

Volume One

The Experience of Attempted Suicide in Later Life: A  
Qualitative Study

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## **Abstract**

Older people constitute one of the highest risk groups to suicide. The existing research on suicide in later life has neglected the role of subjective experience and social context, through largely taking a risk factor approach, which is limited as only a minority of people who are deemed to be at risk actually make a suicide attempt, making prediction and prevention difficult. The present study aimed to capture the experience of older people who had recently acted on their suicidal feelings by exploring their understanding of the pathway to their suicide attempt. It also aimed to capture their experience of ageing, which has received little attention in the research to date. Fifteen participants were interviewed after they had acted upon their suicidal feelings. Their transcripts were analysed using Interpretative Phenomenological Analysis. Three broad themes emerged from the interview data (The Struggle, Control and Visibility), incorporating 20 subordinate themes covering the experience of participants prior to, at the time of and following the suicide attempt. Participants reported losing control and becoming less visible in society prior to their suicide attempt, although they were not entirely helpless at this time and many tried to fight against some of the changes and losses that they were experiencing, even though many of these efforts were in vain and participants were overwhelmed by feelings of hopelessness and helplessness. The themes that emerged following the suicide attempt highlight the vulnerability of individuals at this time, as well as the opportunities available for positive outcome. Ageing was largely experienced as a struggle as participants tried to come to terms with getting old. Most felt marginalised and overlooked by society on account of their age. Several participants made an explicit link between their difficulty in adjusting to growing older and their motivations for attempting suicide. There was no set pattern to which themes came together for participants, demonstrating that the pathway to suicide is extremely complex. Furthermore, risk factors identified in the literature were not always present or salient to participants, suggesting that the risk factor approach to suicide is limited and that role of subjective experience and social context must be considered. Directions for future research and the clinical implications of the findings are discussed.

## **1. Introduction**

The present study is concerned with how older people who have recently made a suicide attempt experience the psychological pathway to their attempt. It is also concerned with how these individuals experience ageing and the extent and nature of their adjustment.

The introduction is divided into three parts. The first addresses the suicide literature, the second covers the ageing literature, and the third brings the two together presenting a rationale for the present study.

### **1.1.1. Overview**

In this initial sub-section details of past, current and future trends in attempted and completed suicide in older people are provided (the terms 'attempted suicide' and 'non-fatal' suicide will be used interchangeably in the present study, as will 'completed suicide' and 'fatal suicide'). The question of whether attempted and completed suicides in older people are more similar than different is then addressed, after which the risk factors pertinent to both are described. The psychological literature detailing cognitive risk factors to suicide is then discussed and the relationship between suicidal behaviour and age is considered. Societal influences on suicide are then introduced after which both suicide prevention and the challenges of researching elderly suicide are outlined. The introduction closes with a summary section indicating the reasons why the present study is relevant to clinical practice and how it fits in with the existing research.

### **1.1.2. Epidemiological Studies: Attempted and Completed Suicide Rates in the Elderly**

According to epidemiological studies, in the 1980s there was a sharp increase in both attempted and completed suicide attempts among older people in Britain. The strongest increase was for completed suicides in men aged over 75 years (Pritchard,1992). This reflected a widespread trend across most developed countries according to World Health Organisation figures (WHO,1992). There was also an increase in attempted and completed suicides in those aged below 65 years, while this trend was less marked. These increases prompted a number of national and international targets and initiatives to reduce the general suicide rate (Health of the Nation: Department of Health,1992; WHO,1992). The identification of older people as an internationally high-risk group generated a marked growth of interest in both research and clinical domains, with an underlying drive towards a reduction of these rates (Kennedy & Tanebaum, 2000).

Since the 1980s, there has been a levelling out and slight reduction in completed suicide rates in the elderly, whilst the attempted suicide rates have stayed constant across Britain and Europe (De Leo et al, 2001; Hoxey & Shah, 2000). Upon closer inspection Pritchard (1996) notes that although 'younger' elderly suicides (65-74 years) have fallen, 'older' elderly suicides (over 75 years) have actually increased, especially for men. In terms of future trends, projected figures compiled from birth cohort analyses predict an increase in suicide rates over the forthcoming decades (Bharucha & Satlin,1997). Other researchers, however, predict further reductions (Hoxey & Shah, 2000). Nonetheless, the figures remain high at present and older adults continue to pose a higher risk of suicide than almost all other age groups (Cattell, 2000).



Suicide prevention continues to be a key aspect of government policy in Britain. Under its current Mental Health Strategy, the government aims to reduce the national suicide rate by at least one fifth of the 1996 baseline level by 2010 (Saving Lives: Our Healthier Nation, Department of Health, 1999). This general target encompasses elderly suicides; however some have argued for specific initiatives and targets to be directed towards the elderly due to their idiosyncratic needs and distinctive patterns of risk (Tadros & Salib, 1999).

According to McIntosh (1992), the ratio between attempted and completed suicides in older adults (estimated at 4:1) is significantly different to that observed in those aged below 65 years (estimated at between 8:1 and 15:1 across the general population, and up to 200:1 in younger adults). Recently, De Leo et al (2001) report from their WHO/EURO Multicentre study of Suicidal Behaviour study an attempted suicide rate of 61.4 per 100,000 and a completed suicide rate of 29.3 per 100,000 of the population, yielding a ratio of 2:1 (the British site's figure was higher at 9:1). The ratios suggest that suicidal behaviour is more lethal in later life; however they tell us little about the factors underpinning completed and attempted suicide in old age and the degree to which these are interrelated.

### **1.1.3. Attempted and Completed Suicides in the Elderly: More Similar than Different?**

Are attempted and completed suicides in older people more similar than different, given that when older people make a suicide gesture they are more likely to die as a result of it

and that suicide attempts decline with increasing age? And if the two groups are similar, what implications does this have for clinicians and researchers?

The argument for non-fatal and fatal suicides being more similar than different rests upon two main premises. First, it is argued that in contrast to younger age groups, when older people make a suicide attempt, they have a stronger determination to die, which is reflected in their choice of more lethal methods and their high level of suicidal intent (Merrill & Owens, 1990; Frierson, 1991; Hoxey & Shah 2000). This is taken as evidence that attempted and completed suicide groups converge in old age, suggesting that the former are 'failed' suicides, distinguishable only by their lethality of dose (Draper, 1996; Kreitman, 1976). Second, there is considerable overlap in the risk factors associated with attempted and completed suicide in old age (see section 1.1.4). On this basis, researchers have advocated that through studying attempted suicide, completed suicides will be better understood (Lindesay, 1986; Draper, 1996). The clinical implication of the two groups overlapping is that suicide attempts in the elderly should be taken very seriously on account of the likely high level of suicidal intent and the risk of future suicide (Hepple & Quinton, 1997; Lawrence et al, 2000). This position would not be advocated for younger non-fatal and fatal suicides, which are seen to be far more distinct.

However, De Leo et al (2001) have recently put the above view in question. They report little correlation between attempted and completed suicide behaviour in the elderly, and suggest that clinicians and researchers should err on the side of caution when treating the two as indistinguishable. However, their correlation is based on just five of the sixteen sites involved in their Multicentre study due to incomplete data. Therefore these findings

will need to be replicated over time before firm conclusions can be made, especially as their findings diverge from previous studies and are likely to prove controversial.

#### **1.1.4. Risk factors Associated with Attempted and Completed Suicide in the Elderly**

The research into elderly suicide has been dominated by a drive to identify risk factors pertinent to the aetiology of non-fatal and fatal suicide in older adults. Findings from this large volume of work will be summarised below.

In his recent review of the literature for elderly suicide Cattell (2000) identifies male gender, being aged over 75 years, living alone, bereavement, psychiatric illness (most commonly depression), alcohol misuse, a previous suicide attempt, vulnerable personality traits, physical illness and pain as risk factors for elderly suicide. In line with findings from an earlier study (Cattell & Jolley, 1995) in which 79 % of the 100 cases of suicide had depressive symptoms, 56% had physical health problems and 61% lived alone, Cattell (2000) suggests that depression, physical health problems and social isolation are the most potent risk factors for completed suicide in old age. Additional factors have been identified elsewhere: reduced brain-stem serotonergic activity (Asberg,1989), a severely stressful life event (Moscicki, 1996), visual impairment, neurological disorder and malignant disease (Waern et al, 2002).

Draper (1994) identified the following risk factors for attempted suicide in older people: depressive symptoms (which were observed in 87% of his sample), sleep disturbance, alcohol or substance abuse, social isolation and loneliness, relationship problems, bereavement, acute psychosocial stress, chronic disability, acute physical illness and

pain, psychiatric history and diagnosis. Other studies report similar findings (see Pearson & Brown, 2000). Draper reported two patterns or 'profiles' of attempted suicide. One group had minor depression, lower suicidal intent, personality dysfunction and high levels of psychosocial stressors and chronic physical illness. For this group it was the interaction of illnesses in the context of the psychosocial stressors that was hypothesized to cause suicidal behaviour. The other group had higher levels of suicidal intent, major depression and fewer physical health problems. For this latter group, Draper proposed that it is the severity of the psychiatric illness that puts them at risk. It is unclear which of these groups most resemble completed suicides. Additional factors for attempted suicide identified elsewhere include a strong fear of being placed in a nursing home (Loebel et al, 1991), poor adaptation to life stresses (Williams, 1997) and hopelessness (Hill et al, 1988).

It is clear from the above studies that both aetiologies are multi-determined and that there is a considerable overlap in the risk factors identified, especially as regards depression, physical illness and social isolation. However several differences have been noted; for example, male gender and older age appear to be more influential in completed suicide. Lawrence et al (2000) found that personality disorder was strongly associated with attempted suicides in the elderly but not with completed suicide, although again depression was found to be the most robust predictor of both in a regression analysis. Pearson & Brown (2000) have indicated that a higher proportion of completed suicides stem from a first episode of depression than is the case for attempted suicides. However, as with all risk factors, none are exclusive to one group and even

when the same factors influence both groups it is unclear whether they come together in a different way. This makes the distinction between the two groups somewhat blurred.

Drawing on the psychological literature on elderly depression is of limited use for the present study. Although depression is the commonest mental health problem in the elderly (Lindesay, Briggs & Murphy, 1989, estimate a 4.3 % prevalence rate for severe depression and a 13.5% prevalence rate for moderate depression) and is one of the strongest risk factors for suicidal behaviour in old age, not all depressed elderly people experience suicidal ideation and an even smaller number actually act on any suicidal feelings they may have (Zweig & Hinrichsen, 1993). Equally not all suicidal older adults are depressed (Hill et al, 1988). In his review, Woods (1999) reports that the mechanisms underlying depression in the elderly are poorly understood. Many of the factors that have been shown to be associated with depression in old age (e.g. adverse life events, social support deficits, loneliness, poor physical health, pain, loss and bereavement) affect those who do not become depressed. Moreover, given the strong association between loss and depression in old age, the prevalence rates are actually remarkably low. This review, taken alongside the risk factor literature discussed above, highlights the difficulty of trying to understand the psychological processes underpinning both elderly depression and suicide, as many older people carry risk factors but do not go on to become depressed or for the purposes of this study suicidal.

Finally, Caine & Lebowitz (1996) question the utility of focusing too heavily on the many risk factors that have been identified as they are not exclusive to those who attempt or complete suicide. They suggest that there are many other 'difficult to define'

factors operating alongside the more commonly recognized factors that have a significant contributory role and warrant further research. It is likely that some of these are age-specific factors (Hill et al, 1988). The methods used in the above studies have been largely quantitative, consisting primarily of retrospective analysis of medical records or inquest notes, or psychological autopsy studies that utilise interviews with health care professionals and family and friends of the deceased to pinpoint risk factors. These methodological approaches have been subject to criticism for lacking objectivity and failing to use standardised measures (Draper, 1996). This criticism is echoed by Pearson & Brown (2000) who call for better-controlled studies utilizing prospective methodologies. However, much of this criticism focuses on how to better detect various risk factors and how to identify which is the most powerful or important risk or group of risk factors. Another approach would be to move away from the objective measurement of risk factors and allow those older people who have acted on their suicidal feelings to discuss their experience related to these risk factors (both those identified above and those that are more 'difficult to define'). No such study has been carried out to date.

One study has used an exploratory methodology to investigate suicidal ideation in older people who did not act on their feelings. Bell (2001) identified the theme of 'losing connections' to be key to the experience of these individuals. Her male sample reported depression and despair following cumulative losses (relationship, health and role losses being most prominent) which prompted suicidal ideation. At this point they experienced a struggle between wanting to die and fearing the consequences of their death. The barrier to them taking their lives was the feared consequences for their family. Social isolation did not feature strongly for this sample, suggesting that social networks may

have served as a 'protective factor' that stopped them from making a suicide attempt. A similar study is needed to explore the experiences of those who do not encounter a 'barrier' and go on to act on their suicidal feelings.

#### **1.1.5. Psychological Approaches to Suicide: Considering Cognitive Risk Factors**

This section outlines the psychological literature on cognitive deficits or 'cognitive risk factors' underlying suicidal thinking. This research has greatly furthered the psychological understanding of suicidal thinking prior to a suicide attempt. However, caution must be exercised in attempting to generalise the findings to older populations, as the empirical evidence that supports it is derived from younger age groups (those aged below 65 years); however it is likely that similar psychological processes underlie suicidal thinking irrespective of age and strongly feature in the pathway to elderly suicide.

Based on the premise that depression and hopelessness underlie most suicidal ideation, according to Beck Kovacs & Weissman (1975), individuals who become suicidal have a propensity to cognitive distortions, cognitive rigidity, cognitive constriction and various errors in logic, and a bias towards recalling more negative aspects of experience. In line with the cognitive model of depression they hold negative thoughts about the self, the future and others (Williams, 1997). These cognitive deficits have been grouped into future-directed thinking, memory deficits, impaired problem-solving skills and a negative attribution style in suicidal thinking, which will now be outlined. It is important to note that, as with all risk factors, it is difficult to disentangle the effect of each of them individually, as they are not mutually exclusive.

Hopelessness is best understood as being a mediator between depression and suicidal behaviour (Beck et al,1975). It can be defined as having two sub-components, each related to future-directed thinking: a negative attitude towards the future and a lack of anticipated future events, which contribute in different ways to the aetiology of suicidal thinking. MacLeod, Rose & Williams (1993) found that negative expectancies contribute to the onset of hopelessness and suicidal thinking, whilst not being able to envisage any positive events in the future (both immediate and distal future) maintains this state. They found this to be independent of depression. Linehan and colleagues (1983) describe the anticipation of positive events or 'reasons for living' and have shown that these buffer against suicidal thoughts and behaviours. They identify six categories of reasons for living: survival and coping beliefs, responsibility to family, child-centred concerns, fear of suicide, fear of social disapproval and moral objections to suicide. It is likely that future-directed thinking and reasons for living change with increasing age.

Certain memory deficits have been associated with suicidal thinking and behaviour. Williams & Broadbent (1986) found that individuals who had attempted suicide had difficulties in retrieving autobiographical memories at a specific level and retrieved them in an overgeneralised way. This is hypothesised to impair problem-solving skills, which require the ability to switch between specific and general memories to create solutions, in those that attempt suicide (O'Connor & Sheehy, 2000). Linehan et al (1987) demonstrated that individuals who had made a suicide attempt were unable to generate as many solutions to their problems as controls, and the solutions they did find tended to be more passive involving others. Another aspect of impaired problem-solving is evident



in the actual decision to make a suicide attempt. Shneidman (1996) calls the state before reaching the decision one of 'cognitive ambivalence'. Here individuals battle between the intention to die and the intention to live. Once their problem-solving strategies fail, they decide on the former and their suicidal intent becomes heightened by an 'opiate' like state (Beck et al,1979).

A negative attribution style has also been shown to contribute to suicidal thinking when combined with hopelessness and life stress (Peterson et al, 1982). Suicidal adults tended to attribute negative events to internal, stable and global causes (seeing them as unchangeable, ever-present and caused by themselves), whereas they attributed successes to external and unstable causes. This was likely to generate a feeling of helplessness.

The cognitive risk factor literature is highly relevant to clinical practice. Cognitive therapy offers individuals the opportunity of increasing cognitive flexibility to prevent distorted thinking, errors in judgement, problem-solving difficulties and a limited view of what the future may hold. Indeed, cognitive therapy has been found to reduce depressive symptoms and suicidal ideation and behaviour in individuals who have a history of suicide attempts albeit in a younger population (Evans et al, 1999; Salkovskis et al, 1990).

Some of the above cognitive deficits feature in Shneidman's (1996) model of the psychological pathway to suicide, although his theory is not based on empirical evidence. These include unbearable psychological pain, frustrated psychological needs, feelings of hopelessness and helplessness, a cognitive state of ambivalence, a drive to

end consciousness, cognitive constriction (dichotomous thinking) and the common goal and purpose of suicide being to seek a solution (which can be accompanied by relief and elation) and to find an escape.

In summary, the above literature has provided important insights into the minds of those who attempt suicide. It remains uncertain whether the same cognitive risk factors play an aetiological role in suicidal thinking in the elderly, and if they are present, whether they are of greater intensity, thus accounting for the higher proportion of completed suicides in this population. For the purposes of this study, little is known about the way in which older people experience these cognitive risk factors and how they come together alongside other risk factors they may experience.

#### **1.1.6. Suicides Across the Lifespan: Same or Different?**

This section will outline some of the commonalities and differences in suicide across the lifespan.

There are several well-established differences in suicide patterns between age groups. First, attempted and completed suicide rates vary over the lifespan; according to De Leo et al (2001) attempted suicide rates fall with age, reaching their lowest levels in the elderly, whilst completed suicide rates increase with age (peaking for women in their late 60s and for men at around the age of 80; Pritchard, 1996). Other differences include a stronger intent in older people (Merrill & Owens, 1990) and the choice of more violent or lethal methods (Tadros & Salib, 1999). De Leo et al (2001) report the most frequent method of elderly suicide is hanging and overdose in men, particularly those aged over

75 years, and overdose alone in women. This is confirmed by Cattell's (2000) review in which he states that 'suicidal behaviour in the elderly is undertaken with greater intent and with greater lethality than in younger age groups' (p.102).

