disease described his disability as "loathsome" and implied that illness somehow made a person less human. Similarly, another informant with untreated depression and memory problems could not accept these changes, instead declaring himself useless and unfit.

There was a link between hopelessness and depression in this study. The literature supports the two often coexist, especially in the context of loss. An objective loss and its subjective realization may be gradually experienced, however in the cases of the informants who lost their wives the loss was experienced as sudden, a rupture of the relationship. In contrast, when the self is slowly eroded, losses may be imperceptible. Hopelessness may develop when a major transition occurs in life and the individual's expectations are not fulfilled (Charmaz, 1980). For the men who retired, there may have

been unfulfilled expectations and therefore an inability to return to the former identity that gave their life substance.

Hope is inextricably linked to meaning in life. If an individual has reasons for living, hope is maintained (Charmaz, 1980). However, recent data have suggested that hopelessness for some older adults may be chronic even after depression remits (Szanto, Reynolds, Conwell, Begley, & Houck, 1998). Future expectations were absent for many of the men in this study. This is likely a component of their despair, although having no expectations for the future may remove a barrier for acting on SI.

Ageist Attitudes

Reviewing the literature on ageism was helpful for this study as self-identity is a composite of personal values, contextual factors, and socialization as individuals age. The literature on ageism focused on the evolution of ageist attitudes across the life span from initial socialization (Neugarten & Datan, 1973) to perpetuation of these values by the self and society (Palmore, 1999). Meanings arise through interactions, but the meaning often extends beyond the content of words alone. In American society, youth is highly prized and aging is both feared and denigrated. As individuals age, they become more cognizant of the overt and covert cultural messages that aging is negative. There is an internalization of these values with a resultant view of the self as negative, one that is useless, dependent, and non-contributory to society (Palmore, 1999). Discerning the impact of ageist attitudes on individuals was not possible as societal attitudes are integral. However, personal attitudes suggestive of internalizing ageist attitudes were apparent in

informant's narratives. Many referred to their aging in disparaging terms, such as lacking worth to others and society due to their age. Further, one informant noted doctors were not interested in older persons as they take too much time from their schedules.

Religious Beliefs

Not surprisingly, there was a pronounced lack of religiosity among study informants. Although the link between religiosity and suicide has not been explored, the connection between depression and religion has been studied. Decreased well-being and self-esteem are correlated with religious orientation among depressed older adults (Miller, 1992; Nelson, 1990). Those individuals with high self-esteem were more intrinsically oriented to religion and less depressed than elders without these religious connections (Nelson, 1990). Similarly, those who expressed satisfaction with their lives in old age had stronger religious beliefs and spirituality (Haight & Hendrix, 1998). Some parallels may be drawn for the men of this study who lacked religious connections, as all were depressed, conveyed low self-esteem, and dissatisfaction with their current lives and at times over the life span. Furthermore, a lack of religious beliefs may heighten disconnection from community and society, thereby endorsing the intent to commit suicide.

Social Losses

An individual's perception that his or her depression has had a damaging effect on a family member and their relationship may be deeply demoralizing. That demoralization may lead an individual to conclude his or her death may bring personal relief from

suffering, as well as, relief to a family member (Zweig & Hinrichsen, 1993). Demoralization was palpable for two men in this study as they expressed feelings of becoming a burden to their spouses. One felt not only burdensome to his spouse, but also guilty for the role he may have played in her recent diagnosis of depression. Furthermore, there was a strong suggestion that an invitation to die (Jourard, 1971) had been received by these two informants. Although no family conflict was discussed explicitly, feelings of being a burden to their spouses were suggestive of having received the message that another's life may ultimately be enhanced by their deaths.

Social risk factors, such as gender, social support, and interpersonal factors may heighten suicide risk. Durkheim (1951) was the first to focus on a social perspective of suicide. He theorized that the suicide rate was determined by the societal level of social integration and the degree of societal regulation of individual desires through societal norms. Research on social support most often supports an association between social isolation and depression and suicide in older adults. Older men, especially white men, have the highest rate of suicide overall. Suicide risk for this current cohort was enhanced by the death of a spouse. The spousal relationship appears to be crucial for many reasons, including the role of a spouse as a confidant and the organizer of social interactions and domestic chores (Canetto, 1995). The two men who had suffered the loss of a spouse were clearly at risk for suicide, however the long term effect of spousal loss was impossible to predict.

Interpersonal and social themes in the data prompted many possible considerations in explaining study findings. The key barrier for suicide was consequences to family members. This would suggest a perception of connectedness with spouse or other family members. It was apparent that most of the informants had not yet severed connections with significant others. Extant research has strongly supported social isolation as a factor in late life depression and suicide (Oxman et al., 1990; Zweig & Hinrichsen, 1993). The findings from this study were limited and hence no comparisons could be made concerning the affects of social isolation on informants. Social isolation was evident in only two of the interviews. For some without family in close proximity, a feeling of connection was maintained. Moreover, many informants reported good relationships with children and other family members. There was evidence for social connections extending beyond family in this group of informants. These included relationships with the community/society, such as volunteering, employment, and leisure pursuits. Half socialized with friends, other than family members, on a regular basis. One remained employed and three noted they did volunteer work. These findings supported that informants were still connected to others.

Despite the appearance of social connectedness, emotional isolation may play a role in the dynamics of suicidality. It has been suggested that emotional isolation or a perception of loneliness may be more important than social isolation in older years (Arve et al., 1999). Just six of the men in this study said they had a confidant. Of these, four identified a health care professional as that confidant. Two of these men had spouses, yet

named their therapists as their only confidants. For the remaining two men of this group, their wives were identified as a confidant. This finding was somewhat surprising with regard to an apparent lack of connection and/or trust in a spousal relationship. The wife is often identified as a confidant for their husbands in extant research (Canetto, 1995). The issue of social isolation is more complex than an absence of social contacts in one's life. Moreover, emotional isolation may be either imperceptible to or not recognized by suicidal older adults, but may be more lethal than social isolation. When an individual is sufficiently distanced from others, the decision to die by suicide may become an acceptable and reasonable solution (Charmaz, 1980). At this juncture, thoughts and feelings for significant others who will be most affected by the decision become secondary.

Whereas social and emotional isolation emphasize the continuing loss of connections with the self and world, interpersonal conflict may serve to hasten the loss of these connections. Interpersonal conflict was evident in some interviews, although it was not a major theme in any. Instead, the data suggested satisfactory relationships with significant others for most. This is in contrast to the literature supporting interpersonal problems as antecedents in many suicide attempts (Hinrichsen & Hernandez, 1993; Zwieg & Hinrichsen, 1993). In this study, both a sense of connectedness and a feeling of obligation to family members may have remained intact and hence remained a barrier for attempting suicide. Alternatively, social and personal values may preclude suicide as an

acceptable death. It is also possible that interpersonal conflict may just not been addressed by informants during the interviews.

Decision-Making

The decision-making literature was not helpful overall for informing this study. Janis and Mann (1977) developed a rational choice model based on seven discrete steps needed to make a decision among alternative actions. Three of the steps were in evidence in decision-making in suicidality. It was apparent that informants had considered some alternative courses of action, were weighing the risks of negative and positive consequences, and had made plans towards the implementation of the chosen course of action. However, a consideration of all alternatives is glaringly absent for most of the informants. This raises the question of whether depression compromises decision-making. In previous research, depression is thought to compromise decision-making, however few studies have been done to support this (Lee & Ganzini, 1992). Furthermore, depression as a cause for treatment refusal is difficult to evaluate (Applebaum & Roth, 1981). Those with terminal or chronic illnesses may have a rational desire to die or to avoid prolonging death (Sullivan, 1998). The study findings lend credence to this point of view for informants who had terminal illnesses.

Ambivalence

There is thought to be less ambivalence in late life suicide. Older adults are more serious and certain in their desire to die (Hassan, 1995). This contention is largely supported in suicide notes left behind and the selection of suicide method. There were

some clues to lethality in the data. In this study, many of the informants discussed possible methods for suicide. Six of the informants identified guns, a very lethal method, as the method of choice. Despite this, ambivalence was present. Of the informants who had stated a gun would be the preferable method of choice, the two individuals who owned guns, hid them so as to provoke reconsideration of suicidal urges. There were other indications of implicit ambivalence in the data, such as a fear of making an unsuccessful suicide attempt. In Stage Three of the BSPP, it was clear that ambivalence is the key to the outcome of suicidality. A balancing act occurs between triggers and barriers and at each decision point at a given time, factors may weight the continuum on one side or another. Many suicide attempts reflect an individual's ambivalence about dying.

Ambivalence may be in part attributed to a fear of death. This may take form in fearing the unknown, fearing the process of dying, and a fear of ceasing to be (Shneidman, 1996). Death emphasizes finality and is the ultimate loss of the self. Fear of death has antecedents in social and cultural structures. In American society, individualism heightens awareness of the self and connotes separateness from community. Through this mechanism, individualism is conjectured to instill a sense of aloneness. Hence, the ultimate form of aloneness is dying (Charmaz, 1980). Despite a desire to die, there was a persistence of both tangible and unconscious barriers noted across interviews. It is likely informants were at various points across the continuum of suicide, with some having fewer barriers and some being more ready to die than others.

Perhaps, as connections of the self with the world are loosened, making the decision to die becomes easier. Before ambivalence can be characterized for study informants, an examination of ambivalence would be necessary to draw conclusions about their fear of dying.

Summary

This section summarized the integration of study findings with the literature reviewed both prior to and during the research process. The original literature review included risk factors for suicide, ageism, decision-making, and self-disclosure. The self-disclosure literature fits better with implications for nursing practice and will be discussed in that section. Subsequent literature reviews encompassed recent studies on suicide in late life, symbolic interactionism, and non-fiction works on depression and suicide. For this study, risk factors were conceptualized as types of loss. As such, their impact on late-life suicidality was discussed. In the BSPP, *Losing Connections*, ambivalence determines the outcome of suicidality. It balances triggers for SI and barriers against suicide. As long as ambivalence is present, the individual will decide to postpone killing himself. The findings of this study supported loss, including physical illness, depression, the need for a confidant, and hopelessness as potential risk factors. However, social isolation was not supported as a risk factor.

Theoretical Framework

Findings of this study were congruent with the theoretical frameworks of symbolic interactionism, life span development, and Newman's ideas on evolving

patterning. The symbolic interactionist viewpoint is congruent with the study findings and was integrated into the previous discussion. In a developmental perspective, human development can occur in late life despite the declines associated with aging. Development occurs throughout the life span, not only in youth (Reed, 1983). In the context of aging, development is related to the ability to trade old behaviors that were useful at a young age for those more useful in aging. If old behaviors are not traded for new ones, the older adult is at risk for depression and suicide. This is applicable to current study findings in that it appears most of the informants had not been able to trade old behaviors for assets that would enrich aging. For all, losses were cumulative, but unresolved. Personal losses such as retirement, illness, disability, and those of family and friends, require an ability to cope with the loss and transform these experiences into energy for development. If this does not occur, depression and suicidality may result.

The pattern of loss over the life span was recognizable in the data. Not only had losses accelerated with aging, but it was apparent many had experienced losses earlier in life and had not resolved them. Several of the informants recounted events during childhood, such as working like a laborer as a child and still wearing shoes with holes in them. Similarly, there was a symbolic loss of a father through desertion and a loss of the self for one man who felt alienated from his family. Clearly these memories of 60 or more years ago were still painful enough to evoke recollection during a brief interview with a stranger. Also, the idea that unresolved losses return and demand attention was supported. For other informants, there were losses as they entered the military, engaged

in combat, and were discharged to resume their lives. There were losses of innocence and crises of faith values- truly life changing losses. The pattern for each informant's life was a compilation of past experiences and current experiences that would unfold in the future. As such, these men had potential for growth, but were entrenched in the losses of the past and the present. Few harbored expectations for future contentment and wellness.

According to Newman (1979), illness or disease is a meaningful manifestation of the underlying pattern rather than something to be eradicated. The pattern is indicative of what is going on in an individual's life and the resultant state is one that is not communicated in any other way. In this case, depression and suicidality were a manifestation of patterning evolving over the life span. They were not discrete, but rather a compilation of life experiences that have evolved into the current state of alienation, depression, despair, and suicidality. If the pattern is unrecognizable to the individual, they may not be able to evolve to higher levels of consciousness nor transform loss into further development.

Implications for Nursing Theory

Grounded theory has the potential to contribute to nursing knowledge through the exploration of complex nursing phenomena in a naturalistic setting. This method explores the richness in the human experience while contributing to the development of nursing theory (Streubert & Carpenter, 1995). Furthermore, grounded theory can be instrumental is gaining a perspective on the whole, as patterns unfold over time during the course of the life span.

This research was contributory to nursing by identifying a BSPP that included loss, life span issues in aging, depression, and suicidality. Illness, whether it is physical or mental, is a compilation of experiences that preceded the onset and the experiences yet to come. As such, it cannot be studied in isolation or as one event in time. Further research on processes in suicidality may result in developing the BSPP into a grounded theory.

The benefit of understanding suicidality is in providing new insights about prevention, intervention, and enhancement of quality of life for older adults. Appreciating subjective viewpoints on suicidality and how suicide becomes an option may expand the nursing profession's understanding of interpersonal and social interactions inherent in suicidal processes. Furthermore, valuing the individual's experience will assist nurses in developing treatment plans that are focused in meeting the needs of individual elders. Continued refinement of these personal perspectives may help nurses develop middle range theories directed at assisting older adults to manage depression and/or use developmental resources to enhance their quality of life.

Implications for Nursing Research

Using qualitative methods of inquiry can enhance development of nursing knowledge through congruence with philosophical and theoretical perspectives of the discipline. They enhance other methods by explicating wholeness (Newman, 1979). This wholism is not only individual, but also collective, related to the context of community. As such, social processes can be identified as integral components of illness, depression, and suicide. Newman (1979) described praxis as a research methodology in which the

researcher is part of the interaction with the client in promoting pattern recognition and choice. In this role, the researcher focuses on the most meaningful persons and events in the interviewee's life. The interaction between the researcher parallels the interaction between client and clinician in the practice setting.

The BSPP identified was *Losing Connections*. This study was an effort to define the subjective experience of the individual as they become depressed and contemplate suicide. It was a beginning effort and as such warrants further research in order to more fully explicate decision-making in late life suicidality. Due to the complexity of suicide, explication of this experience will require time and refining of initial research. Although the major variables of loss and depression were saturated, further in-depth inquiry would contribute both to supporting this BSPP and a more comprehensive explication of the processes surrounding suicidality. From the research perspective, developing theory is the objective so that the identified processes surrounding suicidality can be used as guides in developing suicide prevention and intervention strategies.

Specific questions to help clarify the BSPP of *Losing Connections* should include:

1) How did older adults cope with losses earlier in the life span?
2) What factors move an individual farther along the suicide path as they consider suicide?
3) What information is needed by the individual to overcome ambivalence before attempting suicide?
4) How do individuals define the experience of ambivalence?

The study sample and hence findings were restricted to older white men with SI. This was a strength of the study as white men are at the highest risk for suicide in late life. Further research is recommended with this cohort of white men to support and further refine the BSPP. Also, future research is recommended with older women and those of different cultural heritage to explore similarities and dissimilarities in the process of *Losing Connections*. Religious beliefs emerged as a theme in the data. Further exploration of beliefs and the connection with suicidality may provide additional information important in evaluating risk in older adults.

Implications for nursing research were summarized and recommendations to refine the BSPP were reviewed in this section.

Implications for Nursing Practice

As Newman (1979) suggested, pattern recognition is the key to evolving to higher levels of consciousness. When patterns are identified, the possibilities for action are illuminated and the individual can see possibilities for growth and movement. The nurse facilitates this process by connecting with the client in an authentic way for the purpose of illuminating the pattern and assisting the client to mobilize their resources for growth and development.

The implications of study findings are that current strategies for detecting and treating depression in older adults are not enough. Although depression screening may be successful in identifying older adults who are depressed, it is too simplistic an approach. Depression screening often results in placing an individual on medication with a promise

of recovery. However, without a comprehensive evaluation of individual and social characteristics involved in the process of becoming depressed, the likelihood of reestablishing equilibrium and promoting growth is slender. Once these processes or patterns are identified, an individualized approach is imperative to assist older adults to move from the depths of depression to a place of contentment and growth.

An individualized approach to treatment must include individual psychotherapy or talk therapy during which life span issues are discussed and possibilities for reconciliation are reviewed. Eliciting personal perspectives of life experiences is integral to identifying patterning and how opportunities for future growth can be employed. Regardless of the level of the person's disease or disability (Newman, 1979), the key to their pattern is interpersonal relationships. Through facilitation by the nurse, interactions with others can be explored and rules for engaging in reciprocal relationships may be discovered.