Gunnell & Frankel (1994) identify the following risk factors as being associated with attempted and completed suicide for those aged below 65 years; psychiatric disorder (generally depression, schizophrenia, alcoholism and personality disorders), physical illness (particularly terminal, painful or debilitating), a history of previous suicide attempts (which is the single most significant risk factor for future suicide attempts and actual suicide; Kreitman & Foster, 1991), a family history of suicide or mental illness, being divorced, widowed or of single status, being socially isolated and being unemployed or retired. In addition to these Maris et al (1992) identified relationship problems, substance abuse, negative life events and impulsivity as being important.

The literature directly comparing the two age groups is relatively sparse and this area warrants further investigation (Conwell & Brent, 1996). Although both age groups are vulnerable to similar risk factors, for example depression and social isolation, younger adults have higher rates of personality disorder, drug and alcohol abuse and severe and enduring mental health problems than those aged over 65 years who attempt and complete suicide (Tadros & Salib, 1999). This accounts for their more frequent attempts which are characterised by a low intent to die. Conwell & Brent (1996) report similar findings, although they suggest that depression is more commonly linked to elderly suicides. Henriksson et al (1996) argue that the association between depression and completed suicide strengthens with age, and associate this increment with physical

illness. Merrill & Owens (1990) found that elderly patients were significantly more likely to make a future suicide attempt as compared to their younger counterparts if they exhibited the following risk factors: lived alone; were physically ill; had a psychiatric illness; and displayed high suicidal intent in the original suicide attempt. This suggested that these factors carried greater weight for older people.

Some risk factors have been seen as being unique to elderly suicidal behaviour. These include specific role transitions and life tasks related to age, for example retirement and weariness of life (Schmitz, 1995). Cohler & Jenuwine (1996) highlight the need to recognise the distinct meanings and concepts people have of suicide as a function of their cohort group and age, which are likely to impinge upon suicidal behaviour across the lifespan. Finally, Robins, West and Murphy (1977) found that older people who experienced suicidal ideation (without acting on their suicidal feelings) held a negative attitude to old age and endorsed beliefs such as 'there is no reason for pride in old age' and 'relatives do not treat you as well in old age'. No studies have considered the experience of ageing for individuals who act on suicidal feelings, or the extent and nature of their adjustment.

#### **1.1.7. Societal Influences on Suicide**

This section will take a closer look at the social context of suicide, which the risk factor literature has tended to overlook, other than to acknowledge the role of social isolation prior to a suicide attempt. Durkheim (1897) published his sociological theory of suicide over a century ago, describing four types of suicide: egoistic, altruistic, anomic and fatalistic, each reflecting a distinct pattern of interaction between the individual and

society. He proposed that individuals commit suicide when a number of social constraints are imposed upon them, which threatens their position in society. Although his theory has been criticised for ignoring the role of psychological processes in suicide (O'Connor & Sheehy, 2000), it has proved influential in highlighting the impact of society on suicidal behaviour. This is particularly relevant to the study of elderly suicide as older people are often marginalised in society. Indeed, Lyons (1984) argues that societal attitudes towards the elderly influence suicide rates. He cites data from cross-cultural studies that report lower suicide rates in cultures that have more respect for the elderly in support of this view.

Many representations of suicide circulate in society, originating from historical, cultural and media based sources (see Williams, 1997 for a review). These portray suicide as being a glamorous, sinful and at times legitimate act. Social learning theorists (e.g. Platt, 1993) argue for a 'modeling effect' of suicidal behaviour, which suggests that the behaviour is socially transmitted through such representations to vulnerable individuals. However, the scientific research that has sought to measure this effect, through reporting on fluctuating suicide rates following a television depiction of suicide or the suicide of a public figure, remains inconclusive (O'Connor & Sheehy, 2000). Nonetheless, it is important to consider the role of society, culture, the media and even history on the representations held by individuals who decide to make a suicide attempt.

#### **1.1.8. Suicide prevention**

Various risk factors have been associated with suicide and have helped increase the awareness of clinicians working towards its prevention. However, risk factors do not

predict suicide and only a minority of those people deemed to be at high risk actually make a suicide attempt. Furthermore, preventing a behaviour that is difficult to predict, particularly one that occurs infrequently, is troublesome (O'Connor & Sheehy, 2000).

Recent studies have reported a slight reduction in elderly suicide rates (De Leo et al, 2001). This can be partly accounted for by the influence of public health initiatives targeting professionals and more cautious prescribing of medication that can be used in overdose, although other unknown factors are likely to have been influential (Hoxey & Shah, 2000). The initiatives that have taken place have aimed to promote awareness, improve risk identification and assessment, and enhance liaison with secondary care services. This follows criticism directed at clinicians failing to detect depression in the elderly, which could arguably prevent a suicide attempt. This failure may result from poor reporting in patients as well as misdiagnosis on the part of clinicians. Uncapher & Areean (2000) study suggests that clinicians are able to detect depression and suicidal ideation but are more reluctant to treat it in the elderly, believing that symptoms of depression and a wish to die are 'normal' aspects of ageing.

Ongoing initiatives that dispel myths about ageing and help increase awareness about elderly depression will be critical for future prevention. This is likely to be most effective in primary care services, given that approximately 70% of older people have been shown to contact their GP in the month prior to their suicide (Conwell et al, 1991), that many elderly suicides follow a first episode of depression (Pearson & Brown, 2000), that only 14% of the elderly who commit suicide consult specialist mental health services in the year prior to their suicide (Cattell & Jolley, 1995) and finally that the

repetition rate of elderly suicide is reasonably low (5.4% re-attempt and 1.4% of these complete according to Hepple & Quinton, 1997), limiting the role of secondary care services.

### **1.1.9. Challenges of Researching Elderly Suicide**

Several challenges are faced when carrying out research into elderly suicide. Elderly suicides, both fatal and non-fatal, are statistically rare as the above figures suggest (De Leo et al, 2001). Hepple & Quinton (1997) report an average annual elderly attempted suicide rate of just 32 in a large catchment area in Oxford. This demonstrates the difficulty in recruiting participants to this research. Studies tend to be longitudinal and multi-centre.

A second challenge pertains to defining what constitutes a suicide attempt. Kreitman (1977) defines attempted suicide, or parasuicide, as a non-fatal act in which the individual deliberately causes self-injury or ingests a substance in excess of a generally recognised therapeutic dose. Parasuicide is a term seldom used in the elderly literature, perhaps due to its low prevalence compared to other age groups. The definition is closely linked to the issue of intent, that is whether or not individuals intended to die or harm themselves by their action. It is widely accepted that older people usually have a stronger wish to die when they engage in suicidal behaviour. There are of course exceptions to this pattern. Ascertaining true intent is problematic as it may be subject to the biases of self-report. Some may hide their intent due to shame (suicide is still widely condemned by religious doctrine and is stigmatised in society – see Williams, 1997). Focusing on the method of the attempt can also be unhelpful as the means used may be

incongruent with the intent; this might be, for example, when there is confusion over toxicity of dose. This makes it difficult for clinicians and researchers to decide whether or not a behaviour should be classified as suicidal. It is important to be mindful of the above issues when carrying out research in this area.

#### **1.1.10. Section Summary**

There has been a dearth of psychological research investigating the individual's experience of the pathway to a suicide attempt, including the experience of various losses or changes ('risk factors') that have been repeatedly identified as being pertinent to suicide in the literature to date (and indeed those that have remained unidentified or 'difficult to define'). The existing literature falls largely into two camps: epidemiological studies reporting the changing attempted and completed suicide rate trends and psychiatric studies identifying various risk factors that increase vulnerability to suicide. These studies have proved vital in furthering understanding of suicidal behaviour in the elderly and have made a valuable contribution to suicide prevention initiatives. However, in his review Draper (1996) argues that 'there has been a disappointing lack of refinement in our understanding of the processes by which these and other factors contribute to an older person's suicide attempt' (p.585). Furthermore he questions whether the increase in the number of suicide research studies has been 'associated with a commensurate increase in understanding of the phenomenon' (p.577).

An exploratory study would identify factors that are perceived to be important by those who act on their suicidal feelings and could provide useful insights into the motivations and influences (which may include social influences as well as those of a more



individual and psychological nature) underlying the pathway to the suicide attempt. This would enrich current understandings of suicide, complementing existing research findings.

### **1.2.1. Ageing**

This study is also interested in how older people who act on their suicidal feelings experience growing older, and the extent to which they have felt able to adjust and how this has impinged upon their decision to make a suicide attempt. Few studies have considered the way in which the experience of ageing influences suicide in old age. This section will review the literature that has focused on 'normal' ageing. Emphasis will be placed on adjustment to ageing and, in particular, how various psychological processes are drawn on to protect the self in old age. The influence that representations of ageing have on the way in which older people view themselves will also be discussed. First however, to set the context for the gerontological literature, attention will be given to definitions of ageing and population forecasts.

### **1.2.2. Definitions of Ageing & Population Forecasts**

This study defines older people as being aged over 65 years. As the mandatory age for retirement in British men, it is a well-established benchmark for delineating the old from the young. In fact, it is the age at which the National Health Service typically offers specialist health services, for example Geriatric Medicine to cater for more complex needs related to ageing. However, this age distinction is not definitive; not only does it vary across cultures, it also varies within research settings. Some ageing studies include

adults aged over 55 years, whereas others are more concerned with those aged over 75, or even 85 years.

According to recent estimates (Population Trends, 2001), just over 10.7 million (approximately, 18%) of the British population is over pensionable age (65 and 60 for men and women respectively). People in this segment of the population are currently living longer than they used to - a trend that is set to continue, with an increase to 11.9 million expected by 2011 and 12.2 million by 2021. The trend towards increased average life expectancy appears to be widespread, affecting both developed and developing countries (WHO, 1998).

### **1.2.3. Normal Ageing**

Normal ageing is characterised by a plethora of losses that cover many aspects of functioning. It is a phenomenon best conceptualised within a multi-factorial framework incorporating biological, psychological and social perspectives. Biological ageing is a degenerative process that depletes physiological and adaptive resources. Commonly, older people face a decline in their physical health and sensory function, becoming increasingly vulnerable to disease and disability. Some may be able to minimise the detrimental effects of ageing if, for example, they have historically adhered to a healthy lifestyle and have little genetic susceptibility to illness (Greengross et al,1997), whilst the majority of others who are less fortunate should expect to suffer from a long-standing illness (57% of those aged between 65 and 74 and 64% of those aged over 75, according to the General Health Survey; GHS, 2000). Finally, Khaw (1997) has

calculated that 25% of a person's remaining years, once they reach 65, is likely to be spent with some disability.

Other losses covering more socio-psychological domains of functioning include a loss of independence, mobility, role, status and income. There is also an increased likelihood of experiencing multiple bereavements, which can diminish social support and result in a growing sense of isolation (50% of those aged 75 and over live alone, compared with just 12% of those aged between 25 and 44 years: GHS, 2000). Older people also face a narrowing of future perspective that limits future planning and goal-setting as they become increasingly aware of their reduced life expectancy (Brandstädter, Rothermund & Schmitz; 1999).

Successful ageing results when individuals are able to confront and overcome the difficulties and challenges they face in order to protect their self-esteem and maintain self-efficacy. The following section will focus on the psychological strategies that are drawn on to facilitate this process.

#### **1.2.4. Adjustment to Ageing**

Several adjustment to ageing models originating from the psychological and social-gerontological literatures will now be introduced. Although these models concentrate on normal or 'typical' patterns of ageing they do provide the theoretical basis for understanding why some individuals adjust less well than others. This is important since it may be that older people who make a suicide attempt have adjusted less well.

Earlier models tended to focus on the more negative aspects of ageing, for example disengagement theory (Cumming & Henry, 1961), which has now been largely discredited. This model proposed that older adults adjust by becoming withdrawn and disengaged from society to prepare for their eventual demise, but that this somehow allows for their optimal functioning. In contrast to their predecessors, newer models offer a more optimistic view of ageing, conveying the message that older people draw on many effective coping and management strategies to facilitate adjustment (Coleman, 1993).

According to the Baltes & Baltes (1990) model, three key psychological processes underpin successful adjustment to ageing: selection, optimisation and compensation. The first is used by older people to help focus their attention on goals and pursuits that best utilise their existing skills and attributes when facing internal and external changes. The second entails maximising strategies and approaches that have proved effective in the past to continue fulfilling life goals at an optimal level. Finally, compensation is used to overcome restrictions so that goals are still realised. If the above psychological processes are drawn on successfully, the authors posit that a sense of control and self-efficacy is maintained.

Schulz & Heckhausen's (1996) model of successful ageing builds on the selection and compensation processes outlined above, but introduces the concept of primary control. Primary control is achieved when the individual uses selection and compensation strategies to maintain and enhance their existing competencies and level of motivation following a failure experience. Resources are conserved accordingly through selective

rather than diverse goal-setting, which reduce the likelihood of further failure experiences and therefore threats to self-concept. Primary control guides development over the lifespan through making the individual more resilient, thus increasing the possibility of successful ageing, which here is understood as a time of development rather than decline.

In a reasonably similar vein, Brandstädter (1999) proposes in his model of successful ageing that older people use two complementary yet opposing cognitive strategies to preserve self-efficacy and self-esteem, and essentially 'cope' with old age. Assimilative processes involve the individual attempting to modify a situation so that it better fits with their goal, and ties in with Baltes & Baltes (1990) compensation strategy, allowing individuals to optimise their potential. In contrast, accommodative processes are drawn on when goals become unattainable by facilitating a down-grading of, or disengagement from these goals and a corresponding reorganisation of aspirations to make the unattainable goal less appealing. This helps individuals maintain a sense of perceived control and reduces the likelihood of wasting inner resources (Brandstädter & Baltes-Gotz, 1990). Failing to switch from assimilative to accommodative processes by persisting with unattainable goals can cause feelings of inefficacy and despair, which can contribute to depression (Brandstädter et al 1999). It might also be salient in relation to the pathway to suicide.

The above models appear to be more similar than different. All focus on the drive to fully utilise inner resources, revise personal goals and work towards maintaining an overall sense of control at a time of loss and change. The psychological processes

outlined in the models act remedially to translate potential failure experiences into successes; for example, an unattainable goal is dropped so that a more attainable one can be successfully achieved. This arguably allows old age to be a time of development rather than decline. The models also account for individual differences in patterns of adjustment to ageing. Whether a given experience is construed as being a gain or a loss is determined by the relationship it shares with an individual's personal goals and belief system. This explains why some of the losses inherent to ageing are adjusted to better by some people than by others.

Finally, controversy exists in the literature over which criteria best measure successful ageing and adjustment. In the empirical studies that support the above models, objective measures of successful ageing that rest upon societal and cultural consensus have been used. These have been criticized for overlooking more personally-meaningful goals and aspirations, although it is acknowledged that the models do theoretically account for individual differences in adjustment (Schulz & Heckhausen, 1996). Qualitative measures that ascertain which goals are experienced as important by a given individual as or she grows older have been seldom used in studies to date. Bryant, Corbett & Kutner (2001) report on a model of healthy ageing that emerged from one of the few qualitative studies carried out in this area. Their sample experienced healthy ageing as 'going and doing something meaningful' which entailed having something personally worthwhile to do, having the ability and adequate social support to accomplish the activity, and having a positive attitude and sufficient will to achieve the given task.

All of the above models, irrespective of their methodological approach, emphasise the importance of having realistic goals for the future and the motivation to work towards these goals, which often depends on self-esteem and self-efficacy (in fact they are mutually dependent). Depression is characterised by having a limited sense of future, a lack of motivation and low self-esteem and self-efficacy (Williams, 1997). Furthermore, suicidal people have been shown to have a negative attitude towards the future as well as fewer reasons for living than non-suicidal controls (MacLeod et al, 1993). It is therefore likely that older people who have acted on their suicidal feelings have had difficulty in setting goals for their future and drawing on the necessary psychological processes to facilitate adjustment to the losses they face.

#### **1.2.5. The Ageing Self**

This section will take a more detailed look at the ageing self by considering whether the sense of self remains stable over time and how it is constructed in old age. Emphasis will be placed on the structure of self in order to better understand any changes that do occur.

In his review, Coleman (1999) provides evidence for self-concept and self-esteem remaining stable across the lifespan. He concludes that personality traits tend to remain constant, whereas other core aspects of the self, for example personal goals, values and coping styles, are more vulnerable to change. This fits with the adjustment to ageing models. Indeed, Brandstädter et al (1999) assert that as a person grows older, the self becomes more resilient (and therefore stable) through the employment of assimilative and accommodative processes, which act on the three components of the self: actual, ideal and potential. An effort is made to reduce the discrepancy between actual and

ideal selves to minimise distress and avoid any instability to the overall self. If necessary, immunising processes (e.g. denial and self-deception) are employed in extreme circumstances to suppress the recognition of these self-discrepancies.

Ryff (1991) found evidence to suggest that with age well-adjusted adults have a closer fit between their actual and ideal self. This allows them to have a renewed sense of progress when their lives become more limited, whereas on the whole younger adults have greater discrepancies to keep them more goal-directed. It seems that underlying what appears to be a stable outer self are a number of dynamic self-representations that are ever-changing across the lifespan and, indeed, from one point in time to another.

The capacity of older adults to draw meaning and sense from the ageing process varies greatly (Staudinger & Dittman-Kohli, 1992). For most, successful ageing rests upon a redefinition of life meaning in accordance with changing life circumstances. This can be linked to Erikson (1950) highly influential theory of the life cycle which proposes that as adults embark on old age they strive towards 'integrity' which helps them find a greater sense of meaning and order in their lives. This has implications for self-concept, which may entail a shift in one's attitude towards the self to arrive at a position of greater self-acceptance (Kogan, 1990). Despair acts as an opposing force that threatens the quest for 'integrity' if the individual becomes overly concerned with regrets from earlier life stages and the finitude of life.

In line with Erikson's concept of 'integrity', there seems to be a drive towards constructing a coherent life story in old age to help achieve a stable and continuous self-



concept (Mc Adam, 1993). Hazan (1994) describes the need for individuals to maintain consistency throughout the lifespan, by weaving a common emotional and experiential thread through their life story. Reminiscence helps meet this end (Coleman, 1993) and also keeps important aspects of the self 'alive' or reinforced (Lieberman & Tobin, 1983). However, life stories may remain fragmented, contradictory and therefore hard to piece together with a coherent thread (Ruth & Oberg, 1992), and this incoherence could lead to Erikson's concept of 'despair' obstructing the quest for 'integrity', which could prove damaging to the sense of self. The memory deficits and negative attentional focus common to suicidal thinking may impair reminiscence, preventing the more favourable aspects of the self to be kept 'alive'.