Self-disclosure is viewed as a fundamental process for building and maintaining interpersonal relationships. It is integral to establishing trust between client and clinician. Without it, the clinician cannot appropriately evaluate suicide risk. Barriers to self-disclosure are a decreased ability to do so because of a lack of social skills, fear that negative and/or embarrassing thoughts will result in rejection by the listener, and a need to maintain personal boundaries (Kowalski, 1999). Recent research suggested that depression may confound self-disclosure, however this did not appear to be the case in this study. The informants appeared to be candid and forthcoming during interviews.

Furthermore, most expressed an opinion that they were pleased to have someone take an interest in them. This finding provides some assurance to health care professionals that older adults are not only capable of self-disclosure, but are pleased to be given the opportunity to discuss sensitive thoughts and feelings including those concerning depression and suicidality. This has implications for suicidality intervention with in older adults.

Another clear benefit of psychotherapy or talk therapy was that individuals considered their therapist to be a confidant. Indeed, she was often the only person the older adult considered to be a confidant in their lives. The therapist was viewed as a beacon in the storm. This speaks to the emotional isolation and loneliness of many older, depressed individuals. The benefits of talk therapy to the depressed individual may be multiple, including a non-judgmental confidant and professional relationship focused on facilitating a resolution of their depression. It bears mentioning that not all suicidal older adults are depressed, however all of the men in this study were on antidepressant therapy and had been diagnosed as depressed.

Through an explication of the processes identified in *Losing Connections*, nurses may have a better understanding how older adults define and experience depression. Similarly, understanding the processes surrounding suicidality and addressing them may lead to improved outcomes for older adults. Before the nurse can assist the client in identifying patterning, an exploration of life span development and life experiences of the individual must be reviewed.

In this section, implications for nursing practice were summarized. Newman's (1979) theory provided one of the frameworks for this study. Her ideas on pattern recognition in illness highlight the importance of the nurse-client interaction for depressed and suicidal older adults. Talk therapy provides an opportunity to identify patterning in illness and as such is recommended as the most important modality in managing depression and suicidality.

Summary of Chapter Five

In this chapter, study findings were discussed and integrated with extant research. The BSPP, *Losing Connections*, was reviewed in stages. Extant research was useful in highlighting risk factors in late life suicidality, ageist attitudes as internalized by elders, and the value of self-disclosure in the nurse-client relationship. The literature of decision-making was non-specific and unhelpful in identifying decision-making in suicidality. Implications for nursing theory, nursing research, and nursing practice were presented in this chapter. This grounded theory study contributed to the development of nursing knowledge by explicating personal perspectives of depression and suicidality in late life. However, much work needs to be done to clarify and formalize the process of *Losing Connections*. Further research is suggested with older men, women, and those of ethnic minority groups to discern similarities and differences in depression and suicidal processes. Finally, implications for practice were identified and included the benefits of individualized psychotherapy for depression, developing a therapeutic relationship with

depressed clients to promote pattern identification, and the value for the client of having a confidant.

APPENDIX A: DEMOGRAPHIC INFORMATION

Demographic Information

1. Age
2. Marital Status
3. Do you have children? How would you characterize your relationships with them?
4. Type of Occupation (s).
5. Do you drink alcohol? Did you in the past? Was it ever a problem for you?
6. Do you have any health problems? Do they interfere with daily activities or quality of life?
7. Current medications.
8. Do you have a confidant?

APPENDIX B: MINI-MENTAL STATE EXAM

Mini-Mental State

I. Orientation

1. Date
2. Year
3. Month
4. Day
5. Season
6. Clinic (Hospital)
7. Floor
8. City (Town)
9. County
10. State

I. Registration

1. "Ball"
2. "Car"
3. "Man"
4. Number of trials

II. Attention

5. D
6. L
7. R
8. O
9. W

III. Recall

10. "Ball"
11. "Car"
12. "Man"

IV. Language

13. Watch
14. Pencil
15. Repetition

16. Takes paper in right hand
17. Folds paper in half
18. Puts paper on floor
19. Closes eyes
20. Writes sentence
21. Draws pentagons

Total Score:

Adapted from Folstein, M.F., Folstein, S.E., McHugh, P.R. (1975).

APPENDIX C: SCREENING TESTS-

SCORES ON MMSE AND GDS

Screening Tests: Scores on MMSE and GDS

Name	*Age*	*MMSE*	*GDS*
Ralph	83	30	16
Rick	76	30	27
Leo	74	30	16
Carl	69	29	28
Jay	67	30	17
Jack	80	30	8
Sid	77	30	15
Don	73	28	22
Jake	80	26	28
Gerry	75	30	8
Carroll	79	30	14
Roger	81	30	9
Pete	76	27	21

APPENDIX D: GERIATRIC DEPRESSION SCALE

Geriatric Depression Scale

		Yes	No
1.	Are you basically satisfied with you life?		
2.	Have you dropped many of your activities and interests?		
3.	Do you feel that you life is empty?		
1.	Do you often get bored?		
2.	Are you hopeful about the future?		
3.	Are you bothered by thoughts you can't get out of your head?		
4.	Are you in good spirits most of the time?		
5.	Are you afraid that something bad is going to happen to you?		
6.	Do you feel happy most of the time?		
7.	Do you often feel helpless?		
8.	Do you often get restless and fidgety?		
9.	Do you prefer to stay ah home, rather than going out and doing new thing?		
10.	Do you frequently worry about the future?		
11.	Do you feel you have more problems with memory than most?		
12.	Do you think it is wonderful to be alive now?		
13.	Do you often feel downhearted and blue?		
14.	Do you feel pretty worthless the way you are now?		
15.	Do you worry a lot about the past?		
16.	Do you find life very exciting?		
17.	Is it hard for you to get started on new projects?		
18.	Do you feel full of energy?		
19.	Do you feel that your situation is hopeless?		
20.	Do you think that most people are better off than you are?		
21.	Do you frequently get upset over little things?		
22.	Do you frequently feel like crying?		
23.	Do you have trouble concentrating?		
24.	Do you enjoy getting up in the morning?		
25.	Do you prefer to avoid social gatherings?		
26.	Is it easy for you to make decisions?		
27.	Is your mind as clear as it used to be?		

0-9: Normal
10-19: Mild depression
20-30: Severe depression

Adapted from Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., & Adey, V.O. (1983).

APPENDIX E: STUDY CONSENT FORM

University of Arizona, College of Nursing
Subject's Consent Form

DECISION-MAKING PROCESSES IN ELDERLY...

I AM BEING ASKED TO READ THE FOLLOWING MATERIAL TO ENSURE THAT I AM INFORMED OF THE NATURE OF THIS RESEARCH STUDY AND OF HOW I WILL PARTICIPATE IN IT, IF I CONSENT TO DO SO. SIGNING THIS FORM WILL INDICATE THAT I HAVE BEEN SO INFORMED AND THAT I GIVE MY CONSENT. FEDERAL REGULATIONS REQUIRE WRITTEN INFORMED CONSENT PRIOR TO PARTICIPATION IN THIS RESEARCH STUDY SO THAT I CAN KNOW THE NATURE AND THE RISKS OF MY PARTICIPATION AND CAN DECIDE TO PARTICIPATE OR NOT PARTICIPATE IN A FREE AND INFORMED MANNER.

PURPOSE

I am being invited to voluntarily participate in the above titled project. The purpose of this project is to gather information about suicidal thoughts. This information may assist nurses and other health professionals in better meeting the needs of elderly people.

SELECTION CRITERIA

I am invited to participate in this study because I have or have had suicidal thoughts at times, I am 65 years or older, speak English, am receiving ongoing mental health care for suicidal thoughts, and have no history of psychotic mental health problems or dementia.

PROCEDURE

If I agree to participate in this study, I will be asked to consent to the following:
I will be asked to discuss my thoughts about suicide in as much detail as possible, including my feelings and reasons for attempting or not attempting suicide. I will also be asked to complete 3 questionnaires giving information about myself. I understand that my interview will be audiotaped and transcribed by a typist. The taped interview will be erased after being transcribed. The interview will take approximately 2-2.5 hours of my time.

Prior to the interview, I will be asked some demographic information including age, race, marital status, financial status, and health history. The interview will take approximately one to two hours and will be held in a private setting at a time and location that is convenient for me. The questionnaires will take approximately one to one and a half hours of my time to complete. I understand that I may stop the interview at any time and can end my participation in this study if I so wish without causing any bad feelings or affecting my medical care. I am free to ask questions and receive answers at any time throughout this study.

BENEFITS

The benefit of participating in this study is the chance to share my thoughts and experiences. An indirect benefit is that information from this study may assist nurses to better understand suicidal thoughts in persons in my age group and help them to better assist people my age in dealing with our thoughts and feelings.

RISKS

The risk associated with this study is possible emotional upset while sharing my thoughts and feelings.

CONFIDENTIALITY

All information associated with this study will be held in confidence and only Linda Phillips, PhD,RN, Terry Badger, PhD, RN, Pam Reed, PhD, RN, MaryAnn Bell, MS, RN, and the transcriptionis will have access to the information. If I share information with the researcher during the interview that I am actively considering suicide or if I believe that I am a danger to myself, the investigator will be obliged to share this information with my health care provider, Dr. Anita Goss. When the data are reported, no identification of my participation will be made. I will be assigned an alias to protect confidentiality and there will be no information in the transcribed interview that may identify me. I understand that the information from this study may be presented at conferences or in journals but that I will not be identified. Data will be kept in a locked place for possible further analysis.

PARTICIPATION COSTS AND SUBJECT COMPENSATION

The only cost for me to particpate in this study will be my time. There are no monetary payments for participation in this study.

LIABILITY

I understand that side effects or harm are possible in any research program despite the use of high standards of care and could occur through no fault of mine or the primary investigator. Known side effects have been described in this consent form. However, unforeseeable harm may also occur and require care. I understand that money for research-related side effects or harm, or for wages or time lost, is not available. I do not give up any of my legal rights by signing this form. Necessary emergency medical care will be provided without cost. I can obtain further information from Mary Ann Bell, RN at (520)-626-6151. If I have questions concerning my rights as a research subject, I may call the Human Subjects Committee office at 626-6721.

AUTHORIZATION

BEFORE GIVING MY CONSENT BY SIGNING THIS FORM THE METHODS, INCONVENIENCES, RISKS, AND BENEFITS HAVE BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED. I UNDERSTAND THAT I MAY ASK QUESTIONS AT ANY TIME AND THAT I AM FREE TO WITHDRAW FROM THE PROJECT AT ANY TIME WITHOUT CAUSING ILL FEELINGS OR AFFECTING MY CARE. MY PARTICIPATION IN THIS PROJECT MAY BE ENDED BY THE INVESTIGATOR FOR REASONS THAT WOULD BE EXPLAINED. NEW INFORMATION DEVELOPED DURING THE COURSE OF THIS STUDY WHICH MAY AFFECT MY WILLINGNESS TO CONTINUE IN THIS RESEARCH PROJECT WILL BE GIVEN TO ME AS IT BECOMES AVAILABLE. I UNDERSTAND THAT THIS CONSENT FORM WILL BE FILED IN AN AREA DESIGNATED BY THE HUMAN SUBJECTS COMMITTEE WITH ACCESS RESTRICTED TO THE PRINCIPAL INVESTIGATOR, MARY ANN BELL, MS, RN, OR AUTHORIZED REPRESENTATIVE OF THE NURSING DEPARTMENT. I UNDERSTAND THAT I DO NOT GIVE UP ANY OF MY LEGAL RIGHTS BY SIGNING THIS FORM. A COPY OF THIS SIGNED CONSENT FORM WILL BE GIVEN TO ME.

_____ _____

Subjects's Signature Date

_____ _____

Witness Signature Date

INVESTIGATOR'S AFFIDAVIT

I have carefully explained to the subject the nature of the above project. I hearby certify that to the best of my knowledge the person who is singing this consent form understands clearly the nature, demands, benefits, and risks involved in his/her participation and his/her signature is legally valid. A medical problem or language or educational barriers has not precluded this understanding.

_____ _____

Signature of Investigator Date

APPENDIX F: HUMAN SUBJECTS FORM

Human Subjects Committee

THE UNIVERSITY OF
ARIZONA.
HEALTH SCIENCES CENTER

1622 E.
P.O. Box
Tucson,
(520) 626-6721

14 April 1998

Mary Ann Bell, R.N.,M.S.
College of Nursing
PO BOX 210203

RE: HSC #98-76 DECISION-MAKING PROCESSES CONCERNING SUICIDE IN ELDERLY PERSONS

Dear Ms. Bell:

We received your 8 April 1998 letter and accompanying revised consent form for the above referenced project. All of the conditions as set out in our 31 March 1998 letter to you have been met. Therefore, **full Committee approval** for this subjects-at-risk project is granted effective 14 April 1998 for a period of one year.

The Human Subjects Committee (Institutional Review Board) of the University of Arizona has a current assurance of compliance, number M-1233, which is on file with the Department of Health and Human Services and covers this activity.

Approval is granted with the understanding that no further changes or additions will be made either to the procedures followed or to the consent form(s) used (copies of which we have on file) without the knowledge and approval of the Human Subjects Committee and your College or Departmental Review Committee. Any research related physical or psychological harm to any subject must also be reported to each committee.

A university policy requires that all signed subject consent forms be kept in a permanent file in an area designated for that purpose by the Department Head or comparable authority. This will assure their accessibility in the event that university officials require the information and the principal investigator is unavailable for some reason.

Sincerely yours,

WFDenny

William F Denny, M.D.
Chairman
Human Subjects Committee

WFD:rs

cc: Departmental/College Review Committee

APPENDIX G: APPROVAL OF INTERNAL REVIEW BOARD OF THE DEPARTMENT OF VETERANS AFFAIRS

Department of Veterans Affairs

Memorandum

Date: May 28, 1998

From: Research HCG (0-151)

Subj: Project Approval

To: Mary Ann Bell, M.S.

The Research and Development Committee discussed and approved your proposal entitled, "Desicion Making Processes in Elderly Suicide" at its meeting of May 27, 1998. Your project has been assigned #0001.

Harinder Garewal, M.D., Ph.D.

REFERENCES

Achte, K. (1988). Suicidal tendencies in the elderly. Suicide and Life Threatening Behavior, 18(1), 55-65.

Adler, P.A., & Adler, P. (1994). Observational techniques. In N.K. Denzin and Y.S. Lincoln (Eds.), Handbook of qualitative research (pp. 377-392). Thousand Oaks, CA: Sage.

Aldridge, D. (1998). Suicide- The tragedy of hopelessness. Philadelphia: Jessica Kingsley Publishers.

Alegria, M., Robles, R., Freeman, D.H., Vera, M., Jimenez, A.L., Rios, C., & Rios, R. (1991). Patterns of mental health utilization among island Puerto Rican poor. American Journal of Public Health, 81(7), 875-879.

Alston, M.H., Rankin, S., & Harris, C.A. (1995). Suicide in African American elderly. Journal of Black Studies, 26, 31-35.

Alvarez, A. (1971). The savage God. New York: Bantam Books.

Appelbaum, P.S., & Grisso, T. (1998). Assessing competence to consent to treatment. A guide for physicians and other health professionals. New York: Oxford University Press.

Appelbaum, P.S., & Roth, L.H. (1981). Clinical issues in the assessment of competency. American Journal of Psychiatry, 138, 1462-1467.

Arango, V., Underwood, M.D., & Mann, J.J. (1997). Biologic alterations in the brainstem of suicides. Psychiatric Clinics of North America, 20(3), 581-593.

Arve, S., Lauri, S., Lehtonen, A., & Tilvis, R.S. (1999). Patient's and general practitioner's different view on patient's depression. Archives of Gerontology and Geriatrics, 28, 247-257.

Atkinson, P., & Hammersley, M. (1994). Ethnography and participant observation. In N.K. Denzin & Y.S. Lincoln (Eds.), Handbook of qualitative research (pp. 248-261) Thousand Oaks: Sage Publications.

Badger, T.A. (1993). Physical health impairment and depression among older adults. IMAGE: Journal of Nursing Scholarship, 25(4), 325-330.

Barraclough, B.M. (1971). Suicide in the elderly. British Journal of Psychiatry (special suppl.), 6, 87-97.

Barraclough, B.M., & Hughes, J. (1987). Suicide. London: Croom Helm.