In her study on the construction of life meaning in old age, Dittmann-Kohli (1990) found that older adults tended to be less self-critical and more accepting of their lives than their younger counterparts. Constructing a positive meaning in old age was associated with greater self-acceptance and a view that life goals had been reached and that future aspirations were both realistic and attainable. This contrasted with a tendency amongst younger adults to set goals that were less realistic, which may help have helped foster development, suggesting perhaps that they were using a different goal-setting strategy, which fits with the adjustment to ageing models outlined above.

Dittman-Kohli (1990) reported that the negative expectations held by older adults about ageing fell into three broad categories: the threat of illness and loss of health, loss of autonomy, and the salience of existential time (time is running out), all of which tended to be out of their control. Most of her sample did however manage to use various

strategies to maintain a positive focus and create meaning in their lives. Those who did not tend to have a limited sense of future and thwarted future planning, leading to pessimism and despair.

A link has been established in the literature between reporting a positive outlook in old age and being able to maintain self-esteem and psychological well-being (Blazer, Hughes & George, 1987; Costa & McCrae, 1984). Social comparison processes hypothesised to operate as self-serving biases in cognition are thought to act as a mediating force to buffer self-esteem (Heidrich & Ruff, 1993). By thinking of others who are worse off, older people can create a new frame of reference for viewing their own position, which can promote positive self-acceptance even when experiencing physical decline and loss (Heidrich & Ryff, 1993). Equally, having a more negative outlook that rests upon making comparisons with those who are more advantaged has been shown to negatively impinge upon psychological well-being (Ryff & Essex, 1991). Representations of ageing are often drawn on to make the above comparisons and will now be discussed below.

#### **1.2.6. Representations of Ageing: Social Constructions and Stereotypes**

This section is primarily concerned with how representations of ageing influence the perceptions older adults have of others of a similar age and more importantly of themselves.

According to Hazan (1994), much of our knowledge of and indeed our ignorance about ageing is socially constructed. This knowledge consists of many beliefs (both irrational

and rational) and stereotypes (both negative and positive) that colour people's thinking about the experience of growing old. These stereotypes are riddled with contradiction. Older people are positioned as being powerless and dependent whilst being disturbing and threatening, and as being senile and naïve whilst being supremely wise. All of these stereotypes are rooted in the media and arts, medical knowledge and folklore, and have been moulded over time by various social and political forces (Featherstone & Hepworth, 1993). They serve as reference points that guide the way knowledge about ageing is defined, described and represented in both public and private spheres. Commonly these stereotypes impose constraints and limits on behaviour and create symbolic barriers that are used to distinguish young from old (for example compulsory retirement and social rules relating to conduct).

In their analysis of traditional and modern images of ageing in Britain, Featherstone & Hepworth (1993) found that images of youth characterised by beauty, energy and hope tended to be juxtaposed with images of old age depicting degeneration and decline. Both the polarity and potency of these images appears to be fixed, even if the content changes over time. These images are symptomatic of ageism in society, which has been described as the 'ultimate prejudice' (Butler, 1995), and appears to be widespread in Western society (Bytheway, 1995; Palmore, 2001). Minicheillo, Browne & Kendig (2000) used an exploratory study to examine how a non-depressed elderly sample experienced ageing and whether they encountered ageism. Their sample were aware of being seen as 'old' and described negative experiences of being treated as such, while few experienced overt or brutal ageism in their everyday lives. They seemed to lack a vocabulary to discuss ageism, which the authors argue may be associated with a

reluctance to classify the negative experiences they had as stemming from their age. These older people seemed to use two strategies to cope and distance themselves from the discriminatory attitudes they faced: 'accept what happens' and 'get on with life'. This group were also keen to actively negotiate new images of ageing that countered the more negative ones they came across, which the authors understood as a drive against ageism.

Liggett (1974) discusses the impact of the visible effects of ageing on self identity. The physical transformation caused by wrinkling, greying and reduced mobility can result in what they term a 'masking of the self' in which a person's 'true' identity becomes invisible to others due to the connotations it shares with negative representations of old age. An older person can be seen principally in terms of his and her decline, rather than his or her more valued attributes. This interesting idea can help explain negative stereotyping and ignorant attitudes being directed towards the elderly.

Bengston, Reedy & Gordon (1985) found an association between holding a negative attitude towards the elderly (ageism) and having low self-esteem in their elderly sample, indicating that becoming part of a group that is negatively evaluated threatens sense of self. Negative stereotypes of ageing have been found to undermine self-efficacy in old age by providing older people with a pessimistic view of their future development (Seligman & Elder, 1986). The social stigma that comes from being associated with an unattractive group can heighten the damaging effects of physical decline on perceived competency. Kuypers & Bengston (1973) term this process 'a cycle of social breakdown', which occurs when both social and personal positive regard are lost and a

notable decline in a person's sense of competence results. This demonstrates the power social perceptions have over sense of self and functioning. How do older people protect their self-identity and prevent themselves from internalizing the plethora of negative stereotypes that circulate in society? Do they reconstruct their constructions of ageing, or alternatively distance themselves from the more aversive representations? The literature suggests that it is a mixture of the two.

Tajfel's (1978) social identity theory posits that people identify with an ingroup consisting of people they see as being similar to themselves, and that in order to maintain a positive social identity, the ingroup is favoured over an outgroup of people who are positioned as being different and in some way inferior. As self-identity is partly derived from a person's group membership, identifying with a preferred ingroup helps maintain a positive self-identity. A key aspect of the ingroup and outgroup categorisation is an exaggerated homogeneity of the former which artificially distorts the difference between it and the latter. Growing old may call for a renegotiation of an individual's social identity to protect both social identity and self identity, and this may entail a shift in what is perceived to be the ingroup.

Hochschild's (1973) research suggests this may well be the case. He reports that older adults make sub-group distinctions 'young-old' versus 'old-old' to distance themselves from their frailer counterparts and in doing so class themselves as having superior appearance and functioning. Hummert et al (1994) describe this process as 'otherising'. Otherising or distancing oneself from a former outgroup may be a way of managing a 'spoiled identity'. Goffman (1963) coined this term to describe the identity change that

individuals encounter when they join a group that faces stigma and prejudice from wider society. Being assigned a spoiled identity by society requires a certain amount of management to avoid damaging self-identity. Goffman does not include older people as one of his deviant groups; however, given the negative stereotypes that permeate society and the ageist attitudes that exist, it may be that some parts of the elderly community experience a spoiled identity on account of their age, which they may struggle to manage.

Representations of ageing are often caught up with images and ideas about death and dying. Indeed, old age can be perceived as the plane between life and death (Hazan, 1994), although this has not always been the case when for example other age groups have had higher mortality rates, demonstrating the influence of social context in shaping perception (Hazan, 1994). Kalish (1976) suggests that older people tend not to make such a strong link between old age and death, and argues that death fears are actually at their strongest in mid-life, when old age is looming. Not all older adults apply the label 'old' to themselves due to the connotations it shares with closeness to death, as well as its associations with a stigmatised group (Munnichs, 1992). Perhaps, as Hazan (1994) suggests, once the transition is made to old age, certain defenses such as denial are used to distract the individual from the increasing focus on an ever-decreasing lifespan. Or perhaps, as Lieberman & Tobin (1983) found, older adults confront ageing and talk about it openly, without the hesitancy and reluctance of their younger counterparts.

### **1.2.7. Section Summary**

Ageing is a period characterised by loss and physical decline. Nonetheless, according to the adjustment to ageing models, if certain psychological processes are put into place to protect self-esteem and maintain self-efficacy, older people may be able to find a sense of purpose and meaning in life. This view offers hope and the prospect of continued development into old age. However, not all older people are resilient or have the capacity to adapt to their changing circumstances, and nor do they all have sufficient inner resources to cope with being associated with the many negative stereotypes that circulate in society. These individuals may witness reduced quality of life and attacks on the self, which make adjustment very difficult.

### **1.3.1. Rationale for Present Study**

Studies in elderly suicide have concentrated on objectively measuring and identifying various risk factors for suicide. The findings from these studies have been useful in terms of pointing researchers and clinicians towards factors associated with risk, although the picture formed is rather complex and it remains unclear which factors are most salient and for whom, making prevention difficult. Researchers have shied away from exploring how older people who act on their suicidal feelings make sense of their experience and indeed any risk factors that afflict them. There has also been little consideration of the influence of social context at this time. In addition, few studies have thought about the way in which the experience of ageing impinges upon suicide in old age, either in terms of how well a person who makes a suicide attempt has felt able to adjust, or in terms of how they position themselves in relation to the various negative stereotypes that prevail in society. The purpose of this study is to explore the experience

of older people who have recently made a suicide attempt, placing a particular emphasis on the way they understand the pathway to their suicide attempt and how they experience old age. It is hoped that findings will further current understanding of elderly fatal and non-fatal suicide, as older people who make a non-fatal suicide attempt are thought to closely resemble those who make a fatal attempt.

### **1.3.2. The Rationale for Employing A Qualitative Methodological Approach**

The present study utilises a qualitative methodological approach to address the research questions. Qualitative methodological approaches are concerned with ‘the quality and texture of experience, rather than with the identification of cause and effect relationships’ (Willig, 2001,p.9). They provide an opportunity to study how individuals assign meaning to particular events and how they interpret and ‘make sense’ of their experience.

Interpretative Phenomenological Analysis (IPA) was developed by Smith and colleagues as a method of exploring and capturing the experience participants have of a given phenomenon and the meaning they attribute to it (Smith, 1994). As the term implies, IPA has a dual nature: it is ‘phenomenological’ in that it is interested in exploring the participant’s perception of an event or object of study and it is ‘interpretative’ in that it acknowledges the dynamic and interactive process between the researcher’s own perspective and the interpretation of the research data (Smith, 1994). IPA can be used to explore beliefs and attitudes, as well as to shed light upon an individual’s behaviour and experience (Willig, 2001). It has been used within clinical and health psychology settings and Smith (1995) commends its use ‘...where one is particularly interested in



complexity or process or where an issue is controversial or personal' (p9). It is also an approach well suited to the study of psychological processes, whereas another approach such as Grounded Theory is more suited to the study of social processes (Willig, 2001). IPA is therefore highly appropriate to studying the experience of older people who have recently made a suicide attempt and was therefore chosen as a method of analysis in the present study.

### **1.3.3. Research Aims**

The main aim of the present study was to explore and capture the experience of older people who had recently made a suicide attempt by asking four main questions:

1. How do they understand and experience the pathway to their suicide attempt?
2. What is their subjective experience in relation to various 'risk factors' for suicide and how did these factors come together alongside other 'unidentified' factors prior to the suicide attempt?
3. Does their experience of ageing, and the extent to which they have felt able to adjust to it, impinge upon their suicidal thinking?
4. What beliefs do they hold about suicide, and how do these influence their decision to act on their suicidal feelings?

## **2. Method**

This study utilised a qualitative methodology to explore and capture the experience of fifteen older people who had recently made a suicide attempt. A semi-structured, in-depth interview was employed as part of this methodology to capture the experience of participants, the meanings they ascribed to their experience, and in addition, the beliefs, perceptions and feelings they held related to the phenomenon under study. Interpretative Phenomenological Analysis (IPA) was used to extract key themes from the interview data.

### **2.1. Ethics**

Ethical approval was granted by the Local Research Ethics Committee responsible for Camden & Islington Mental Health NHS Trust (C&I) - see Appendix 1. In considering ethical issues related to this study, it was acknowledged that talking about suicidal thoughts and feelings soon after acting on them may well be distressing, but that people can also find it a relief to talk about how they have felt. In view of this, five precautions were taken to reduce the likelihood of distress. First, staff from Mental Health Care for Older People services (MHCOP) provided ongoing risk assessment and regular monitoring of the mental state of participants before and after the interview, and the suitability of the patient was discussed prior to the interview taking place. Second, all participants were free to end the interview at any time without having to give a reason, and were invited to request the company of their keyworker or somebody close to them if they became distressed. Third, as interviewer, I was able to draw on my clinical experience of interviewing clinical populations to monitor the effect that the interview was having on the participant. Fourth, sufficient time was allocated at the end of the

interview for debriefing. Finally, feedback was provided to staff after the interview regarding the participant's level of risk.

## **2.2. Research Setting & Recruitment**

All fifteen participants were recruited from MHCOP in C&I. This inner-London trust configures its services into five sectors each pertaining to a geographical catchment area, with its own multi-disciplinary community team and inpatient service. All participants were under the care of one of these teams at the time of recruitment. The five consultant psychiatrists responsible for MHCOP in C&I agreed to collaborate in this study and provided access to patients.

Each of the community and ward based teams were visited and given a short talk detailing the nature and purpose of the study, and what it required from them as potential referrers. Ward round, early afternoon hand-over, or a weekly referral and business meeting for the community teams provided suitable forums to present the talk. Staff were able to raise any practical concerns they had about the recruitment process and one link person was nominated from each of the ten teams to facilitate access to potential participants. This link person was contacted on a once-weekly basis to find out whether there had been any suicide attempts within the team, either from their existing caseload or from a new admission or referral over the past week.

### **2.3. Participants**

The following inclusion criteria were used in the study: being in contact or having been referred to local MHCOP services following a suicide attempt made between mid-April 2001 and mid-January 2002, and being aged 65 years or over. Patients were excluded if they had a cognitive impairment (based on clinical judgement or a MMSE score of <24/30), a psychosis, or if they had made a euthanasia-driven attempted suicide. The rationale underlying the first two exclusion criteria was to avoid interviewing patients who may have found it difficult to think about their lives in recent years or who may have been too distressed to be interviewed about their experience. In terms of the last criterion, it was felt that the psychological processes underpinning euthanasia were likely to differ from those underlying a suicide attempt. However, during the period of data collection, no patients presented to services meeting any of the exclusion criteria.

Table 2.1. (see below) provides details of the patients from across the five sectors that met the inclusion criteria for the present study and the number who agreed to participate. As the Total row indicates, twenty-one patients met the inclusion criteria for the study, of which approximately just over two thirds (71%) agreed to participate. Five out of the six who declined did so at the initial point of contact (i.e. with a professional known to them). One patient declined at the point of interview. Of the six who declined, four did not give a reason and two said that they simply wanted to “get on with their lives and put the suicide attempt behind them”. Once the interview began, no participants stopped the interview before the end.

**Table 2.1: Summary Figures for Population and Sample of Participants across the Sector Teams**

<b>Sector Team</b>	<b>Suicide Attempts</b>	<b>Participated</b>	<b>Declined</b>	<b>% Agreement Rate</b>
1	8	4	4	50%
2	9	7	2	78%
3	2	2	0	100%
4	2	2	0	100%
5	0	0	0	N/A
<b>Total</b>	<b>21</b>	<b>15</b>	<b>6</b>	<b>71%</b>

Table 2.2. (see below) provides descriptive information on the sample. There were nine women and six men aged between 65 and 91 (mean age 69.5, median age 66). All participants were diagnosed as being depressed at the point of suicide attempt, either retrospectively or according to a pre-existing record. Twelve of the fifteen suicide attempts were deemed to be of serious intent by a clinician, with the intent behind the remaining three being unclear. The overdose method varied greatly amongst participants. Interviews took place between 5 and 143 days after the suicide-attempt.

In terms of ethnic origin, all participants were White European. Twelve were from the UK, two from Ireland and one from Eastern Europe. Only two participants were identified as having a religious belief: one Catholic, One Christian).

#### **2.4. Procedure**

In line with requirements of the Local Research and Ethics Committee, participants were approached about the study by a mental health professional known to them with a view to being interviewed as soon as possible after their attempt. They were given the opportunity to read and consider a patient information sheet (see Appendix. 2) before

Table 2.2. Description of the sample

Participant identifier	Age	Sex	Marital Status*	Diagnosis	Contact with MHS prior to attempt	First Suicide Attempt	Clinician View of Intent	Overdose details	No. of days between suicide attempt and interview
Mrs B	75	F	M	Depression & Anxiety Disorder	Yes	Yes	Unclear	9 Lithium tablets	9
Mrs A	66	F	D	Manic Depression***	Yes	No (4 <sup>th</sup> )	Unclear	16 Co-Proxamol, 6 Warparin & other meds unspecified.	89
Mr J	91	M	C	Depression***	Yes	No (3 <sup>rd</sup> )	Serious	60 Temazepan tablets	15
Mrs K	87	F	W	Depression **	No	Yes	Serious	10 Paracetomal tablets	51
Mrs G	76	F	D	Depression /Alcohol Abuse	Yes	No (>5)	Serious	1 Large bottle of Whiskey	22
Miss F	77	F	S	Depression	No	Yes	Serious	10 Amitriptiline tablets	8
Miss C	83	F	S	Depression	No	Yes	Serious	26 Paracetomal and 32 Nytol tablets	47
Mr S	80	M	W	Depression	No	No (2 <sup>nd</sup> )	Serious	26 Paracetomal tablets	5
Mr C	79	M	S	Depression /Alcohol Abuse	Yes	No (>5)	Unclear	20 Paracetomal tablets	58
Miss M	67	F	S	Depression **	No	Yes	Serious	Diazepam, Gabapentin, Trimipramine unspecified quantity	8
Mr H	71	M	M	Depression **	No	Yes	Serious	180 Temazepan tablets	143
Mrs S	66	F	D	Depression **	No	Yes	Serious	Weeks worth of meds from dose-it box. Approx. 42	22
Mrs P	66	F	D	Depression	Yes	No (2 <sup>nd</sup> )	Serious	90 Aspirin tablets	8
Mr Z	72	M	S	Depression	No	Yes	Serious	48 Tricyclic antidepressants	15
Mr W	65	M	W	Depression	No	Yes	Serious	80 Paracetomal & 50 Beta-blockers	14

\* Marital Status: Cohabiting (C), Divorced (D), Married (M); Single, never married (S), Widowed (W)

\*\* Diagnosis given retrospectively by clinician in MHCOP. \*\*\* With personality difficulties.

considering whether they would like to participate. Once it was established that participants were willing to be interviewed, they were contacted either by myself or by a member of staff known to them to arrange an interview time and location.