Bayles, K.A, & Kaszniak, A.W. (1987). Communication and cognition in normal aging and dementia. Boston: College-Hill/Little, Brown.

Beck, A.T. (1967). Depression: Clinical, experimental, and theoretical aspects. New York: Harper & Row.

Beck, A.T. (1972). Depression: Causes and treatment. Philadelphia: University of Pennsylvania Press.

Beck, A.T., Kovacs, M., & Weisman, A. (1979). Assessment of suicidal intention: The Scale for Suicidal Ideation. Journal of Consulting and Clinical Psychology, 47, 343-352.

Beck, A.T., Steer, R.A., Beck, J.S., & Newman, C.E. (1993). Hopelessness, depression, suicidal ideation, and clinical diagnosis of depression. Suicide and Life-Threatening Behavior, 23, 139-145.

Bell, M.A. (1998). Decision-making processes in late life suicide. Unpublished pilot study.

Berube, M.S. (Ed.) (1982). American Heritage Dictionary (2nd Ed.). Houghton Mifflin Company: Boston.

Black, D.W., & Winokur, G. (1986). Prospective studies of suicide and mortality in psychiatric patients. Annals of the New York Academy of Sciences, 487, 106-113.

Blixen, C.E., Wilkinson, L.K., & Schuring, L. (1994). Depression in an elderly clinic population: Findings from an ambulatory care setting. Journal of Psychosocial Nursing, 32(6), 43-49.

Blumer, H. (1969). Symbolic interactionism. Engelwood Cliffs, N.J.: Prentice-Hall.

Bohm, D. (1980). Wholeness and the implicate order. London: Routledge.

Breed, W., & Huffine, C.L. (1979). Sex differences among older white Americans: A role and developmental approach. In O. Kaplan (Ed.), Psychopathology of aging (pp. 289-309). New York: Academic Press.

Brown, J.H., Henteleff, P., Barakat, S., & Rowe, C.J. (1986). Is it normal for terminally ill patients to desire to die? American Journal of Psychiatry, 143(2), 208-211.

Buchanan, D.M. (1991). Suicide: A conceptual model for an avoidable death. Archives of Psychiatric Nursing, 5(6), 341-349.

Buchanan, A.E., & Brock, D.W. (1989). Deciding for others: The ethics of surrogate decision-making. Cambridge, UK: Cambridge University Press.

Burbank, P.M. (1992). An exploratory study: Assessing the meaning in life among older adult clients. Journal of Gerontological Nursing, 9, 19-28.

Burvill, P.W. (1995). Suicide in the multiethnic elderly population of Australia, 1979-1990. International Psychogeriatrics, 7, 319-333.

Butler, R.N. (1994). Dispelling ageism: The cross-cutting intervention. In D. Shenk & W. Achenbaum (Ed.), Changing perceptions of aging and the aged. New York: Springer.

Butler, R.N., Lewis, M.I., Sunderland, T. (1998). Aging and mental health. Positive psychosocial and biomedical approaches. Boston: Allyn & Bacon.

Callahan, C.M., Hendrie, H.C., Dittus, R.S., Brater, D.C., Hui, S.L., & Tierney, W.M. (1994). Improving treatment of late life depression in primary care: A randomized clinical trial. Journal of the American Geriatric Society, 42, 839-846.

Camus, A. (1955). The myth of Sisyphus and other essays. New York: Random House, Vintage Books.

Canetto, S.S. (1992). Gender and suicide in the elderly. Suicide and Life-Threatening Behavior, 22(1), 80-97.

Canetto, S.S. (1995). Elderly women and suicidal behavior. In S.S. Canetto & D. Lester, Focus on women (pp.215-233). New York, NY: Springer Publishing Co. Inc.

Canetto, S.S., & Lester, D. (1995). Women and suicidal behavior. Issues and Dilemmas. In S.S. Canetto and D. Lester (Eds.), Women and suicidal behavior (pp. 3-8). New York: Springer.

Canetto. S.S., & Sakinofsky, I. (1998). The gender paradox in suicide. Suicide and Life-Threatening Behavior, 28(1), 1-23.

Carraci, G, & Miller, N.S. (1991). Epidemiology and diagnosis of alcoholism in the elderly. International Journal of Geriatric Psychiatry, 6, 511-5.

Carpenter, B.N. (1987). The relationship between psychopathology and self-disclosure: An interference/competence model. In V.J. Derlega & J.H. Berg (Eds.), Self-disclosure: Theory, research, and therapy (pp. 203-228). New York: Plenum.

Cattell, H.R. (1988). Elderly suicide in London: an analysis of coroner's inquest. International Journal of Geriatric Psychiatry, 3, 251-261.

Chance, S.E., Kaslow, N.J., Summerville, M.B., & Wood K. (1998). Suicidal behavior in African American individuals: Current status and future directions. Cultural Diversity and Mental Health, 4(1), 19-37.

Charmaz, K. (1980). The social reality of death. Reading, MA: Addison-Wesley Publishing Company.

Clark, D.C. (1993). Narcissistic crises of aging and suicidal despair. Suicide and Life-Threatening Behavior, 23(1), 21-26.

Clum, G.A., & Lerner, M. (1990). A problem-solving approach to treating individuals at risk for suicide. In D. Lester (Ed.), Current concepts of suicide. Philadelphia: The Charles Press.

Cohen, G.D. (1993). African American issues. Geriatric Psychiatry & Neurology, 6, 195-199.

Cohen, F., & Lazarus, R. (1979). Coping with the stresses of illness. In G. Stone, F. Cohen, & N. Adler (Eds.), Health and psychology: A handbook (pp. 217-255). San Francisco: Jossey-Bass.

Conwell, Y., Caine, E.D., & Olsen, K. (1990). Suicide and cancer in late life. Hospital and Community Psychiatry, 41(12), 1334-1339.

Conwell, Y., Duberstein, P.R., Cox, C., Herrmann, J., Forbes, N., & Caine, E.D. (1998). Age differences in behaviors leading to completed suicide. The American Journal of Geriatric Psychiatry, 6(2), 122-126.

Costa, P.T., & McCrae, R.R. (1992). NEO PI-R professional manual: Revised NEO Personality Inventory (NEO-PI-R) and NEO Five-Factor Inventory. Odessa, FL: Psychological Assessment Resources.

Coupland, M., Coupland, J., & Giles, H. (1991). Language, society and the elderly: Discourse, identify, and aging. Cambridge, MA: Basil Blackwell.

Courage, D.M., Godbey, K.L., Ingram, D.A., Schramm, L.L., & Hale, W.E. (1993). Suicide in the elderly: Staying in control. Journal of Psychosocial Nursing, 31(7), 26-31.

Cowgill, D. (1974). Aging and modernization. In J. Gubrium (Ed.), Late life, communities, and environmental policy. Springfield, IL: Charles C. Thomas.

Cummings, J.L., & Benson, D.F. (1992). Dementia: A clinical approach (2nd ed.). Boston: Butterworth-Heinemann.

Davies, J.L., & Janosik, E.H. (1991). Mental health and psychiatric nursing. Boston: Jones & Bartlett.

Deluty, R.L. (1989). Factors affecting the acceptability of suicide. Omega, 19, 315-326.

Denzin, N.K. (1989). Interpretive interactionism. Newbury Park, CA: Sage.

Denzin, N.K., & Lincoln Y.S. (Eds.). (1994). Handbook of Qualitative Research. Thousand Oaks, California: Sage Publications.

Diekstra, R.F.W. (1998). In D. DeLeo, A. Schmidtke, & R.F.W. Diekstra (Eds.), Suicide prevention: A holistic approach. Boston: Kluwer Academic.

Douglas, J.D. (1967). The social meaning of suicide. Princeton, N.J.: Princeton University Press.

Draper, B. (1996). Attempted suicide in old age. International Journal of Geriatric Psychiatry, 11, 577-587.

Draper, B. (1994). Suicidal behavior in the elderly. International Journal of Geriatric Psychiatry, 9, 655-661.

Duberstein, P.R. (1995). Openness to experience and completed suicide across the second half of life. International Psychogeriatrics, 7(2), 183-198.

Duberstein, P.R., Conwell, Y., Seidlitz, L., Lyness, J.M., Cox, C., & Caine, E.D. (1999). Age and suicidal ideation in older depressed inpatients. American Journal Geriatric Psychiatry, 7(4), 289-296.

Durkheim, E. (1951). Suicide: A study in sociology. New York: Plenum Press. (first published in 1897).

Eaton, W.W., Kramer, M., Anthony, J.C., Dryman, A., Shapiro, S., & Locker, B.Z. (1989). The incidence of specific DIS/DSM-III mental disorders: Data from the NIMH Epidemiologic Catchment Areas Program. Acta Psychiatrica Scandinavica, 79, 163-178.

Eisenberg, L. (1992). Treating depression and anxiety in primary care. New England Journal of Medicine, 14, 237-247.

Emblen, J.D. (1992). Religion and spirituality defined according to current use in nursing literature. Journal of Professional Nursing, 8(1), 41-47.

Englund, E., Brun, A., & Gustafson, L. (1989). A white matter disease in dementia of Alzheimer's type- clinical and neuropathological correlates. International Journal of Geriatric Psychiatry, 4, 87-102.

Fillenbaum, G.G., George, L.K., & Palmore, E.B. (1985). Determinants and consequences of retirement among men of different races and economic levels. Journal of Gerontology, 40, 85-94.

Fineman, N. (1994). Health care providers' subjective understandings of old age: Implication for threatened status in late life. Journal of Aging Studies, 8, 255-270.

Firestone, R.W. (1997). Suicide and the inner voice. Risk Assessment, Treatment, and Case Management. Thousand Oaks, CA: Sage Publications.

Fishbain, D.A., Goldberg, M., Meagher, R.B., Steele, R., & Rosomoff, H. (1986). Male and female chronic pain patients categorized by DSM-II criteria. Pain, 26, 181-197.

Folstein, M.F., Folstein, S.E., & McHugh, P.R. (1975). "Mini-Mental State": A practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research, 12, 189-198.

Forbes, S., & Hoffart, N. (1998). Elders'decision making regarding the use of long-term care services: A precarious balance. Qualitative Health Research, 8(6), 736-750.

Frankl, V. (1959). Man's search for meaning. New York: Beacon Press.

Frankl, V. (1984). Man's search for meaning. New York: Washington Square.

Fremouw, W.J., de Perczel, M., & Ellis, T.E. (1990). Suicide Risk- Assessment and response guidelines. New York: Pergamon Press.

Freud, S. (1935). A general introduction to psychoanalysis. New York: Simon and Schuster.

Garden, F.H., Garrison, S.J., & Jain, A. (1990). Assessing suicide risk in stroke patients: Review of two cases. Archives of Physical Medicine Rehabilitation, 71, 1003-1005.

Garrison, C.Z. (1992). Demographic predictors of suicide. In R.W. Maris, A.L. Berman, J.T. Maltsberger, & R.I. Yufit, Assessment and prediction of suicide (pp. 484-498). New York: The Guilford Press.

Glaser, B.G. (1978). Theoretical sensitivity. Mill Valley, CA: The Sociology Press.

Glaser, B.G. (1992). Basics of grounded theory analysis. Mill Valley, CA: Sociology Press.

Glaser, B.G., & Strauss, A.L. (1967). The discovery of grounded theory-Strategies for qualitative research. Chicago: Aldine Publishing Company.

Glasser, W. (1965). Reality therapy: A new approach to psychiatry. New York: Harper & Row.

Goodstein, D., & Reinecker, V.M. (1974). Factors influencing self-disclosure: A review of the literature. In B.A. Maher (Ed.), Progress in experimental personality research (pp. 49-77). New York: Academic Press.

Gordon, W.A., & Hibbard, M.R. (1997). Poststroke depression: An examination of the literature. Archives in Physical Medicine & Rehabilitation, 78, 658-663.

Griffith, E.H. (Chairman). (1989). Suicide and ethnicity in the United States. Group for the Advancement of Psychiatry. New York, NY: Brunner/Mazel, Inc.

Grisso, T., & Appelbaum, P.S. (1995). Comparison of standards for assessing patient's capacities to make treatment decisions. American Journal of Psychiatry, 152(7), 1033-1037.

Grisso, T., & Appelbaum, P.S. (1998). Assessing competence to consent to treatment. New York: Oxford University Press.

Guba, E.S., & Lincoln, Y.S. (1981). Effective evaluation. San Francisco: Jossey-Bass.

Haight, B.K., & Hendrix, S.A. (1998). Suicidal intent/life satisfaction: Comparing the life stories of older women. Suicide and Life-Threatening Behavior, 28(3), 272-284.

Harber, K.D., & Pennebaker, J.W. (1992). Overcoming traumatic memories. In S.A. Christianson (Ed.), The handbook of emotion and memory (pp. 359-387). Hillsdale, NJ: Erlbaum.

Hassan, R. (1995). Suicide explained. Australia: Melbourne University Press.

Hillman, J. (1964). Suicide and the soul. New York: Harper & Row.

Hinrichsen, G. A., & Hernandez, N.A. (1993). Factors associated with recovery and relapse from major depressive disorder in the elderly. American Journal of Psychiatry, 150(12), 1820.

Horton-Deutsch, S.L., Clark, D.C., & Farran, C.J. (1992). Chronic dyspnea and suicide in elderly men. Hospital and Community Psychiatry, 43(12), 1198-1203.

House, A., Dennis, M., Mogridge, L., Warlow, C., Hawton, K., Jones, L. (1991). Mood disorders in the year after first stroke. British Journal of Psychiatry, 158, 83-92.

Hummert, M., Gartska, T.A., Shaner, J.L., & Strahm, S. (1995). Judgements about stereotypes of the elderly: Attitudes, age associations, and typicality ratings of young, meddle-aged and elderly adults. Research on Aging, 17, 168-189.

Jacobs, J. (1971). Adolescent suicide. New York: Wiley.

Jacobs, D.G., Kopans, B.S., & Reizes, J.M. (1995). Reevaluation of depression: What the general practitioner needs to know. Mind/Body Medicine, 1(1), 17-22.

Janis, I.R., & Mann, L. (1977). Decision Making- A psychological analysis of conflict, choice, and commitment. New York: The Free Press.

Jones, J.S., Stanley, B., Mann, J.J., Frances, A.J., Guido, J.R., Traskman-Bendz, L., Winchel, R., Brown, R.P., & Stanley, M. (1990). CSF 5-HIAA and HVA concentrations in elderly depressed patients who attempted suicide. American Journal of Psychiatry, 147, 1225-1227.

Jorm, A.F. (1990). The epidemiology of Alzheimer's disease and related disorders. London: Chapman & Hall. Similarly, 54% of older adults with chronic illness attempted suicide.

Jourard, S.M. (1971). The transparent self. New York: D. Van Nostrand.

Kapeller, P., Schmidt, R., Offenbacher, H., Payer, F., & Fazekas, G. (1996). The relation of cerebral magnetic resonance signal hyperintensities in Alzheimer's disease. Journal of the Neurological Sciences, 142(1-2), 121-125.

Kaszniak, A.W. (1996). Techniques and instruments for assessment of the elderly. In S.H. Zarit & B.G. Knight (Eds.), A guide to psychotherapy and aging: Effective clinical interventions in a life-stage context (pp. 163-219). Washington, DC: American Psychological Association.

Kaszniak, A.W, & Scogin, F.R. (1995). Assessing for dementia and depression in older adults. The Clinical Psychologist, 48(2), 17-24.

Kastenbaum, R. (1964). The crisis of explanation. In R. Kastenbaum (Ed.), New thoughts on old age (pp. 316-323). New York: Springer.

Kettl, P. (1998). Alaska Native suicide: Lessons for elder suicide. International Psychogeriatrics, 10(2), 205-211.

King, C.A. (1998). Suicide across the life span: Pathways to prevention. Suicide and Life-Threatening Behavior, 28(4), 328-337.

Klerman, G.L. (1987). The nature of depression. In A.J. Marsella and R.M.A. Hirshfeld (Eds.), The measurement of depression (pp. 3-19). New York: The Guilford Press.

Ko, S.M., & Kua, E.H. (1995). Ethnicity and elderly suicide in Singapore. International Psychogeriatrics, 7, 309-317.

Kowalski, R.M. (1999). Speaking the unspeakable: Self-disclosure and mental health. In R.M. Kowalski & M.R. Leary (Eds.), The social psychology of emotional and behavioral problems (pp.225-247). Washington, DC: American Psychological Association.

Kral, M.J., & Sakinofsky, I. (1994). Clinical model for suicide risk assessment. Death Studies, 18, 311-326.