Participants were interviewed in one of three settings: an acute psychiatric ward for older adults (9); a medical ward for older adults (2) or their own homes (4). In all but one case for the ward-based interviews, a private room was used. For this one interview, which was conducted on a busy (and noisy) medical ward, curtains were used to try to increase privacy. All participants completed a consent form (see Appendix 3) giving their consent to the interview. Most interviews lasted between 1 and 1.5 hours (ranging from 50 minutes to 2.25 hours) and were tape-recorded. Every participant was debriefed at the end of the interview, and if the interview was ward-based, participants were monitored by staff following the interview.

After the interview had taken place, the medical records of participants were scrutinised for demographic details. When participants were interviewed at home, their keyworker provided their demographic details over the phone or through a meeting. Collecting this information allowed for greater communication with staff both on wards and in the community. It also allowed for feedback to be provided in terms of risk after the interview.

Information pertaining to the identity of participants was removed during the transcription process. Each interview took approximately one day to transcribe. Data collection took place over a six month period (mid-July 2001 – mid-January 2002).

## 2.5. Qualitative Interview Schedule

A semi-structured interview (see Appendix 4) was developed for the study in conjunction with Smith's (1995) guidelines to explore the following key areas:

- Background information. This section was used to orient the participant to the interview and gather information about their recent past.
- The psychological pathway to a suicide attempt. This section was concerned with the participant's thinking prior to the suicide attempt, and how suicidal thoughts evolved over time.
- How the possible risk factors came together and contributed to the decision to make a suicide attempt. This area was concerned with participants' experience of various risk factors and other 'unidentified risk factors'.
- Adjustment to ageing and attitudes and beliefs about growing old. This area examined how well the participant felt they had made the transition to growing old, and whether this process was experienced as being turbulent or smooth. The advantages and disadvantages of ageing were also explored to elucidate stereotypes of ageing and internalised ageism.
- The beliefs held about suicide. This section was concerned with exploring beliefs held about attempted and completed suicide over the life span.

The interview questions were anchored in the above areas of exploration. Once the schedule was in draft form, it was given to two experienced clinical researchers for comment, after which it was revised. Following this initial revision it was piloted using



two 'mock' interviews in which an experienced clinician and an older person from a non-clinical population role-played potential interviewees. This resulted in further revisions being made and also provided the interviewer with the opportunity to practise dealing with issues of complexity and distress that could arise when interviewing. Piloting the schedule on a clinical participant was not possible due to the paucity of patients meeting the inclusion criteria for the study.

Once in final draft, the interview schedule served as a guidance tool rather than a strict protocol and was drawn upon during the interview to ensure that the key areas of exploration were examined. Interviewees were positioned as expert and encouraged to discuss their experiences, thoughts and perceptions about the phenomenon under study, thus inviting the interviewer to enter their psychological and social world (Smith, 1995). The schedule was therefore used in a flexible manner in an attempt to produce richer data.

In line with Smith's (1995) approach, every effort was made to ask open-ended, non-leading and jargon-free questions. Some solution-focused techniques, e.g. de Shazer's (1985) miracle question, were also drawn upon to facilitate discussion of complex issues such as thoughts experienced prior to the suicide attempt. Solution-focused techniques also proved useful when debriefing interviewees.

## **2.6. Method of Analysis**

Once the interviews were transcribed, IPA was used to systematically identify key themes within the data. Smith, Jarman & Osborn (1999) provides useful guidance on

how to analyse data using this approach. Each transcript was read and re-read using the margins to note anything of interest or significance. These notes consisted of key words, initial reflections, summaries of connections, preliminary interpretations, emerging themes and generally any material that conveyed the essential quality of the text. The transcripts were read and re-read to enable the researcher to become more intimate with the data.

The second stage involved listing the emerging themes on a separate sheet to help cluster the initial themes into groups. These were then further refined by returning to the original transcript in a cyclical process. The third stage was to develop a master list of themes and sub-themes substantiated by verbatim quotations from the transcript. Once this was done for the first transcript, the master list of themes was used to guide the analysis of the second transcript allowing it to be further refined and developed with themes that emerged. This process was repeated for all fifteen transcripts. The emerging theme lists were regularly checked against verbatim quotes within the transcripts to ensure that they were an accurate reflection of the data, in an effort to enhance validity. Diagrams also proved helpful in mapping out the themes and shaping my ideas and thinking.

It was important to approach the analysis in a systematic and rigorous manner. It was also important to value the creativity and curiosity of the researcher as "...the crucial part of the analysis remains the particular interpretative analysis the investigator brings to the text." (Smith et al, 1999, p.238). At times this created a tension which seemed to be most fraught at the point of quality control, i.e. carrying out various credibility checks on the

analysis. These checks are essential, but care must be taken to ensure that they are meaningful. Fortunately, guidelines have been published to address quality control in qualitative research and these were drawn on in this study (e.g. Elliott, Fischer & Rennie, 1999). Those guidelines concerned with validating the individual researcher's interpretation will be discussed here, whereas those concerned with reflexivity will be discussed in the sub-section below (Note: issues of quality control and reflexivity will be returned to in the Discussion chapter).

At various stages during the analysis emerging themes were presented alongside quotations and excerpts from the transcript to four other researchers familiar with IPA for comment and discussion. This regular consultation aided the process of finding connections and inter-relationships between the themes, and was aimed at reducing researcher bias. In addition, early on in the analysis two complete transcripts were analysed by an independent researcher experienced in IPA who then drew up her own list of themes, which were compared to the existing theme list and discussed. Again, this helped sharpen the existing theme list. A research journal was kept to note the discussions and refinements of themes.

After the analysis of the fifteen transcripts was complete and the master theme list had been revised, a selection of quotations from each of the master themes and their corresponding sub-themes was given to another researcher who was asked to create her own theme labels and organise them into clusters of her own master themes. The aim of this exercise was not to reach consensus but to allow me to think about the data from a different perspective, and to think about how I arrived at the specific organisation of my

account. Each of the above checks was carried out in an attempt to assess the validity of the individual researcher's interpretation, rather than to check on the objectivity of the master theme list, which would have been irrelevant in the context of a qualitative approach such as IPA (Yardley, 2000).

## **2.7. Researcher's Perspective**

Willig (2001) highlights the importance of understanding the researcher's perspective when utilising qualitative methodologies, particularly during the stage of analysis. The researcher views the data and therefore the phenomenon through the lens of her own experience. It is therefore necessary to outline my motivation for choosing this research area.

I have a keen interest in the phenomenon of suicide across the life-span and how the decision to make an attempt evolves over time, having worked clinically with patients experiencing suicidal thoughts, both those who have and have not acted upon them. I have also been involved in health service research linked to serious incident enquiries in which individuals known to mental health services have made fatal suicide attempts. This involved tracing coroner's court and trust records for each suicide case, and identifying points at which services could have intervened differently. The research was primarily concerned with evaluating risk assessment procedures and considering ways in which risk could have been better managed. Little attention was paid to the experience of the individual prior to the attempt, which is perhaps understandable given the context of the research. Nonetheless, reading through reams and reams of this information undoubtedly fostered my interest in this area.

I am also interested in the relationship between ageing and suicidal thinking. This seems to be borne out of clinical work carried out with older people, and thinking about the way they manage to live with the prospect of death, reduced life expectancy and the many losses that accompany growing older. One expectation I had as a researcher (perhaps coming from the position of being a young researcher), was that the experience of growing old would be salient to older people who act on their suicidal feelings, regardless of whether they had a history of suicide attempts prior to the age of 65. This may have been linked to a piece of clinical work that I carried out with an older man who had tried to hang himself following his retirement and a decline in his physical health. Finally, another expectation I had was that older people are 'giving up' when they make a suicide attempt. Again it is likely that this assumption may have originated from my clinical work.

With a keen interest in working with older adults, I carried out a specialist elective placement within C&I (Sector 2) as part of my clinical training which has further developed the above interests. I draw on cognitive behavioural and solution-focused models in my clinical work, all of which have influenced my thinking in this research.

### 3. Results

#### 3.1. Presentation of the Findings

This chapter presents 20 themes that are organised into three main groupings (The Struggle, Control and Visibility) and that cover the experiences of participants prior to, at the time of and following their suicide attempt (see Table 3.1). The themes are interrelated and overlap at times, and each will be discussed in turn, with one exception, coming to terms with getting older (4) which will be presented after the Visibility theme grouping. Representations of suicide that emerged from the interviews will be presented at the end of the chapter, before a closing summary.

Table 3.1: **Master Theme Groupings with Subordinate Themes**

Master Theme Groupings	Subordinate Themes
1. The Struggle	1a. Turning point: <i>Life got tough when</i>
	1b. Feeling trapped: <i>This is as far as I can go</i>
	1c. Feeling unable to cope: <i>It just felt too much for me</i>
	1d. Getting dragged down: <i>I was going down, down and down</i>
	1e. The inner battle: <i>I was at war with myself really</i>
	4. Coming to terms with getting older: <i>I mean I'm joining the club myself</i>
2. Control	2a. Losing control: <i>Mother you have let yourself go</i>
	2b. Trying to maintain control: <i>I tend to push myself</i>
	2c. Finding a solution: <i>It seemed like a solution</i>
	2d. Giving up: <i>There was nothing else left</i>
	2e. Impulsive Vs. planned decision to act on suicidal feelings: <i>It was entirely a momentary decision Vs. I had this feeling anyway that that would be my out</i>
	2f. Failing to find a solution: <i>I should have done it properly</i>

	2g. No more control: <i>Where do I go from here?</i>
	2h. Regaining control: <i>I'm already getting a bit better</i>
3. Visibility	3a. Becoming less visible: <i>I am sort of isolated I think</i>
	3b. Being overlooked or written off by others: <i>You're getting old, you've had your life</i>
	3c. Trying to keep visible: <i>I was a very feminine person, very sexy</i>
	3d. To become invisible: The intention behind suicide attempt - <i>To lie down and get ready to die Vs. I was hoping that I might just go to sleep</i>
	3e. Becoming visible again: <i>I was missed more than I thought I would be</i>
	3f. Becoming visible as a burden: <i>Well you are sort of making extra work for them...</i>

Key

■	Prior to the suicide attempt
■	The suicide attempt
■	After the suicide attempt
■	Experienced prior to and after the suicide attempt

### 1. The Struggle

This theme runs through all of the interviews. Most participants acknowledge a specific turning point in their lives when they began to struggle. For those with a history of mental health problems, this may have been many years ago, whilst for those without it tended to be more recent. Some participants experienced multiple turning points in the period up to their suicide attempt. Immediately prior to the suicide attempt the experience of participants was characterised by a feeling of being dragged down, entrapped and ultimately feeling unable to cope. Often these feelings came together in descriptions of an inner battle that was heightened immediately before the suicide

attempt. The pace of the struggle was conveyed strongly in the interviews. Participants reported feeling weighed down and exhausted by the time they made their suicide attempt. 'Coming to terms with getting older' was also experienced as a struggle for many participants and will be presented after the visibility theme as it was often talked about quite separately from the suicide attempt.

### **1a. Turning point: *Life got tough when ...***

This theme emerged for many participants when their lives took on a different course and became a struggle, and this was usually discussed in response to the initial interview question asking them how their life had been in recent years. Although the nature and timing of the turning point varied considerably among participants, a common thread in all accounts was the disruption experienced to the former *status quo*, and much of the tumultuous struggle that followed entailed trying to return to this prior state of equilibrium.

Some of those participants with a previous history of suicide attempts discussed their first 'breakdown' as a significant turning point, marking the onset of their struggle.

*Let me think, umm, my brother he got married and I went to live with him for a time. I had one or two relationships, which were quite satisfactory. And uhh, then I soon realised that I was not normal. I was from time to time having breakdowns. Anyway this went on until later in life. (Mr J)*

Or the turning point may have been associated with their first suicide attempt.

*But soon after that [initial suicide attempt], I never really picked up. (Mrs P)*

Others identified a more recent turning point when things had changed for the worse.

This was often associated with a stressful life event.



LC (Interviewer): *What has life been like for you in recent years?*

Mr S: *Well, if you want me to start more or less from the beginning, life got tough I suppose, really, when I suppose, first when my wife got cancer you see.*

*I was working in the Jewellery trade for myself up until when was it? Last November, last October, then I retired. I wasn't feeling too good then and I thought, well at my age it's just as well. Then my brother died as I was retiring so I had all that stress to face of getting him cremated in Plymouth, where he lived. Uh, then I had a lot of, I was all right at the beginning... [pauses and then changes the subject]. (Mr H)*

Sometimes a link was made between the suicide attempt and a very recent turning point in which things 'blew up' (Mr J) or participants felt 'wiped out' (Mr Z). For several participants this was a sharp worsening of their health, which was accompanied by a significant increase in pain.

*And then about three weeks before D day or F day [suicide attempt] the pain got so severe, I was just practically screaming. I just couldn't do anything and I just couldn't believe that there was such pain around you know. (Miss M)*

Being unable to cope was also identified as a turning point (see 1c).

*Well I've always coped well until August I don't know why, whether they've changed the tablet or what and I got very nervous, and [then] not Christmas day, Boxing day I took 80 Paracetamol. (Mr W)*

Although most participants tended to identify a single turning point when their life took a turn for the worse and became intolerable (e.g. being mugged, having a fall etc.), it became apparent over the course of the interview that many participants were experiencing multiple struggles that had been exhausting their coping resources and wearing them down for quite some time.

*Well I've taken a back seat from my previous attitude to life. I used to be very generous and umm, and outgoing. I trusted everybody. Now I've got the attitude that you can't trust any body. [...] I was mugged once in my hallway in my home [...] and that was one of the reasons I moved into sheltered accommodation. (Mr C)*

Sometimes it was the suicide attempt itself that was described as a turning point.

*The thing that surprises me is why I waited for now to do it. I mean I could have done it two years ago three or four or five years ago why wait? But as I said I could always cope until then and I got to a certain point then when I thought “Oh to hell with it all. What’s the point of going on?”* (Mr W)

### **1b. Feeling trapped: *This is as far as I can go...***

Prior to acting on their suicidal feelings, most participants held a strong belief that their future was either bleak or non-existent. This belief generated a sense of entrapment that was characterised by a rising tension and frustration. One participant described feeling ‘*just totally blocked in*’ (Mr S), another felt that ‘*the end had been reached*’ (Mr C) and that he ‘*couldn’t see no future, no. It was just a blank*’ (Mr C). Another participant felt that ‘*Everything seems to shrink and shrink and get worse*’ (Mrs P). In the following excerpt Miss C describes reaching a dead-end:

*It’s just that I felt that, well this is as far as I can go. There was nothing else left. This is it. There was nothing else left.*

All participants elaborated on the reasons why they felt that they had reached this point and these reasons varied considerably. Lengthy descriptions were provided detailing both internal and external stressors (e.g. deteriorating health, an increasing intensity of pain, isolation, increased dependency, losses), which were seen to contribute to their suicide attempt. Most frequently, participants spoke of an actual or perceived decline in their general functioning and their quality of life.

*Yes, yeah, I thought well I can’t live like this. I can’t live like some old invalid, it’s not for me.* (Miss C)

Thoughts and feelings similar to those outlined above seemed to contribute to the decision to act on suicidal thoughts and will be returned to under the discussion of either the 'finding a solution' or 'giving up' (2c & 2d).

### **1c. Feeling unable to cope: *It just felt too much for me...***

In becoming entrapped, participants described feeling overwhelmed by a mounting pressure in which the accumulation of various external and internal stressors undermined their capacity to cope and in doing so transported them to breaking point or in Mr C's terms the '*end of my tether*'.

*...I just couldn't take anymore and seemed to have frustration everywhere.* (Mrs P)

*...But if you are human there is only so much that you can take.* (Mr J)

*...I was in a bad way, I was in a low state. You know I had no resilience, no mental resilience.* (Mr Z)

*...and uhh, as I say when I got back out of hospital after a couple of days the pain was even worse. And I just couldn't stand it. I got up one morning and I couldn't move out of bed and as I went to stand up, it really, really knocked me down again. I mean I couldn't, every thing went black you know and I thought to myself, I just can't stand it, I just cannot stand the pain.* (Mrs K)

A key aspect of feeling entrapped and unable to cope was a rising pressure that gathered pace over time.

*But, as time went on of course, time started getting shorter and as time started getting shorter, I was getting very uptight about it.* (Mr S)

### **1d. Getting dragged down: *I was going down and down and down***

The experience of depression was seen to be a key element of the overall struggle and for some participants was akin to being dragged down: '*I was going down and down and*

down'. (Mr J). Participants described spiralling further and further into a depressed state, becoming increasingly powerless so that they were left feeling disoriented and forlorn:

*You feel lost with depression. You didn't know where you was and that, you didn't know where you were going or whatever like. Like a big dark hole. You just want to get out of it. (Miss F).*

At times, the force of being dragged down felt so great that several participants feared bringing down those close to them.

*I brought two extra lots [Aspirin], just in the last few weeks and I wrote two suicide notes just basically on the premise you know "I'm dragging you [family] down. I'm dragging you down. You'll be better off on your own and you'll just recover from this". (Mrs P).*

### **1e. The Inner Battle: Well I'm at war with myself really...**

In the build up to their suicide attempt, most participants described being involved in some kind of ongoing struggle. For some this was related to an inner turmoil in which they were fighting against mounting depression and anxiety.

*Some times I can get back to sleep but other times my thoughts just race, racing, racing round like. All kinds of things, things that I didn't want to particularly think about but came forward. But I just pushed them away as much as I could like. (Mr S)*

War and battle-like metaphors were sometimes used to describe this struggle.

*...Well I'm at war with myself really. You know I do silly things really. I'm at war with myself. I start condemning myself for doing certain things. (Mr C)*

For some the struggle involved fighting against others for example those who were seen to pose a threat to the elderly or in Miss M's case to medical professionals who did not believe she was ill.

*Well a disadvantage to growing old now is what I've just said – that you've got to either stand on your own two feet and fight them off or go down. (Miss C)*

*Before my attitude has been don't let the bastards grind you down and I'll prove that I've got something and it's not in the mind and I was still proving it. (Miss M)*

The battle was mostly described as being ongoing and relentless: *'I seem to just struggle on and on.'* (Mrs P) and *'It's been a long, long struggle. It's been long and slow and painful struggle.'* (Miss M). Participants fought against this struggle, although they felt less able to fight towards the time of the suicide attempt.