Lee, M.A., & Ganzini, L. (1992). Depression in the elderly: effect on patient attitudes toward life-sustaining therapy. Journal of the American Geriatric Society, 40, 983-988.

Leenaars, A.A. (1992). Suicide notes of the older adult. Suicide and Life-Threatening Behavior, 22(1), 62-79.

Leininger, M. (1994). Evaluation criteria and critique of qualitative research studies. In J.M. Morse (Ed.), Critical issues in qualitative research methods (pp. 95-115). Thousand Oaks, CA: Sage.

Lesser, I.M., Miller, B.L., Boone, K.B., Hill-Gutierrez, E., Mehringer, C.M., Wong, K., & Mena, I. (1991). Brain injury and cognitive function in late-onset psychotic depression. Journal Neuropsychiatric Clinical Neuroscience, 3, 33-40.

Lester, D. (1992). Why people kill themselves. Springfield: Illinois, Charles Thomas.

Lester, D. (1988). The biological basis of suicide. Springfield, Illinois: Charles C. Thomas.

Lester, D. (1997). Suicide in an international perspective. Suicide and Life-Threatening Behavior, 27(1), 104-111.

Lester, D., & Tallmer, M. (Eds.). (1994). Now I lay me down. Philadelphia: The Charles Press.

Levin, J., & Levin, W. (1980). Ageism: Prejudice and discrimination against the elderly. Belmont, CA: Wadsworth.

Lewis, R.J., & Shepeard, G. (1992). Inferred characteristics of successful suicides as function of gender and context. Suicide and Life-Threatening Behavior, 22, 187-198.

Lincoln, Y., & Guba, E. (1985). Naturalistic inquiry. Beverly Hills: Sage.

Llorente, M.D., Eisdorfer, C., Loewenstein, D.A., & Zarate, Y.A. (1996). Suicide among Hispanic elderly: Cuban Americans in Dade County, Florida 1990-1993. Journal of Mental Health and Aging, 2(2), 79-87.

Lopata, H. (1973). Self-identity in marriage and widowhood. The Sociological Quarterly, 14, 407-418.

Lyness, J.M., Noel, T.K., Cox, C., King, D.A., Conwell, Y., & Caine, E.D. (1997). Screening for depression in elderly primary care patients. Archives in Internal Medicine, 157, 449-453.

Mann J.J., & Malone, K.M. (1997). Cerebrospinal fluid amines and higher lethality suicide attempts in depressed inpatients. Biological Psychiatry, 41, 1612-171.

Maris, R.W. (1981). Pathways to suicide. Baltimore: Johns Hopkins University Press

Maris, R.W. (1992). Overview of the study of suicide. In R.W. Maris, A.L. Berman, J.T. Maltsberger, & R.I. Yufit (Eds.), Assessment and prediction of suicide (pp. 3-22). New York: The Guilford Press.

Maris, R.W. (1995). Suicide prevention in adults (age 30-65). In M.M. Silverman & R.W. Maris (Eds.), Suicide prevention: Toward the year 2000 (pp. 171-179). New York: Guilford.

Maris, R.W., Berman, A.L., & Maltsberger, J.T. (1992). Summary and conclusions: What have we learned about suicide assessment and prediction? In R.W. Maris, A.L. Berman, J.T. Maltsberger, & R.I. Yufit (Eds.) Assessment and prediction of suicide (pp.640-672). New York: The Guilford Press.

Matthews, S. (1979). The social world of old women: Management of self identity. Newbury Park, CA: Sage.

McIntosh, J.L. (1995). Suicide prevention in the elderly (Age 65-99). Suicide and Life-Threatening Behavior, 25(1), 180-192.

McIntosh, J.L., Santos, J.F, Hubbard, R.W., & Overholser, J.C. (1994). Elder suicide: Research, theory and treatment. Washington, DC: American Psychological Association.

Mellick, E., Buckwalter, K.C., & Stolley, J.M. (1992). Suicide among elderly white men: Development of a profile. Journal of Psychosocial Nursing, 30(2), 29-34.

Menninger, K. (1938). Man against himself. New York: Harcourt, Brace, & World.

Michelson, C., Mulvihill, M., & Hsu, M.A. (1991). Eliciting medical care preferences from nursing home residents. Gerontologist, 31, 358-363.

Miller, J.F. (1992). Coping with chronic illness: Overcoming powerlessness. Philadelphia: F.A. Davis.

Miller, M. (1978). Geriatric suicide: The Arizona study. The Gerontologist, 18(5), 488-495.

Miller, S.J. (1965). The social dilemma of the aging leisure participant. In A.M. Rose & W.A. Peterson (Eds.), Older people and their social world (pp. 77-92). Philadelphia: F.A. Davis.

Montgomery, G.T., & Orozco, S. (1985). Mexican-Americans' performance on the MMPI as a function of level of acculturation. Journal of Clinical Psychology, 41(2), 203-212.

Moore, S.L. (1997). A phenomenological study of meaning in life in suicidal older adults. Archives of Psychiatric Nursing, 11(1), 29-36.

Morgan J.P. (1994). Bereavement in older adults. Journal of Mental Health Counseling, 16, 318-326.

Morse, J.M. (1991). Strategies for sampling. In J.M. Morse (Ed.), Qualitative nursing research: A contemporary dialogue. (pp. 127-145). Newbury Park: SAGE.

Moscicki, E.K. (1989). Epidemiologic surveys as tools for studying suicidal behavior: a review. Suicide & Life Threatening Behavior, 19, 131-146.

Moscicki, E.K. (1995). Epidemiology of suicidal behavior. Suicide and Life-Threatening Behavior, 25(1), 22-35.

Motto, J.A. (1992). An integrated approach to estimating suicide risk. In R.W. Maris, A.L. Berman, J.T. Maltsberger, & R.I. Yufit (Eds.), Assessment and prediction of suicide (pp.625-637). New York: The Guilford Press.

Mulkay, M. (1993). Social death in Britain. In D. Clark (Ed.), The sociology of death (pp.31-49). Oxford Great Britain: Blackwell Publishers.

Nelson, P.B. (1990). Intrinsic/extrinsic religious orientation of the elderly. Journal of Gerontological Nursing, 16(2), 29-35.

Neugarten, B. & Datan, N. (1973). Sociological perspective on the life cycle. In D.A. Neugarten (Ed.), The meanings of age (pp. 96-113). Chicago: The University Chicago Press.

Neuringer, C. (1974). Rigid thinking in suicidal individuals. Journal of Consulting Psychology, 28, 54-58.

Newman, M.A. (1979). Theory development in nursing. Philadelphia: Davis.

Newman, M. (1995). Toward a theory of health. In NLN Publications, A developing discipline: Selected works of Margaret Newman (pp. 91-99). New York: National League for Nursing Press.

Nezu, A.J. (1986). Cognitive appraisal of problem solving effectiveness: Relation to depression and depressive symptoms. Journal of Clinical Psychology, 42(1), 142-48.

O'Donnell, C.R. (1995). Firearm deaths among children and youth. American Psychologist, 50, 771-776.

Osgood, N. (1985). Suicide in the elderly. Rockville, MD: Aspen Systems Corp.

Osgood, N. (1992). Suicide in later life. New York: Lexington Books.

Oxman, T.E., Berkman, L.F., Kasl, S., Freeman, D.H., & Barrett, J. (1990). Social support and depressive symptoms in the elderly. American Journal of Epidemiology, 135(4), 356-368.

Palmore, E.B. (1999). Ageism. Negative and positive. New York: Springer.

Pandey, G.N., Pandey, S.C., Dwidvedi, Y., Sharma, R.P., Janicak, P.G., & Davis, J.M. (1995). Platelet serotonic 2A receptors: A potential biological marker for suicidal behavior. American Journal of Psychiatry, 152(6), 850-855.

Pearson, J.L., & Conwell, Y. (1996). Suicide in late life: Challenges and opportunities for research. In J.L. Pearson & Y. Conwell (Eds.), Suicide and Aging-International Perspectives. New York: Springer Publishing Co.

Pollock, L.R., & Williams, M.G. (1998). Problem solving and suicidal behavior. Suicide and Life-Threatening Behavior, 28(4), 375-387.

Pokorny, A.D. (1983). Prediction of suicide in psychiatric patients. Archives General Psychiatry, 40, 249-257.

Prigogine, I., Allen, P.M., & Herman, R. (1977). In E. Laszlo & J. Bierman (Eds.), Long term trends in the evolution of complexity. Goals for Mankind (pp. 1-63). New York: Pergamon.