*See I'm a fighter you see normally. But I know one of these days I'm going to lose the fight as although I've got a good wife and good friends, things don't seem to be working for me. I don't know what's missing. There is something missing and I can't seem to put my finger on it. (Mr H)*

Another aspect of this theme was that previously effective coping strategies were no longer working to alleviate illness, stress, or help the individual cope with a difficulty.

*I wasn't feeling so good. That was one of the main reasons I suppose. I never felt like that, so bad you know. My blood pressure all went up and down. It would go up and then a few hours later go down. I could always cope but then they put me on these tablets and I don't think they were as effective as the old ones I was taking for about 20 years. And then I started feeling depressed and I wasn't feeling so good each day (silent). (Mr W).*

And occasionally this encouraged the use of maladaptive coping strategies.

*...For the last month or two I've been getting these pains in the head and I've turned to drink to solve it as it helps me sleep. Helps me sleep. Whiskey helps me sleep. (Mr C)*

The inner struggle sometimes emerged close to the time when participants were making a decision to act on their suicidal feelings. This seemed to entail an ambivalent attitude towards life and death: *'Will I do it, will I not, will I do it, will I not.'* (Mrs A)

*But I, know uh, I'm 76 and um, I know that times catching up. But, I still don't want to go but I had a very bad day with my son and then I thought why bother, you know ... (Mrs G).*

## 2. Control

The theme of control permeated all of the interviews. Participants felt increasingly helpless as they witnessed a loss of control over important aspects of their lives and often made desperate attempts to regain this control prior to, at the time of and after their suicide attempt.

### 2a. Losing Control: *Mother you've let yourself go...*

Participants voiced concern and desperation as they experienced losing control of aspects of their health and functioning. This was commonly related to the following: a loss of health and the prospect of ongoing physical decline, a loss of mobility that was accompanied with a fear of falling, and finally a loss of independence or forced lifestyle change that was characterised by a fear of becoming dependent on others. Some of these losses were inextricably linked to the ageing process, whilst others were quite unrelated. For example, one of the younger participants spoke of losing control of her daily routine and home-life following eighteen months of building works in her house that had left her in personal chaos and feeling unable to cope.

*I took on board the disorder and the dirt, and I was quite scruffy. My daughter said "Mother you've let yourself go". (Mrs P).*

Witnessing the body becoming less reliable through declining physical health also produced the feeling of losing control: '*... the body wasn't just able to get it together like*' (Miss M). Some associated this with ageing: '*[Its] just wear and tear, as you get older*' (Mr H). In most cases the effect of this loss of health was quite profound, and spilled over to other aspects of participants' lives.

*Well, I thought to myself, I thought to myself well life you know, what have I got in life now? I've got all these bloody illnesses and uh, you know I can't do anything. I thought what quality of life, I haven't really got a lot of that, as I haven't really got anything to look forward to anymore because I've got this medical problem and one or two apart from my liver. That's it really. (Mr H)*

Alongside their physical decline, some participants were overwhelmed by their experience of pain. Here, participants seemed to have been stripped of all their coping strategies, leaving them with little or no control.

*...and uhh, as I say when I got back out of hospital after a couple of days the pain was even worse. And I just couldn't stand it. I got up one morning and I couldn't move out of bed and as I went to stand up, it really, really knocked me down again. I mean I couldn't, every thing went black you know and I thought to myself, I just can't stand it, I just cannot stand the pain. (Mrs K).*

Almost half of the sample described having had a fall in the months prior to their suicide attempt, which left some of them feeling very helpless both at the time of the fall and in its aftermath.

*...I couldn't move, I was flat on my back (Mrs K)*

*So I had dreadful aggravation. I couldn't get out. I was collapsing all over the bloody place[...] So, I just couldn't move. I couldn't sort of, the helplessness. I think that's what got me really. (Miss M).*

All of these participants were haunted by the incident, suffering a loss in confidence and reduced mobility. Although their degree of impairment varied, most were left feeling less autonomous and increasingly dependent on others.

*I might get halfway up the stairs and it would go and that's what I'd worry about. I mean if I fell over I'd never get up, someone would have to get me up, I couldn't get up, yeah... (Mrs G).*

Reduced mobility served to compound their difficulties, exposing other difficulties such as their isolation. Furthermore, some participants began to see themselves as a liability.

*Well it just made things so much more difficult. Things like eating and buying food and cooking and even cleaning and washing. Just coping with everyday things [...] Yes I was literally collapsing, dropping and falling on the floor. (Miss M)*

Another feature of 'losing control', was the fear of becoming increasingly dependent on others in the future. This fear was usually discussed alongside an incident in which participants temporarily became dependent on others, or had experienced a hospital stay in which they witnessed dependency in others both of which allowed them to better imagine what this dreaded prospect would entail for them if they were to decline further.

*Oh it's always on my mind and it has been ever since I had the blood pressure. I think going back 15, 20 years I suppose. Not being able to do anything for yourself, it's the worse thing of all like. I mean I can get up and go to the loo and do things myself. I can shave myself. I don't need anyone to help me. But if I lost that kind of freedom I think it really would be the end for me. I'd rather they give me something and let me die. (Mr W).*

Another way in which a number of participants spoke of an eroding autonomy was when they were forced into a position of little choice where in effect someone had made a decision for them. A prime example of this was Mr Z's compulsory redundancy due to his age:

*Umm, but unfortunately about two years ago I was made redundant because I was seventy and they said "I'm sorry we can't keep you anymore" ...I was offered redundancy; well I was told (laughs) I wasn't offered it I was told.'*

And his experience of having to wear a catheter:

*I had a leg bag, which was just unbelievably unpleasant, and I mean so revolting but it worked. I mean it was just so depressing, so demoralising, humiliating and got me down such a lot, such a lot.*

A small number of participants gave particularly dramatic descriptions of an occasion in which they suddenly and somewhat alarmingly noticed changes to their physical



appearance, which indicated to them that they were growing old. It was as if these changes had taken place over night.

*So it was this year, yes this January I had some new photographs taken by a woman (Taken for professional reasons). But then I suddenly thought as I was looking through them all "Jesus, god I'm old, I look so old" ... (Mr Z).*

The ageing process was seen to be omnipotent and inescapable: *'You can't defeat age.'*

(Mr Z) and *'...of course we're getting on now and uh, as I say old age is creeping on...'*

(Mrs K). This seemed to contribute to the feeling that autonomy was being lost and that changes were taking place that were beyond their control.

*I just began to think, "It's just all not on. I'm just fed up to the back teeth with every thing." I thought "I'm getting old, I can't bear it, I look in the mirror and I feel sick when I look in the mirror. Every thing is going wrong," I thought and you know "Every thing is going wrong and I just don't want to know". (Mr Z).*

Sometimes participants experienced losing control of multiple aspects of their lives leading to an intensification of their feelings, which may have signified a turning point when they felt unable to cope. Finally, Mrs G's experience around the time of her suicide attempt seems to epitomise the loss of control over routine and daily functioning that some participants experienced prior to their suicide attempt:

*I was all dirty, all my trousers and I had an old pair of slippers on and um, my top was filthy. They [ward staff once hospitalised] said what on earth have you been doing? I don't know what I'd been doing, I was filthy.... I think I went to bed with all my clothes on and everything and got up and carried on. ...I was bewildered. I felt bewildered and desperate.*

## **2b Trying to maintain control: I tend to push myself...**

Many participants tried hard to regain some of their lost control by desperately holding onto any power and dignity they did have, using it to fight against their losses, even if this was sometimes in vain:

*... And I try to keep my mind occupied and I try to spend as much as I can trying to make myself look as young as I possibly can, without any surgery or anything like that (laughs) (Mr Z)*

*Yes and I mean people have the wrong idea about why people pay. People pay because they are so utterly desperate and they have no other way out. (Miss M describes her motivation for seeking help through private practice, therefore exerting her control when she felt that the NHS was failing her).*

And for Mrs B who was becoming increasingly dependent on others for her self-care:

*One nurse, on the night. She said that I had to go to toilet in the bed, in my bed. [...] So I held it.*

Another aspect of this theme was the effort made to try and occupy one's time, and keep going, as if to maintain control of one's daily life. Often underneath this drive there was a fear of losing purpose in life:

*LC: How would you say you managed the adjustment to retirement?*

*Mr Z: Not very well, not very well. I didn't know what to do with my day. Barry [partner] was very supportive. [...]. He's more calmer and adjusted than I am. He said "Just take that day as it comes, read the paper, go out and get the paper, do the chores around the house and things like that" and I thought "Oh god, all unconstructive things".*

*And later in his interview:*

*.. And then the fact that once I retired and had no further aim, nothing to get up for, then it all began to sort of think "Oooh, it's all crumbling, crumbling"(Mr Z)*

*..Yes, came back with the paper and by that time it was about half-past one and quarter to two and you see after I had read the paper, cos there was nothing for me to do until the, until about 5pm when I tend to push myself to get my dinner in, you know that kind of thing, then watch television and that kind of thing. (Mr S)*

Some participants felt that their lives lacked purpose and meaning, which is likely to have contributed to the detachment they felt from society at large (see themes 3a and 3b).

### **2c Finding a solution: *It seemed like a solution***

For many participants the suicide attempt, irrespective of their level of intent to die, was a way of taking control of a helpless situation, and enabled them to feel empowered again.

*I thought, well the doctor was giving me tablets for it but they weren't doing nothing for it, it was there, the pain all the time. So I thought if they won't do nothing then I will and I just took all the tablets I had. (Miss F).*

Mrs P's view that: '*It seemed like a solution*' as it would '*..solve all the problems*' was echoed by other participants who termed it as their '*out*' (Mr H), a way of getting '*relief*' (Mr J), being able to '*finish it off*' or as Miss M dramatically termed it her '*D day*'. It was as though participants had managed to regain the power and control they had previously lost to solve their problems, whatever their nature.

*So I flipped. I thought "Well she'd be better off without me. [...]I thought this [housing repair works] could all be untied in five minutes if I died". I thought if I died, it would go up for sale, go up to auction and no one would care about these details. They would all get mopped up in the thing. [I thought] that she was better off without me, which I know was stupid. (Mrs P)*

Once their decision had been made, some participants described themselves as being unstoppable, which seemed to show their determination to bring about a significant change: '*I don't know. I don't think anything would have stopped me.*' (Miss S). In describing finding a solution, participants' descriptions were full of energy and vigour.

### **2d Giving up: *There was nothing else left...***

Some participants did not describe their suicide attempt as being a way of exerting their control over a helpless situation; instead, it was more a matter of giving up.

*...I just thought I can't stand this, I'm 87 and it's never going to get any better and I just thought to myself that I didn't want to know. (Mrs K)*

*...It's just that I felt that, well this is as far as I can go. There was nothing else left. This is it. There was nothing else left. (Miss C).*

The distinction made between 'finding a solution' and 'giving up' is quite subtle and seems to reflect a difference in the amount of control and power held by the individual during the build up to the suicide attempt. The processes are not mutually exclusive and overlap within the accounts of some participants. Mr W succinctly captures the experience of simultaneously 'giving up' and the intention to take control of the situation.

*You get to a stage and you just can't go on. You don't want to go on. You want to finish it all you know. (Mr W).*

**2e. Impulsive Vs. Planned Decision-Making: *It was entirely a momentary decision Vs. I had this feeling anyway that that would be my out***

Many participants described their suicide attempt as being impulsive, as though they had lost control: '*It was a quick decision*' (Mrs S), '*It was entirely a momentary decision*' (Mrs K). However in contrast others said that they had given it considerable thought, indicating that it was reasonably, or in a few cases meticulously, planned and suggesting they had greater control.

*Well it was on my mind. I had this feeling anyway that that would be my out, to take an overdose as I was fed-up with life. [...] Yeah. I did more or less plan it. I just was waiting for the courage to do it. (Mr H)*

Commonly there were contradictions within accounts in which a mixture of the impulsive and planned decision-making processes was endorsed. This might have been a function of the interview process, whereby participants were still trying to piece together

a coherent account of their experience, or alternatively they might have felt ashamed at having planned a suicide that subsequently 'failed' (see theme 2f).

Often those who reported a more premeditated suicide attempt described a 'snapping' process in which the suicide attempt shifted from being a plan (ideation) to a reality (action). This 'snapping' was reported with a hastening of pace.

*Well it was always there. Well I thought, that's the alternative for me, taking my life and that's what happened. It's always there. I just snapped one evening and that's what happened you see.* (Mr H)

The decision to make a suicide attempt was quite hazy and difficult to articulate for most participants: *'I don't know how, but I made up my mind to commit suicide.'* (Mr J). It was also sometimes disowned as though it was a decision made for them by an external force *'I didn't decide, that's what happened.'* (Mr H).

Others presented their suicide attempt as an everyday occurrence. This seemed to distance them from the significance and meaning of their actions. This was common in accounts when the suicide attempt was discussed quite mechanically, in behavioural terms, rather than conveying the emotional and thought-based processes that lay beneath the surface.

*Uh, you know it's just one of those things that happens. I didn't want to do it to her [granddaughter] but these things just happen you know.* (Mr S)

#### **2f: Failing to find a solution: *I should have done it properly...***

Almost half of the participants felt thwarted by their survival immediately after the attempt and were astonished to find that their overdose had not proved fatal. Here

confusion was expressed over the quantity of medication necessary to produce a lethal effect.

*I mean, I thought one tablet puts me into a wonderful sleep so taking ten, I thought that would knock me out all together, but it never and I didn't think I'd wake up. (Miss F)*

*I just couldn't understand it. You know, I thought to myself you know twenty bloody Paracetamol is enough to see me away like you know. But it didn't and when I looked at the clock I thought my god I've only been asleep two hours. I really couldn't understand it. (Mr S)*

This resulted in the suicide attempt being construed as a failure experience: a failure to problem-solve or regain some sort of control in a helpless situation. This generated feelings of embarrassment and irony that were often cloaked in humour and shame.

*...I was actually ashamed of myself. If I was going to do it, I should have done it properly (laughs)' (Miss M)*

*I know that when I came round and I realised what I done, and that I had done it wrong I probably said to myself daft old cat! You know do it right. (Miss C).*

## **2g. No more control: *Where do I go from here?***

Following their suicide attempt, some participants felt more empowered (see theme 2h), others continued to face an uncertain future and remained helpless, as though placed at a crossroads unsure of which way to turn, whilst others still expressed both feelings.

*Well I've often thought what the hell am I doing here like [psychiatric ward], if I go home where do I go from there kind of thing? (Mr S).*

*I felt terrible then and I looked at her and she looked so sad. I thought I couldn't bear to stay and I can't bear this either... (Mrs P talking to her daughter following her overdose).*

## **2h. Regaining control: *I'm already getting a bit better...***

Some participants reported having more control over their life after the suicide attempt. This was often associated with an alleviation of pain, physical health symptoms or even depression due to the medical care they received when hospitalised.

*Yes and uhh, when I came out of hospital, I was already getting a bit better because I didn't have that same excruciating pain. (Mrs K)*

Or alternatively, some participants spoke of letting go of unattainable goals and trying to adjust to changing circumstances, especially those that had been related to their struggle prior to their suicide attempt.

*Anyway, I think I probably have to do my very best to adapt to the fact that I am getting older. (Mr Z)*

*I think the moral of this is to plan your retirement easily. And if I'm giving up my plan for staying in this awful house, which I think will have to be sold on, umm, why not then go for the little cottage, little flat, bungalow? Make sure that everything is easy. Plan it so that you don't get into difficulties. (Mrs P)*

The improvements noted under section 3e also pertain to regaining control over one's life through increased social contact and support.

## **3. Visibility**

The Visibility theme featured in most interviews and encompasses four sub-themes (see below). It captures a growing sense of being distanced from society prior to the suicide attempt, and the ways in which participants struggled to manage the isolation, loneliness and distress that this brought. It also captures a marked shift in focus following the suicide attempt in which some participants felt more integrated with others, re-

establishing connections that had previously been severed, allowing some of them to feel less isolated and more hopeful about the future.

### **3a. Becoming less visible: *I am sort of isolated I think***

The lives of almost all participants were characterised by an overwhelming sense of isolation and loneliness, which seemed to make them feel less visible to the outside world. This theme was presented with great sadness, desperation and helplessness.

*I'm sort of a bit alone and on my own.* (Miss F).

*You see being on your own that's the trouble.* (Mr S)

This was often directly linked to the experience of losing friends and loved ones, which left participants feeling deserted and somewhat remote.

*And umm, of course as you get older your friends all die (laughs). I seem to think that everybody attached to me dies. I had a very, very, useful bloke who lived next door but one to me when I was at number 32 and when I moved up here he used to come by once a week and perhaps help with the garden and things like that and he was someone to talk to. Then of course he died.* (Mrs K)

Loneliness was described as being ever-present, thus dominating the daily experience of many participants. Its potency was such that it often marred the enjoyment of any social exchanges that were available to participants due to the fear that it would resurface once they were alone again:

*I mean it's all right when you are talking to them [others] and having a chat like, maybe a laugh like but when they've gone it all comes back.* (Mr S)

Embedded within the feelings of loneliness and isolation that participants described, was a growing sense of disconnection from the social world that was associated with a



diminishing social circle, detachment from the wider community and the daunting prospect of a solitary future. Miss C described this experience as being similar to 'vanishing':

*Maybe I kept, as I've said, I kept losing people and if I, to tell you the truth it felt a bit like the first time I lost them [referring to those lost in World War Two] and when it got to this second stage [prior to suicide attempt] it felt like this again you know, vanishing, you know and I thought I can't go on, on my own. And its funny that because I've always been a loner. (Miss C)*

### **3b. Being overlooked or written off by others: *You're getting old; you've had your life***

Feeling overlooked or written off by others emerged as a key theme for most participants and came in several guises. Usually a particular incident was described in which participants felt neglected, vulnerable or even victimised by isolated individuals or society as a whole. Central to this experience was their status as senior citizens in a society where certain ageist attitudes and beliefs prevail. For some participants the theme revealed itself as they sought treatment in a medical setting and were made to feel a nuisance.

*Oh, I think when you're getting old people don't bother with you anymore. Like the doctor, you know, they don't bother you've had your life, now get on with it sort of thing. That's what I think about it. (Miss F).*

And again later in her interview:

*Yes, he said he hasn't got a magic wand to wave it away [toe pain]. That made me depressed. I thought, well he don't care, you know. I thought I'd finish it off altogether myself.*

*Mr J...But now it's got to the stage where people think that I'm malingering. My GP, he said I can't give you a referral to a hospital for an operation, he said I can't do that. I realised that it was a death sentence.*

LC: A death sentence?

*Mr J: People don't believe me. You know, I called him about two or three times. I don't know if you know Dr B? He's a very good GP, but it got to the stage where he believed that I was malingering.*

Often these experiences evoked a feeling of helplessness in which participants were unsure of whom they could trust and to whom they could turn. This contributed to their growing sense of detachment from others in society. Some participants felt overlooked and cast aside by society at large which exacerbated their experience of being disconnected and less visible due to the loss of close friends and family. They reported discriminatory attitudes and behaviour being directed towards them from a range of sources on account of their age, as though old age masked their capabilities and true self:

*Oh, I think when you're getting old people don't bother with you anymore...(Miss F).*

*There were three of us who were over 50 and we all lost our jobs in a sort of management shake-up. It was in everyone's interest to get rid of older people because young, new graduates were half the money. (Mrs P)*

*People aren't very nice to you. I think they're ignorant. They think you are simple you know. Talk to you like children. (Mrs S)*

Participants described living with an ongoing threat from society which exposed their vulnerability on account of their frailty, dependency or isolation.

*I wouldn't like to be growing old now, see, there I've just said it, I've just said it. I don't call this living and growing old having to watch your step and waiting for the clout on the back of the head and all that. (Miss C)*

A similar feeling was evoked for those participants who had been direct victims of crime as in Mrs K's case below. Mrs K was left stripped of her confidence and pride, as well as being reminded of her frailty. Although this example is quite specific, the experience it conveys was mirrored in other accounts.

*...I've had three handbags stolen since I've been in it [new flat] and all my jewellery stolen. [...] And I know who did it because some jobs came around the front and they jibed at me [...] Anyway that was that. I don't often talk about that as it makes me very sad. It took away my confidence, yes it took away my confidence and pride. (Mrs K)*

Some participants associated their experience of feeling vulnerable and overlooked with a fundamental change in society's attitude towards the elderly, characterised by a loss of respect and a growing danger.

*You could leave your door open in the olden days. (Mrs S)*

*Well it's people's attitudes now, people's attitudes. You know 'blow you Jack, I'm alright', stepping on each other like, which we never did. We never used to be like that. [...] But this seems to be a general trend of things. It seems to be like a group of their own, you know. (Miss C)*

The experience of exclusion because of age left many participants feeling that they no longer belonged and that *'things have changed'* (Mr H). Several spoke of the emergence of age-defined groups used to segregate one sector of society from another, leaving them feeling overlooked and somewhat invisible; *'I'm suddenly conscious that I'm not in that group.'* (Mrs P).

*I don't think younger people think much of older people do they...I suppose if I was young myself, I'd probably feel that way you know, live in my own world sort of thing you know, wouldn't care about old people. I think a lot of young people feel that way too. [...] Out of mind out of sight I suppose. (Mr W)*

*Well, I was thinking. All the older ones I knew, they've gone. Then the one's coming up to the age I was then, I think we were drifting apart and I was getting too old to go and join in anything. I couldn't go with them as much as I did. And of course the younger ones they don't want to know let's face it. I don't suppose I did when I was that age. And that was it. So I thought this is it and what are we going to do now? And, uh, I just began to get into a slough you know and I couldn't pull myself out of it. I kept going deeper and deeper into it and I thought well if this is the future, having to sit round like this and doing sweet Fanny Adams, this isn't for me. I'm too lively for this sort of lark.' (Miss C)*

Other participants described feeling de-skilled, incompetent or generally out of touch with society in light of changes that had taken place.

*I used to be an expert typist but I mean I'm out of favour with all this Internet and that nonsense. I mean I don't know what it's all about. It annoys me really because I'm very good at crosswords and when it comes to that, the Internet, I'm just stymied... (Mrs K)*

A final expression of the invisibility theme carried an element of internalised ageism, suggesting that it is more acceptable and less tragic when suicide occurs in the elderly, as though an elderly death would go unnoticed.

*Yes, in the papers. As I say, I read about university students about 18 years old. There was a young boy found hanging from a tree, a young person. I thought well I'm getting old, but you know I was shocked that a boy of 18 would want to commit suicide and hang himself. (Miss S).*

### **3c. Trying to remain visible: *I was a very feminine person, very sexy....***

During the interview some participants, particularly those who were frail or who had become less mobile, provided vibrant descriptions of how they used to be both in terms of the person they were known for and their physical appearance, as though this helped them keep former parts of their self alive and visible in the interview, as well as their minds and in the minds of others.

*Oh yes, I've been independent since I was born let's put it that way. I was a tear about you know and I was always independent. I never really depended on anybody or relied on anybody. I did my own thing the whole way through. [...] I was very, very independent. I was a very feminine person, very sexy.... (Miss C).*

Another aspect of trying to keep visible and connected with society emerged as participants thought about what brought meaning to their daily lives. Examples include attending a local club, being seen by a warden once a day, getting out of the house to go shopping and maintaining a garden.

*Well no, I made a lovely garden in the front and that's when I got friendly with that bloke. He used to compliment me and tell me that I've made a nice little garden. (Mrs K)*

These activities offered the prospect of social interaction and integration with others. However, trying to remain visible required effort and was at times frustrating for participants if for example they became unable to get out of the house. This was notable

in Mrs K's case when she was unable to attend to her garden in the months prior to her suicide attempt. Not only was she frustrated by seeing it become overgrown and unkempt, but the garden represented a platform for social contact that was lost, distancing her further from the outside world.

**3d. To become invisible: The intention behind the suicide attempt: *To lay down and get ready to die* Vs. *I was hoping that I might just go to sleep***

Participants assigned different meanings to their suicide attempt, although all were characterised by a desire to become invisible either temporarily or permanently. These included an intention to sleep, to block things out, to switch off or to search for oblivion.

*Well I was completely lost and uh, I really can't go back to that, I just thought, oh I must get a drink. That was the first thing, anything that would let me sleep.* (Miss O)

Others had a relatively clear-cut death wish wanting to '*lay down and get ready to die*' (Mrs S). Here participants were seeking a permanent exit rather than a temporary respite.

*..And then I thought you'd just curl up and go to sleep and you'd be gone forever. But it wasn't like that.* (Mrs P)

The intention underlying the suicide attempt varied across the sample and was not clear-cut. Participants either presented a rigid view of their intention to die or frequently contradicted themselves in their accounts, oscillating from one explanation that minimised the intent to die to another that fully acknowledged it. Shame may have influenced reporting of intention.

*You don't intend to take an overdose but you are saying I'll take a couple. I've got to get rid of this pain. You're not thinking along overdose lines. You're just thinking along the lines of getting rid of it as you've just had enough.* (Miss M)

And then later in her interview:

Miss M: *I was hoping that I might just go to sleep, ideally for a few days, ideally. [...] Just knock myself out, for a while.*

LC: *For a while.*

Miss M: *Well I wasn't really bothered one way or the other quite frankly.*

(Miss M left a detailed suicide note instructing medical staff not to resuscitate her).

### **3e. Becoming visible again: *I was missed more than I thought I would be...***

This theme featured for many participants following the suicide attempt and involved a growing visibility and to some extent a re-integration into society. Participants were overwhelmed by the response of others to their suicide attempt and the new opportunities that seemed to be created; notably, the chance to re-establish and strengthen former links with significant others, or indeed to forge new links with people previously unknown. In becoming visible participants seemed to feel noticed again and cared for by others. This theme was presented with surprise, laughter and energy.

*...I thought I didn't have proper neighbours like, you know cos nobody used to bother. But when I wasn't round they wondered like where I was. [...] I was missed more than I thought I would be like. I didn't think anybody would miss me. I thought no one will care, I'll end it all.* (Miss F)

*Yes and when I committed suicide, tried to commit suicide, that response I got, had from people, staggered me, staggered me! ...I mean I was just overwhelmed by it....* (Mr Z)

*I've had a great many lovable people do wonders for me, who have given me a new lease of life.* (Mrs K)

The effect of this renewed contact and involvement with others was striking. The suicide attempt seemed to have mobilised some participants and their support system, providing them with help that was not available beforehand, and in doing so gave them a renewed energy and a marked sharpening of focus and interest in life.

*LC: So before you went into hospital [following suicide attempt], you didn't have the library...*

*Mrs K: Didn't have the library. Didn't have the garden. Didn't have anything. Didn't have anything! See since I've come back from hospital it's opened up like a flower [...] In one respect it has been a jolly good thing [the suicide attempt] and it sounds ridiculous but I think that's the way God moves. I know that's a funny remark for me to make.*

### **3f. Becoming Visible as a Burden: *Well you are sort of making extra work for them...***

Following the suicide attempt, some participants described becoming visible to others as a burden and a nuisance. Many spoke of fears that they were perceived as time wasters particularly in a medical setting.

*Yes, well the doctors here weren't very cheerful about it and took a dim view of it. We um, make people better see, people come in here to be made better not to commit suicide and that. Well you are sort of making extra work for them whereas they wouldn't have that job would they? If you wasn't, making extra work for them, cos the nurses in there like, they come and do things for me but I think they do it grudgingly. "If it wasn't for her like, we could be looking after someone who deserves it more". You don't deserve to get better. (Miss F)*

Others described bringing shame upon their family 'I'm afraid it's all down to me.' (Mr S).

### **4. Coming to terms with getting older: *I mean I'm joining the club myself***

This theme emerged as participants described how they struggled to come to terms with growing older. This theme evoked stereotypes of old age, alongside beliefs and expectations about how old age should be managed. Most of these stereotypes were anchored in rich images that carried a sense of threat, loss, dependency and decline. The ageist nature of many of these representations was striking.

*Somebody who wears glasses. Somebody who has false teeth. Somebody who is bald. Somebody who has a walking stick. Somebody who is not terribly astute and on the ball. Somebody who moans and groans and complains. Somebody who is inactive. All those sorts of things. You can't defeat age. But I mean joining the club myself. (Mr Z describing a 'typical' older person)*

*I loved my grandmother and she was very old, 89 or something when she died and she would just sit in the chair and she couldn't do much and she was nearly blind. I remember her hair was white and sort of all in a bun on top. She wasn't bed-ridden or anything. She was just fragile like a little leaf so there's a sweetness about some old age I think and there's the other side which I have really rather discounted, which is the being a dependent and a nuisance. You know being Alzheimer's or bed-ridden or something... (Mrs P)*

Death was often discussed within the context of this theme. Ageing and death seemed to be closely linked in the minds of some participants.

*When you see old people you think "Oh well it's not far off you know. He's near the end of the line you know. It's one foot is in the grave sort of thing". (Mr W)*

*I mean my next door neighbour, when I spoke to him, I mean as a matter of fact, I retired before he did but he was a year older than me, I asked him how he was enjoying it? Oh he said it's like waiting to die, he said, ain't it? So I said, oh blimey don't start thinking like that, at that time. That's not the way to think is it really? You've got to think ahead really. But that was then. (Mr S)*

The uncertainty and unpredictability of when and how death would occur seemed to generate anxiety and discomfort for some participants.

*I don't fear death. The thing I fear about death is that I, they put my on some kind of machine for days and weeks and months and all that. I want to go quickly. I hope it's over with in a few hours (pause). (Mr H)*

Participants tried to come to terms with growing older in a variety of ways, which will be outlined below. For example, some positioned themselves as being old but also as being different from other elderly people.

LC: *Thinking about yourself you said you don't consider yourself to be old?*

Mrs G: *No, no dear, no, my mind, I've still got the young mind dear.*

An effort was made to dismiss age as being unimportant when some participants thought about themselves as older people. This was common in the accounts of the older and frailer participants when an effort was made to focus away from the physical aspects of



ageing: *'It's how you feel inside.'* (Mrs S). Value was placed on aspects of the individual that remain ageless: *'If you lose that humour you are finished.'* (Miss C) and *'Well no, I'm very young minded'* (Mrs K). Again participants seemed to be distancing themselves from the more negative representations of ageing. Younger participants drew on some of the more extreme representations of ageing to consider others worse off than themselves.

*Yeah. When I look, when I look at some of these old people, some of them are worse off than me Louise. Let's face it my sister, her husband is dying of cancer of the spine. And, eh, she's got a, what do you call it, a frame and two sticks.* (Mrs A)

When considering themselves in relation to their chronological age and the meaning underlying this figure, some participants said that they did not feel their age, for example: *'I don't feel as if I am a very old person but I am.'* (Mr J, 91 years). Others did feel old and identified a point in which they became old: *'When I realised that I was growing old when I reached the age of eighty'* (Mr S).

In spite of being able to give rich stereotypes of old age, some participants struggled to talk directly about their views of ageing, cutting the interviewer short and making the topic taboo. This may have reflected the direct questioning style used by the interviewer, or alternatively it may have indicated a reluctance to think about this topic. In a similar vein some participants described various ways in which they had avoided ageing.

*LC: When would you say that you became an older person?*

*Mrs S When I took all my mirrors out of the house and didn't look at myself for a year.*

Some participants went so far as to alienate themselves from other older people: *'I never mix with old people, funny thing.'* (Mr W). These participants found being in the company of other older people aversive and preferred to mix with younger people.

*But I don't feel old! No! In fact old people are very nice but they annoy me. [...] I would go with all young people but not old people.* (Mrs G)

*I said "I don't want to go and sit a long a lot of old fogies" and he said, "What do you think you are!" (laughs).* (Mr Z)

*I went to Newcastle once and that is very much an old town [...] I thought "All these old people about in the day. How depressing." I was only a few years younger than I am now.* (Mrs P)

When asked about the advantages of growing old, some participants were unable to comment, and answered: *'Well I'd have to pass comment on that really.'* (Mr H) or *'I can't think of a damn thing, I can't think of a damn thing at the moment!'* (Miss C).

When then asked to describe a childhood memory of an old person, which perhaps took the attention away from their own experience of ageing, most participants described a loving grandparent figure. A stereotypical image arose from this description of a *'sweet old person'* who was typically *'lovable'* (Mrs K) and *'wise'* (Mrs B), and was there to make a contribution to the family and others: *'The idea that elderly people are there really to give nice things to children.'* (Miss M).

One advantage to being old identified by a few of the participants was that of being a grandparent. Less than half of the sample were parents and even fewer were grandparents, which may well have prevented them from fulfilling this role.

*On the other hand I think the good thing about it, is that I think you do have a contribution and this is apparently why there is the menopause in women, that it is, they have a very good social role of helping the existing children to survive and the*

*grandchildren to survive and I think I have been cut off from that because my daughter with her two children, I no longer see them. (Mrs P)*

Participants also discussed other older people who were exceptions to the rule, those who did not fulfil the negative stereotypes and who had somehow managed to defeat the ageing process.

*The Priest he's the oldest man I know, he's eighty something but he's fit, he's fit! He's been all round the world. (Mrs G)*

They presented these descriptions with excitement and energy. However, they never applied these descriptions to themselves.

Participants discussed certain rules that should be adhered to when growing old, which reflected both their expectations about ageing as well as those of society. Examples include growing old gracefully, slowing down and planning for future decline. However, participants expressed discomfort and anxiety for failing to have adhered to these rules, which meant that their lives were not going down the pathway they had anticipated.

*So it was this year, yes this January I had some new photographs taken by a woman, but then I suddenly thought as I was looking through them all "Jesus, god I'm old, I look so old", and I thought I'm old trying to look young and I thought, no I thought, no don't like that. I mean the way that I was trying to do my hair, I thought, "You're trying to look young, it doesn't look nice". (Mr Z)*

*Well I still think that my mistake was a few years ago I should have trimmed down a bit, recognising that people do get old and I didn't because I was feeling very energetic. I felt I could go on working and do lots of things and I think that was a mistake. When my own friends, my contemporaries had already retired or were thinking in different terms. My mistake was that I didn't recognise that. (Mrs P).*

Finally, many participants discussed aspects of their past, especially missed opportunities, losses and regrets, indicating that they would do things differently.

LC: *What would you say are the disadvantages to growing old?*

Mrs P: *The bad things, I think one of the bad things is, and this does impinge on suicide, is that one thing about your mistakes, you haven't got time to recover from them and that is the worst thing.*

Some participants compared feelings of despair they had experienced immediately prior to the suicide with those they had experienced at early points in time.

*My life finished when they went [friend and boyfriend lost in Second World War]. That did it. That did it, I lived, but it's not the same. [...] It will never leave there [points to head], it will be there for the rest of your life. (Miss C)*

### **Representations of Suicide: Shameful to Romantic**

Participants held shame-based and romantic notions of suicide. Although polarised, these often co-existed in the minds of participants, suggesting that a dual representation of suicide was held. On the one hand they conceptualised it as being sinful and shameful, especially when looking back at views they had held earlier in their life when it was a taboo topic of conversation and heavily stigmatised.

*...I'd always thought that it was a sinful thing to do. You know I couldn't understand anybody doing such a thing. (Mrs K)*

*If you commit suicide or murder then you would never see the face of god. And that's right in there [gestures to head], you're brought up to believe that. I never thought that I'd have thought like it, but then you never know. (Mrs G)*

On the other hand, many had a rather romantic conceptualisation of suicide that stood in stark contrast to the more shame-based perceptions. These representations of suicide involved film star overdoses, kamikaze suicides in the name of national bravery and also literary figures. The common thread linking these representations was the admiration and respect with which they were conveyed during the interviews.

*I knew that Virginia Wolf committed suicide but then I regard it as something that belonged to creative people who were very unusual like Wittgenstein the philosopher who had two brothers apparently who committed suicide. I thought that was an example of an extremely intelligent family where they are going off the rails...(Mrs P)*

One third of participants had a family experience of suicide. This information was often withheld until later in the interview suggesting that it evoked feelings of shame.

*Yes, he [his father] came to the business one day and said "I've just taken a whole bottle of Aspirin." So we phoned up the ambulance. In those days it was a criminal offence. (Mr J)*

In discussing their earlier experiences of suicidal behaviour in others, some participants were extremely unsympathetic and intolerant, indicating a possible resentment for having links with a stigmatised group through their recent actions, and wanting to portray their own attempt as being different.