Purcell, D., Thrush, C.R.N., & Blanchette, P.L. (1999). Suicide among the elderly in Honolulu County: A multiethnic comparative study (1987-1992). International Psychogeriatrics, 11(1), 57-66.

Quinn, J. (1987). Attitude of professionals toward the aged. In G. Maddox (Ed.), The encyclopedia of aging. New York: Springer.

Rabins, P.V., Pearlson, G.D., Aylward, E., Kumar, A.J., & Dowell, K. (1991). Cortical magnetic resonance imaging changes in elderly patients with major depression. American Journal of Psychiatry, 148, 617-620.

Reed, P.G. (1983). Implications of the life-span developmental framework for well-being in adulthood and aging. Advances in Nursing Science, 6(11), 18-25.

Reed, P.G. (1986). Developmental resources and depression in the elderly. Nursing Research, 35(6), 368-374.

Reed, P.G. (1989). Mental health of older adults. Western Journal of Nursing Research, 11(23), 143-163.

Reker, G.T., Peacock, E.J., & Wong, P.T.P. (1987). Meaning and purpose in life and well-being: A life span perspective. Journal of Gerontology, 42(1), 44-49.

Richman, J. (1992). Preventing elderly suicide. New York: Springer Publishing Co.

Rickelman, B.L., & Houfek, J.F. (1995). Toward an interactional model of suicidal behaviors: Cognitive rigidity, attributional style, stress, hopelessness, and depression. Archives of Psychiatric Nursing, 9(3), 158-168.

Rogers, M.E. (1970). An introduction to the theoretical basis of nursing. Philadelphia: Davis.

Rosnow, I. (1973). The social context of the aging self. The Gerontologist, 12, 82-87.

Roy, A. (1992). Genetics, biology, and suicide in the family. In R.W. Maris, J.T. Maltsberger, & R.I. Yufit (Eds.), Assessment and prediction of suicide (pp. 574-588). New York: The Guilford Press.

Roy, A. (1983). Family history of suicide. Archives of General Psychiatry, 490, 971-974.

Rushing, W.A. (1968). Individual behavior and suicide. In J.P. Gibbs (Ed.), Suicide. New York: Harper and Row.

Salthouse, T. (1996). Commentary: A cognitive psychologist's perspective on the assessment of cognitive competency. In M. Smyer, K.W. Schaie, & M.B. Kapp (Eds.), Older adults' decision-making and the law (pp. 29-47). New York: Springer Publishing Co.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. Advances in Nursing Science, 16(2), 1-8.

Schofield, J.W. (1990). Increasing the generalizability of qualitative research. In E.W. Eisner & A. Peshkin (Eds.), Qualitative inquiry in education- the continuing debate (pp. 201-232). New York: Teacher College Press.

Schwartz, P., & Ogilvy, J. (1980). The emergent paradigm: Changing patterns of thought and belief (Analytical report No. 7, Values and Lifestyles Program). Menlo Park, CA: SRI International.

Seiden, R.H. (1981). Mellowing with age: Factors influencing the nonwhite suicide rate. International Journal of Aging and Human Development, 13, 265-284.

Shah, A., & De, T. (1998). Suicide and the elderly. International Journal of Psychiatry in Clinical Practice, 2, 3-17.

Shneidman, E.S. (1985). Definition of suicide. New York: Wiley.

Shneidman, E.S. (1996). The suicidal mind. New York: Oxford University Press.

Shneidman, E.S., Farberow, N.L., & Litman, R. (1970). The psychology of suicide. New York: Science House.

Smyer, M. (1993). Mental health and aging: Progress and prospects. New York: Springer.

Stenager, E., & Stenager, E. (1998). Disease, pain, and suicidal behavior. New York: The Haworth Medical Press.

Stenager, E.N., Warmouth, L., Stenager, E., & Boldsen, J. (1994). Suicide in patients with Parkinson's disease. Acta Psychiatry Scandanavica, 90, 70-72.

Stern, P.N. (1980). Grounded theory methodology: Its uses and processes. Image, 12(1), 20-23.

Stillion, D.M. & McDowell, E.E. (1996). Suicide across the life span. Washington, DC: Taylor & Francis.

Streubert, H.J., & and Carpenter, D.R. (1995). Qualitative research in nursing. Advancing the humanistic imperative. Philadelphia: J.B. Lippincott Company.

Sullivan, M.D. (1998). Depression and the refusal of life-saving medical treatment. In M.D. Steinberg & Youngner, S.J. (Eds.) End-of-life-decisions- A psychosocial perspective (pp. 55-75). Washington, DC: American Psychiatric Press.

Szanto, K., Prigerson, H., Houck, P., Ehrenpreis, L., & Reynolds, C.F. (1997). Suicidal ideation in elderly bereaved: The role of complicated grief. Suicide and Life-Threatening Behavior, 27(2), 194-204.

Szanto, K., Reynolds, C.F., Conwell, Y., Begley, A.E., & Houck, P. (1998). Journal of the American Geriatrics Society, 46(11), 1401-1406.

Tallmer, M. (1994). Symptoms and assessment of suicide in the elderly. In D. Lester & M. Tallmer (Eds.), Now I lay me down- Suicide in the elderly. Philadelphia: The Charles Press.

Teitelbaum, M. (1995). Evaluation of long-term care survey. Unpublished report under review by HCFA. Cambridge, MA: ABT Associates.

Thomas, C.L. (Ed.). (1993). Taber's Cyclopedic Medical Dictionary. Phildelphia: F.A. Davis Company.

Trenteseau, J.A., Hyer, L., Verenes, D., & Warsaw, J. (1989). Hopelessness among later-life patients. The Journal of Applied Gerontology, 8, 355-364.

Uncapher H., Gallagher-Thompson, D., Osgood, N.J., & Bongar, B. (1998). Hopelessness and suicidal ideation in older adults. The Gerontologist, 38(1), 62-70.

U.S. Bureau of the Census. (1996). Statistical abstract of the U.S. (116th ed.). Washington DC: Author.

U.S. Department of Health and Human Services. (1990). Healthy people 2000. Washington DC: Author.

U.S. Senate 104th Congress. (1996). Suicide and the elderly: A population at risk (Serial 104-16). Washington DC: U.S. Government Printing Office.

Vasil, L., & Wass, H. (1993). Portrayal of the elderly in the media: A literature review and implications for educational gerontologist. Education Gerontology, 19, 71-85.

Vogel, R., & Wolfersdorf, M. (1989). Suicide and mental illness in the elderly. Psychopathology, 22, 202-207.

Weisman, A. (1991). Vulnerability and suicidality in the aged. Journal of Geriatric Psychiatry, 24(2), 194-201.

Weiss, D., & Coccaro, E.F. (1997). Neuroendocrine challenge studies of suicidal behavior. The Psychiatric Clinics of North America, 20(3), 563-579.

Welu, T.C. (1973). Psychological reactions of emergency room staff to suicide attempters. Omega, 3, 103-109.

West, C. (1993). Race matters. Boston: Beacon Press.

Wheeler, D.L. (1996). Scholars seek a biological basis for suicide. The Chronicle of Higher Education, Dec 13, A15-16.

Whitfield, W., & Southern, D. (1996). The prevention of suicide: some practical steps. Journal of the Royal Society of Health, 116(5), 295-298.

Willis, S.L., & Schaie, K.W. (1993). Everyday cognition: Taxonomic and methodological considerations. In J.M. Puckett & H.W. Reese (Eds.), Lifespan developmental psychology: Mechanisms of everyday cognition. Hillsdale, NJ: Erlbaum.

Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M., & Leirer, V.O. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. Journal of Psychiatric Research, 17(1), 37-49.

Yufit, R.I., & Bongar, B. (1992). Suicide, stress and coping with life cycle events. In R.W. Maris, A.L. Berman, J.T. Maltsberger, & R.I Yufit (Eds.), Assessment and prediction of Suicide. New York: The Guilford Press.

Zubenko, G.S., Sullivan, P., Nelson, J.P., Belle, S.H., Huff, J., & Wolf, G.L. (1990). Brain imaging abnormalities in mental disorders of late life. Archives Neurology, 47, 1107-1111.

Zweig, R.A., & Hinrichsen, G.A. (1993). Factors associated with suicide attempts by depressed older adults: A prospective study. American Journal of Psychiatry, 150(11), 1687-1692.