*But I remember reacting very strangely once to somebody whom I didn't know very well, who I was told had made an attempt and it had failed in as much as they had woken up and I don't know why, I mean it was a terrible thing to do but I laughed. The fact that she'd woken up (laughs) and thought "Oh damn" you know. Where as I had no intention of waking up. It was absolutely, as far as I was concerned, deadly serious. But it sounds terribly callous doesn't it. I mean I haven't really got that sense of humour. (Mr Z)*

### **3.2. Results Summary**

Three broad themes emerged from interviews with participants following a recent suicide attempt: The Struggle, Control and Visibility. The onset of 'The Struggle' was marked by a significant turning point in which participants witnessed their lives taking on a new course. This was often related to participants feeling that they were 'losing control' over important aspects of their life, both at proximal and distal points in time along the pathway to their suicide attempt, which they found difficult to accept and often tried to fight against. The Visibility theme manifested itself in the experience of

'becoming less visible' and 'being overlooked or written off by others', and also in the way that participants often tried to resist this by 'trying to keep visible', which was difficult at times given their changing circumstances. As the suicide attempt drew closer participants experienced 'feeling unable to cope', 'getting dragged down' and an 'inner battle', leaving them 'feeling trapped'. This resulted in an impulsive or well planned decision to make a suicide attempt or 'become invisible' through seeking temporary oblivion or death. For some, the suicide attempt represented 'finding a solution', for others it was 'giving up', whilst for others still, it was a mixture of the two. Following the suicide attempt participants experienced either a sense of failure, little change in how they felt when they were 'losing control' or conversely felt that the suicide attempt had allowed them to regain control over aspects of their lives. Some participants witnessed 'becoming visible again' through renewed contact with the outside world. However, others felt that they had become visible as a burden. Another aspect of 'The Struggle' that participants described was 'coming to terms with getting older'. This seemed to be experienced alongside the pathway to suicide and was talked about quite separately during the interviews. Several representations of suicide emerged during the interviews, reflecting participants' awareness of cultural and social stereotypes of suicide. Finally, figure 3.1 (see Appendix 5) maps out the findings diagrammatically to help illustrate the temporal positioning of the subordinate themes in relation to the suicide attempt.

## **4. Discussion**

In this chapter, the findings of the present study will be discussed in relation to the existing literature. This will then be followed by a critical reflection on the study, highlighting its strengths and limitations. Areas for future research will then be identified before clinical implications of the findings are discussed. The discussion then closes with a summary.

### **4.1. Summary of the Findings**

The present study aimed to explore and capture the subjective experience of older people who had recently made a suicide attempt. Four main research questions were asked: How do older people who have recently acted on their suicidal feelings understand and experience the pathway to their suicide attempt? What is their subjective experience in relation to various 'risk factors' for suicide and how do these factors come together alongside other 'unidentified' factors prior to the suicide attempt? Does participants' experience of ageing, and the extent to which they have felt able to adjust to it, impinge upon their suicidal thinking, and finally, what beliefs do they hold about suicide and how do these influence their decision to act on their suicidal feelings?

Three main theme groupings emerged from the interview data: The Struggle, Control and Visibility, incorporating 20 themes. The themes permeate three time periods covering the experience of participants prior to, at the time of and following their suicide attempt, which is shown diagrammatically in Figure 3.1. (see Appendix 5). As the diagram helps illustrate, there was no set pattern to which the themes came together for individual participants, and the intensity with which specific themes were evident varied

considerably amongst the sample, thus illustrating the complexity of their experience around the time of the suicide attempt.

These themes will be discussed within the context of the existing literature and in relation to the first three research questions. The representations of suicide that emerged from the interview data will then be discussed in relation to the fourth research question. It is important to emphasise that these findings are based on a small sample of older people who acted on their suicidal feelings, and may not reflect the experience of all older people who make a suicide attempt. Furthermore, although the existing literature suggests that older people who make a non-fatal suicide attempt closely resemble those who make a fatal attempt (Draper, 1996), given the small size of the current sample one must be cautious in assuming that their experience reflects that of those older people who die as a result of their suicidal behaviour.

### *The Psychological Pathway to the Suicide Attempt*

In the pathway to their suicide attempt all participants experienced a struggle. The onset of the struggle was marked by a turning point, or a series of turning points, at which their lives took a turn for the worse. The nature and specific details of the turning point and struggle varied greatly amongst the sample, as did its timing and the strength of its impact. However, underlying the struggle, participants shared in their experience of losing control of their lives and functioning, which seemed to signify an overall reduction in their level of independence and autonomy. This was met with a desire to return to a previous state of equilibrium and was met with a growing awareness that this was no longer viable as they drew closer to the suicide attempt.



Some of the losses and changes that became embedded in the Struggle have been identified elsewhere as risk factors for suicidal behaviour in old age (Cattell, 2000; Draper, 1996; Schmitz, 1995). These include physical illness, depression, pain, social isolation, a stressful life event, relationship problems, bereavement, retirement and a previous suicide attempt. What seemed important in the present study was not the mere presence of these 'risk factors' in the pathway to the suicide attempt, but the way in which participants 'made sense' of them. Commonly, they evoked fears of future decline, dependency and marginalisation from others, emerging under the themes of losing control, becoming less visible and being overlooked. It is argued that these broad themes cover some of the more 'difficult to define' aspects of the attempted suicide that other researchers have not focused on to date.

Here it is useful to draw on the two factor theory of emotion (Schachter & Singer, 1964). This theory suggests that it is the interpretation or appraisal of an emotion rather than its presence which makes it meaningful and significant to an individual. In relation to this study, it highlights the importance of focusing on the meaning assigned to a given loss or change to ascertain whether it becomes salient for an individual in the pathway to their suicide attempt. For example, some participants did not recognise a decline in their physical health or a bereavement (recognised 'risk factors') as being relevant to their experience prior to their suicide attempt. This helps account for the idiosyncratic ways in which losses and changes came together in the current sample's experience, and more importantly, why a risk factor approach to elderly suicide can be limited.

### *Losing control*

The experience of losing control prior to the suicide attempt may be similar to the concept of learned helplessness (Seligman, 1975). Participants would have attributed losses and changes to internal causes that were seen as being global and stable over time, rather than to external, more transient ones, and it is likely that this would have produced a strong feeling of helplessness. However, this idea may only be partially useful because not all participants appeared to be helpless in the pathway to their suicide attempt (until the point of entrapment), even though they were becoming increasingly aware of losing control. Some fought strongly to try and exert their control over changes that had taken place and that they had found difficult to accept, which suggests that they were not entirely powerless, and possibly, as depressed as other participants who felt helpless early on in their struggle.

It is important to highlight that many of the losses and changes contributing to the experience of losing control were not strictly related to old age, even though they tend to be more commonplace in old age e.g. declining physical health, reduced mobility or loss of friends and family. Participants in the present study did however experience them within the context of growing old, making it impossible to disentangle them from this context. It is possible that some participants would have been able to manage their difficulties at an earlier point in their lives. This raises the question of whether difficulties in adjustment to ageing contributed to the growing sense of helplessness evident in their accounts prior to the suicide attempt. Models of adjustment to ageing (Baltes & Baltes, 1990; Brandstädter, 1999; Schulz & Heckhausen, 1996) assert that an

overall sense of control can be maintained at a time of loss and change if goals are modified to remain achievable. However, some participants in this study continually persisted with goals that had become unattainable due to their changing circumstances before their suicide attempt, which seemed to threaten their self-efficacy and self-esteem, and has been shown elsewhere to contribute to depression (Brandstädter et al, 1999). Whether an experience is construed as a gain or a loss will be determined by the relationship it shares with the individual's personal goals and belief system, again accounting for subjective differences in experience prior to the suicide attempt. It will also be influenced by the socio-cultural context within which an individual lives, as Hazan (1994) has emphasised in his work; knowledge and expectations about ageing are socially constructed.

The experience of losing control for some participants seemed to tap into a fear of future decline and dependency that was strongly linked to negative expectations they held about old age. These negative expectations were similar to those reported elsewhere by Dittman-Kohli (1990). She found that if older people do not maintain a positive focus, become less self-critical, plan for the future and create meaning in their lives to counter their fears about growing old, they are left with feelings of pessimism and despair. Indeed, participants in this study seemed to share in this experience. This would also seem to support the findings of Robin et al (1977) that associated a negative attitude to old age with suicidal ideation. It is likely that a negative view of ageing contributed to an overall negative attitude towards the future, together with a lack of anticipated future events. These are features that characterise hopelessness and are typical of suicidal

thinking prior to a suicide attempt (MacLeod et al, 1993), although there are few studies in the existing literature that have examined this in detail.

Finally, for those participants who found it difficult to negotiate the transition to old age, it is useful to draw on Durkheim's (1897) concept of 'fatalistic' suicide, even though he seeks to understand suicide as being a product of more social forces rather than psychological ones. He proposes that fatalistic suicide occurs when individuals feel that they have lost direction in their lives and have little control over their own destiny. This helps emphasise the influence of the social context upon suicidal behaviour, which the risk factor approach to suicide largely ignores.

#### *Trying to maintain control*

Some participants reported being able to fight against the losses and changes they encountered in trying to maintain control over their lives. Again this suggests that they were not entirely helpless throughout the pathway to their suicide attempt, which accounts for their experience of a struggle rather than merely submitting to an early defeat when confronted with difficulties. This challenges Williams (1997) view that suicidal behaviour is rooted in a longer-term state of helplessness that can often stem back to early environmental influences in which individuals had little control. He suggests that following this background, individuals will adopt a 'submit' response when faced with difficulties, which many participants in this study did not, until far later in the pathway to their attempt and even then, during the period of entrapment, some participants understood their suicide attempt as a means of exerting their control ('finding a solution').

Nonetheless, as the suicide attempt drew close, participants generally began to find that their efforts to regain control were often in vain, suggesting in Brandstadter's (1999) terms that they were unsuccessfully trying to use assimilative processes to modify a situation rather than adopting accommodative processes to disengage from their goals, for example trying to remain independent instead of accepting assistance from others. As participants became acutely aware of the discrepancy between their goals and their actual circumstances, they did not seem to be able to 'carry on going' and to 'do something meaningful' in their lives, which Bryant et al (2001) have shown to be strategies that promote adjustment to loss and change in old age.

#### *Becoming less visible & being overlooked by others*

The experience of becoming less visible and integrated with society was reported by almost all participants in the pathway to their suicide attempt. On the one hand this entailed feeling extremely lonely and detached from others and was crystallised in the daunting prospect of a solitary future, whilst on the other, it entailed feeling overlooked and marginalised, which was often on account of age. Both experiences were characterised by a fear that things would become worse, again affecting participants' expectations for the future.

Many participants reported becoming isolated because they had fewer opportunities for social interaction, for example due to retirement, death of people close to them or reduced mobility. Other participants who did not experience these changes and had social support available to them also reported becoming less visible. This is similar to

the 'losing connections' theme that emerged for older people experiencing suicidal thoughts interviewed by Bell (2001). However, her participants encountered a 'barrier', which prevented them from acting on their suicidal thoughts. They described this barrier as the feared consequences that their suicide would have on the others. It is possible that participants in the present study may have felt even less connected with others than those in Bell's study, which may have impacted on their decision to act on their suicidal feelings. According to Williams (1997), failing to draw on available social support is commonplace prior to a suicide attempt. Indeed, some participants did not become aware of the support they had available until 'becoming visible again' after their suicide attempt.

Several participants who were socially isolated prior to their suicide attempt did not report feeling lonely, whilst several participants who were not socially isolated did. This demonstrates that people have different expectations about the level of social contact they need to feel integrated in society. What seemed important here was not social isolation, which Wenger et al (1996) define as the objective state of having little contact with others, but it was loneliness; the subjective state of having negative feelings associated with perceived social isolation. This highlights the difficulty of adopting a risk factor approach to suicide as it ignores the subjective meaning an individual assigns to a given loss or change, such as social isolation, to understand whether it is salient for them.

Many participants experienced discrimination from others prior to their suicide attempt, and usually this was on account of age. The discrimination was not necessarily overt and

brutal, although some did encounter this, but it commonly left participants feeling overlooked, unimportant and even vulnerable, which supports findings from studies investigating ageism (Bytheway, 1995). Liggett's (1974) concept of the 'masking of self' can be drawn on here to explain some of the negative stereotyping some participants reported when becoming less visible and feeling overlooked. The physical effects of ageing can hide a person's 'true' identity so that others perceive them principally in terms of their decline. Some participants experienced society being divided into age-specific groups from which they felt excluded, adding to their experience of being overlooked. Together, this shows the impact that the social stigma of being associated with an unattractive group had on some participants' sense of self. Kuypers & Bengston (1973) describe this process the 'cycle of social breakdown' which occurs when both social and self positive regard are lost. The experience of depression may have contributed to this cycle for participants in the present study.

Finally, Durkheim's (1897) sociological theory of suicide is useful in understanding the above position some participants were in prior to their suicide attempt. He asserts that 'egoistic' suicide occurs when a person focuses inwardly on the self because they feel greatly marginalised from society.

#### *Trying to remain visible*

Most participants did not readily accept becoming less visible in society and tried to keep themselves integrated and connected. Some tried to create positive meaning from the contact they did have with others. For some this involved keeping aspects of their former self 'alive' through reminiscence. However, as they drew closer to the suicide

attempt, their efforts to remain visible became less frequent and they became increasingly aware of their disadvantaged position in society, making them less hopeful about the future.

### *The role of social context*

It is important to emphasise that the losses and changes that participants reported were experienced within a social context, which would have influenced the meaning that they assigned to them. It is likely that their goals for old age prior to their suicide attempt were heavily influenced by social norms and the negative representations of old age that circulate in society, particularly an individualised society that places great value on independence and youth (Featherstone & Hepworth, 1993). The themes of losing control, becoming less visible and being overlooked appear to have strong social underpinnings, showing the importance of social context in participants' experience prior to their suicide attempt. This aspect of the pathway to suicide is overlooked by a risk factor approach.

### *Feeling trapped*

Losing control, becoming less visible and feeling overlooked by others were experienced as part of the struggle prior to the suicide attempt and although the timing and intensity of these experiences varied across the sample, commonly participants became more helpless, hopeless and eventually trapped immediately prior to the suicide attempt (feeling 'dragged down' and 'unable to cope'). This fits with Williams' (1997) model of suicidal behaviour in which individuals feel trapped by uncontrollable external circumstances, uncontrollable internal anguish and the impossibility of escape. Many



participants described an increasing pressure when becoming entrapped as their struggle intensified, which is similar to Shneidman's (1996) concept of unbearable psychological pain that produces a rising tension within the individual prior to a suicide attempt. This seemed to be heightened by a narrowing of attentional focus akin to that described by MacLeod et al (1993) in younger adults who make a suicide attempt, which may have interfered with their ability to utilise problem-solving strategies at this time.

The purpose of suicide according to Shneidman (1996) is to seek a solution, and indeed upon reaching a point of feeling entrapped, some participants construed their decision to act on their suicidal feelings as 'finding a solution', as though they were taking control of a helpless situation. This was described with an energy and optimism during the interviews, reflecting perhaps the feelings participants had prior to their attempt, which seemed to be similar to what Beck et al (1979) describe as an 'opiate-like' state that serves to intensify suicidal intent. It is hypothesised that some participants saw their suicide attempt as a solution because it had the empowering effect of allowing them to regain control over their circumstances. For those participants who were finding it especially difficult to adjust to ageing and to negotiate their changing position in society, the suicide attempt may have represented a chance to 'freeze' the ageing process and preserve the former self. This idea has not featured in the existing literature on elderly suicide.

Not all participants experienced their suicide attempt as a way of regaining control over a helpless situation. Instead, for some, it seemed to epitomise their lack of autonomy; they were 'giving up'. This was often experienced as another forced choice, which

added to their feelings of helplessness. When describing 'giving up', participants seemed to be less willing to 'own' their decision to act on their suicidal feelings, which contrasted with those who solely conceptualised their suicide as 'finding a solution'. In spite of their polarity, the above two conceptualisations of the suicide attempt were not mutually exclusive. Many participants experienced both at points before their suicide attempt, suggesting that the two may rest on a continuum. Underlying both of these experiences was a common motivation for escape, which is widely acknowledged in the literature as being common to suicidal behaviour (Williams, 1997; Shneidman, 1996). Baumeister (1990) argues that it is in a state of disinhibition that suicide is perceived as a viable escape and as a solution. Many participants described the experience of 'snapping' after planning their suicide attempt for a considerable amount of time, or suddenly acting on their feelings after 'finding a solution', but there were exceptions to these patterns in the current sample.

In the pathway to their suicide attempt, and particularly close to the time when they acted on their suicidal feelings, some participants described the experience of 'an inner battle'. Shneidman (1996) terms this a 'cognitive state of ambivalence' in which the individual contemplates life and death. The intention underlying the suicide attempt varied across the sample and within the accounts of participants. Some talked mostly of their need for a temporary oblivion. Others talked mostly of having a clear wish to die, whilst others still, oscillated between the two positions. Nonetheless, all participants described having a wish to die at some point prior to the suicide attempt, demonstrating the serious nature of elderly suicide attempts. This supports Cattell (2000) who argues that older people who make a suicide attempt have a strong intention to die.

### *Following the suicide attempt*

Within the Control and Visibility groupings, several themes emerged pertaining to the experience of participants following their suicide attempt. Although the main focus of the study was to explore the pathway to the suicide attempt, these themes provided an interesting insight into the feelings older people face after they have made a suicide attempt; an area that has received little attention in the existing literature on elderly suicide. There was a striking divergence in the feelings held by participants. Some reported an ongoing desperation and helplessness similar to that experienced prior to the suicide attempt. This was characterised by 'failing to find a solution' to their problems and was accompanied by feelings of shame and feeling uncertain about the future. Many of these participants were still hospitalised at the time of their interview, perhaps indicating that not all participants had been able to 'move on'. Those who were still hospitalised were also more likely to experience 'becoming visible as a burden' following the attempt. Some participants reported unsympathetic attitudes from staff in medical wards and to a lesser extent on psychiatric wards who construed their suicide attempt as being 'attention-seeking', which may have added to their distress.

In contrast to the above group, some participants reported having greater control over their lives following their suicide attempt, which often involved letting go of unattainable goals (e.g. maintaining independence) related to their age and circumstances, which they had pursued in vain prior to their suicide attempt and that had contributed to their struggle. This suggests that participants were drawing on what Brandstadter (1999) terms accommodative processes, in his model of successful ageing, to downgrade or reorganise goals that had become unattainable so that they became less

appealing, and that this was reducing feelings of inefficacy and despair. The experience of regaining control did not appear to be contingent on time. Some participants described an immediate positive outcome, whilst others interviewed some weeks after their suicide attempt still felt helpless.

Many participants reported a growing visibility following the attempt, irrespective of whether they felt that they had a renewed control over their life and future goals. This was in contrast to the reduced visibility reported prior to their suicide attempt, when participants felt lonely and overlooked by others. Cumming & Henry's (1961) disengagement theory suggests that older people usually adjust to old age by becoming withdrawn and disengaged from society. This theory has now been largely discredited, but it is useful in understanding the experience of 'becoming less visible' as a process of disengagement that prevented many participants from adjusting to old age. Equally, the creation of new links and the re-establishment of former ones after the suicide attempt seemed to provide participants with hope for the future. It is possible that this more positive attitude towards the future may have given some participants more reasons for living which serves as a protective factor against suicidal behaviour (Linehan et al, 1983).

Finally, it is likely that participants became less focused on their disadvantaged position in society as they began to feel more integrated again.

### *Coming to terms with getting older*

The third research question was concerned with participants' experience of ageing, to what extent they had managed to adjust to it, and whether this impinged upon their suicidal thinking (which has been addressed above). This section discusses the experience of ageing which emerged as a struggle for many participants as they tried to adjust to the changes they faced and tried to negotiate their changing position in society. This was discussed quite separately from the suicide attempt during the interview, although it is possible that this theme influenced the pathway to and from the suicide attempt, as shown in figure 3.1. (Appendix 5).

Participants held stereotypes of ageing that were anchored in strong images of threat, decline and dependency. These stereotypes closely resembled the ageist representations that are reported to circulate in society at large (Featherstone & Hepworth, 1993). Participants in this study seemed to be more aware of ageist attitudes in others than non-depressed participants were in Minichiello et al's (2000) study and also seemed less able to minimise the impact of ageism on their experience by 'accepting what happens' and 'getting on with life'. It is likely that holding a negative attitude towards ageing reduced participants' self-esteem and self-efficacy, leading to a negative perception of the self, which intensified their feelings of depression.

In being associated with a group that faces stigma and prejudice from society, it is possible that some participants were negotiating what Goffman (1963) calls a 'spoiled identity' prior to their suicide attempt, which compounded their depression and suicidal feelings. Participants did seem to be trying to manage and protect their sense of self

by using a variety of strategies outlined below, which again shows that they were not entirely 'helpless' prior to their attempt and were able to draw on various resources.

Some participants used social comparison processes to position themselves as being different from other stereotypical older people, thinking of others worse off than themselves, making distinctions between being and feeling old and erecting a barrier between the 'young' old and 'old' old (This was more common in younger participants). Similar processes have been reported elsewhere (Hochschild, 1973; Heidrich & Ryff, 1993 & Minichiello et al, 2000). It is likely that participants used these to create a distance between themselves and the group with which they were being associated to protect their sense of self. In Hummert et al's (1994) terms they were 'otherising'.

Another way in which participants seemed to be protecting their sense of self was to alienate themselves from other older people. This indicated that some participants carried ageist views themselves, which strengthened their wish to position older people as 'other'. Some participants seemed to be reluctant to think about ageing at all, making it a taboo topic of conversation within the interview. This was unlike non-depressed participants in the Lieberman & Tobin (1983) study who talked freely about ageing, suggesting again that participants in the present study had adjusted less well.

The use of the above strategies strongly suggests that many participants were unable to move towards a position of greater self-acceptance as they grew older. Again their experience of depression may have hindered this process and may have made it more difficult to create positive meaning to their lives in old age. Ryff (1991) suggests that

individuals should have a closer fit between their ideal and actual self as they grow older to facilitate adjustment. It is possible that some participants in this study had not managed to reduce the discrepancy between their ideal and actual self over time, making it harder for them to adjust to old age, and that these discrepancies were heightened by the experience of depression.

The more negative stereotypes of ageing that participants held were often juxtaposed with images of sweet, selfless older people whose role is to give to others; although most participants did not identify with these more positive aspects of old age. The idea that people are there to make a contribution to younger generations is central to Erikson's (1950) concept of 'generativity', which is hypothesised to be a goal of middle age. Most participants did not identify with this role, suggesting that they had found it difficult to work towards it earlier in mid-life, leaving them susceptible to what Erikson terms 'stagnation' which can hinder successful adjustment to ageing. Fulfilling the goal of 'generativity' is dependent on opportunities within the social environment and as less than half of the sample had children and even fewer were grandparents this may have been difficult for them. It is acknowledged however, that there may be other ways of contributing to younger generations.

Erikson's life-stage theory is also helpful in understanding the way in which some participants focused heavily on missed opportunities and regrets from earlier stages in their lives around the time of their suicide attempt. The goal of 'integrity' in later life is achieved when individuals accept the way that they have lived their lives, which brings them a sense of meaning and order in their life, as well as greater self-acceptance. The

consequence of not fulfilling this goal, according to Erikson, is 'despair'. This involves the feeling that one has failed and does not have time to attempt another life. It is possible that memory deficits found to be typical of suicidal thinking (Williams & Broadbent, 1986), made it difficult for participants to retrieve autobiographical memories at a specific level, thus making the achievement of the 'integrity' goal more difficult for participants to achieve. Again, it is important to consider the social and cultural underpinnings of 'integrity' and self-acceptance, as the expectations individuals have about their lives are likely to be heavily shaped by the wider socio-cultural context within which they live.

Another component of the 'integrity' goal is to accept death and lose the fear of it, which some participants seemed to struggle with in the present study. Death was strongly associated with ageing in the minds of some participants, which contrasts with Kalish's (1976) finding that older people become less focused on death as they grow older, often due to their use of certain defences such as denial which commonly distract them from the inevitability of death (Hazan, 1994). It is likely that focusing heavily on death prevented some participants from constructing a positive meaning in old age and from moving towards greater self-acceptance which has been suggested elsewhere (Dittman-Kohli, 1990).

### **Representations of Suicide**

The fourth research question was concerned with the beliefs participants held about suicide and how these might have influenced their decision to act on their suicidal feelings. Representations of suicide did emerge from the interview data, reflecting



participants' awareness of cultural and social stereotypes of suicide. Their representations portrayed suicide as shameful and heroic. Participants also recounted descriptions of familial suicide. However, in most cases they gave little indication of whether any of these representations influenced their thinking at a conscious level prior to the suicide attempt, or had what Platt (1993), drawing on social learning theory, terms a 'modelling effect' on their behaviour. Some participants drew comparisons between their suicide attempt and that of others, but this was discussed more in relation to their thinking after the attempt. No firm conclusions could therefore be drawn about the impact of participants' representations of suicide on their own attempt.

#### **4.2. Strengths and Limitations of the Study**

Through aiming to explore and capture the experience of older people who had recently acted on their suicidal feelings, this study represents an important move away from more traditional quantitative methodological approaches used to research elderly suicide that have ignored the subjective experience of older people prior to their suicide attempt by focusing heavily on retrospectively measuring risk factors and epidemiological trends. This study has shown three broad themes to be pertinent to the experience of participants around the time of their suicide attempt; The Struggle, Control and Visibility. However, there appears to be no set pattern to which the above themes came together for participants prior to, at the time of and following their suicide attempt, which highlights the complexity of their experience at this time, and the need to consider the perspective of the individual and indeed their social context, rather than the mere presence or absence of 'risk factors'. This section will focus on the strengths and limitations of the

present study by considering methodological issues pertinent to qualitative research and by reflecting on the experience of carrying out this study.

### ***Methodological Issues***

Elliott, Fischer & Rennie (1999) provide guidelines for reviewing qualitative research to encourage better quality control in psychological studies that use this methodological approach. The study will be now considered in relation to the guidelines.

Elliott et al (1999) suggest that qualitative researchers should 'own their perspective'. This is particularly important when using IPA as a method of analysis, as this approach reflects the unique interaction between the participant's account and the researcher's interpretation of this account. In this study, the researcher's perspective was discussed in the Method chapter and will be considered further below when I discuss the likely effect of my age, expectations about the research and orientation on the research process.

First, it is likely that as a young researcher, coming from a position of not having had the 'lived experience' of an older person, the expectations I held about the impact of ageing on participants may have differed to those held by a more mature researcher. It is also likely that the age differential between participants and myself influenced the context of the interview. Several participants remarked on my age during the interview; one asked whether I thought he was antiquated, whilst another felt that I was too young to understand a particular experience that she described. This demonstrates the awareness participants had of the age differential, and its likely impact on the interview. Second, an expectation that I had as a researcher was that the experience of growing old would be

salient to participants. It was therefore important for me to explore with participants during the interview their thoughts about the advantages of growing old. Another expectation that I had was that older people are 'giving up' when they act on their suicidal feelings. This assumption was challenged early on in the research when one participant described their suicide attempt more proactively as 'finding a solution'. This made me more receptive to this experience in subsequent interviews. Third, drawing on cognitive-behavioural and solution-focused models in my clinical practice is likely to have influenced my thinking about the experience of participants both within the interview and during the analysis process. Coming from this perspective, I was perhaps more interested in how participants made sense of their experience and the strengths and resources they had used to cope over time than, for example, a psychodynamic researcher would have been. He or she may have placed a greater emphasis on the participant's less conscious motivations for suicide and the role of the early environment. A sociological researcher would, in contrast, have placed more emphasis on social processes than I have done.

Elliott et al (1999) advocate that the sample should be described in sufficient detail for the reader to be able to understand their position. In the present study describing the sample in terms of their age, gender, marital status, ethnicity and religious background has followed this guideline. Information has also been provided on their psychiatric diagnosis, a clinician's view of their suicidal intent, the method used in their attempt, the location of their interview and whether they were in contact with MHCOP services prior to their attempt. It is hoped that the information that I have provided about my position

as a researcher and the sample will enable the reader to understand the social context within which the data were generated.

Elliott et al (1999) recommend that researchers should 'ground' their findings in examples, to allow the reader to assess the fit between in this case the participant's description of the phenomenon and the researcher's interpretation of it. I have therefore provided excerpts from the interviews within the results chapter to illustrate the themes, and I have also used quotations from the data to complement the subordinate theme labels.

Elliott et al (1999) recommend that researchers should provide suitable credibility checks on the interpretations they make of the interview data to increase the validity of their findings. The IPA approach acknowledges that the analysis of interview data draws on the subjectivity of the researcher and therefore that the findings reflect the unique interaction between the researcher and participants, rather than some 'objective truth'. Therefore alternative interpretations are always possible given this subjectivity. Nonetheless, several steps were taken in the present study to try to reduce researcher bias during the analytic process and to ensure that the analysis process was carried out in a rigorous and systematic manner, so that in theory replication would be possible. These have been described in the method chapter under 'Method of analysis'. In addition to these, a further check was carried out whereby a clinical psychologist working in MHCOP was asked to read through a draft of the findings to see whether they resonated with her experience of working with this client group, in line with the Elliott et al 'Resonating with readers' guideline. Not only did her feedback prove useful as a

credibility check, it also offered another perspective on the findings (see Appendix 6 for summary). Finally, it was decided not to carry out a respondent validation check (Silverman, 1993), as it was assumed that some participants might not have wanted to re-visit the information they disclosed during the interview, regardless of whether or not they had been able to 'move on' from the suicide attempt.

Another guideline outlined by Elliott et al (1999) is that qualitative findings should be presented with coherence and integration while preserving nuances in the interview data. In the present study 20 themes were presented in three main groupings. However, it is acknowledged that the subtleties of participants' experience may have been lost at times by using this framework. Therefore a diagram (Figure 3.1., Appendix 5) was used to depict the temporal order in which the themes emerged in relation to the suicide attempt, and to illustrate that there was no single pathway to and from the suicide attempt, and therefore that many contingencies were possible.

Finally, this study had what Elliott et al (1999) term 'a specific research task' that aimed to explore and capture the experience of fifteen older people who had acted on their suicidal feelings. The findings are not necessarily generalisable to all older people who make a suicide attempt due to the limitations discussed below, however it is hoped that they reflect the experience of the sample interviewed.

In terms of generalisability, the findings of this study reflect the experience of a small number of older people who acted on their suicidal feelings and were willing to be interviewed about this experience. It is possible that their experience differed from the

six patients who declined to participate, other older people who make a suicide attempt and indeed those who die as a result of their attempt. Participants were recruited from an urban-based sample and were reasonably homogenous in terms of their ethnicity, being of white European origin. Older people from more diverse backgrounds may have experienced their suicide attempt differently. However, the current sample did vary in terms of age, marital status, psychiatric history, the quantity and form of their overdose and included older adults who had made a suicide attempt before the age of 65 years, as well as those who had not.

### ***The experience of researching attempted suicide in older people***

This section will provide my reflections on the research process. The aim of this research, as with all phenomenological research, was to try and describe how participants experience the phenomenon under study, rather than to seek to explain why it occurs. It was important to bear this in mind throughout the research process, and this was challenging at times due to the life-threatening nature of the attempted suicide. Working with suicidal patients in either a research or clinical setting seems to evoke a strong desire to try to understand why this behaviour occurs with the hope of trying to prevent it and ultimately reduce fatal suicide rates. It was important to utilise research supervision to discuss some of these issues.

One of the principal challenges in carrying out research into elderly suicide attempts is the relative infrequency with which it takes place. In order to prevent any suicide attempts that did occur from being missed, it was imperative to ensure strong links with the ward and community based teams. Therefore following ten initial team

presentations, I made weekly phone calls to a nominated team member to find out whether a suicide attempt had taken place. Although this was time-consuming, it was necessary, and over time team members became more proactive in initiating this contact.

It was decided that screening measures to assess levels of depression and hopelessness would not be administered prior to the interview as they may have shaped the thinking of participants, making the interview less exploratory. Similarly, participants were not explicitly asked whether they experienced specific losses or changes ('risk factors'). Therefore if participants did not voluntarily offer the information during the interview and it was not available in their medical records, this information was not obtained. However, given that the aim of the study was to gain an insight into factors participants saw as being important to them prior to their suicide attempt, it is likely that most of this information has been captured in the findings.

The interval between the suicide attempt and interview date varied considerably amongst participants which may have influenced the coherence and reliability of their accounts due to their changing mental state and the course of time. Previous studies recruiting younger adults who have made a suicide attempt advocate that interviews should be carried out within five days of a suicide attempt to capture cognitive deficits that characterise suicidal thinking prior to the suicide attempt, as these deficits are believed to recover over time (MacLeod et al, 1998). Even though it was not the aim of this study to capture 'active' deficits in thinking. Initially it seemed important to interview participants as close to their suicide attempt as possible so that they could provide fresh accounts of their experience. Following consultation with MHCOP staff who

recommended a longer interval to account for the frequent medical complications that occur when older people make a suicide attempt, a limit of a two-week interval was set. However, this had to be extended after the initial recruitment drive as some patients were only willing to talk about their experiences when their mood had lifted closer to their discharge date, and given that there was no set treatment pattern for older people following a suicide attempt (their length of ward stays varied from days to months) it was necessary to be flexible. Nonetheless, every effort was made to interview participants as close to their discharge date as was practically feasible.

It useful to think about the decision participants made in agreeing to be interviewed within the context of the themes that emerged following the suicide attempt. Some participants may have only agreed to participate in the research once they had 'moved on' from their attempt and felt less vulnerable, whilst others may have only talked about their experience before they had 'moved on'. It was therefore important to cater for individual differences in participants' willingness to talk after a suicide attempt, rather than assume that there is any 'correct' time to capture the experience of participants through an interview.

Initially, some staff were unsure about the research and feared that it might cause participants distress at a time of vulnerability. The Ethics Committee shared in this apprehension. In countering these concerns, it was argued that participants might find it helpful to talk about their experience and that participants would be encouraged to stop the interview if they became distressed. It was essential that a strong rapport was established with participants due to the sensitivity of the topic under discussion.



Participants were also encouraged to take breaks during the interview if they felt it necessary. Fortunately, none of the participants became distressed during the interview, and some participants even reported finding it helpful, seeing it as an opportunity to 'tell their story'.

It is likely that I was perceived as being part of the local MHCOP team providing participants' care, given that many interviews took place within a service setting, participants were initially approached about the research by a member of staff, and that they were told that I would be feeding back any risk concerns I had to staff. It is possible that some participants chose not to disclose information during the interview because they saw me as part of the service context. For example, it was surprising that some participants did not express any suicidal ideation within the interview when their suicide attempt had brought them little resolution of their difficulties. It is also possible that they withheld this information due to being audio-taped.

Staff were provided with brief feedback of any concerns I had about the mental state of participants after the interview. Occasionally however, they requested more general feedback about a participant and it was important to respect confidentiality at this time. This was particularly challenging in the sector where I was on placement for three months during the data collection phase of the research, when several clinicians saw the research interview as an opportunity for clinical assessment.

Liaising with staff both during the development of the study and the data collection phase provided an interesting insight into staff views on older people who make a

suicide attempt. Initially some staff warned against the study fearing that I would not obtain a sufficient sample size as they could think of few patients from their recent clinical work who would be suitable candidates for the research. Staff seemed to focus on one of two stereotypes when thinking about older people who make a suicide attempt; a person with a history of repeated suicide attempts and a person (usually a man) experiencing major depression for the first time in later life with no history of MHCOP service contact. I was struck with how participants diverged from the two stereotypes discussed in the initial meetings I had with the teams. Over the course of the study, several staff expressed surprise by the number of older people who had made a suicide attempt across the Trust, and seemed to thinking more about this clinical group. Finally, after the data collection period ended, I was informed by staff in three of the five sectors that there had been an increase in the number of referrals to psychology of patients who had made a suicide attempt, suggesting that the study influenced MHCOP staff to think more about the role of psychologists in working with this client group.

#### **4.3. Areas for Future Research**

The current study has highlighted the importance of considering individual experience and social context, although further research is needed to support this move away from risk factor approaches so that the experience of attempted suicide in later life is better understood. Three recommendations are made for future research. First, future studies could interview older people at a later stage following their suicide attempt to see whether the suicide attempt was a 'turning point' for them, whether it signified the end of their struggle and what resources they drew on if they did manage to experience a positive outcome, given that several important themes emerged in participants'

experience following the suicide attempt. Second, as sub-group comparisons were not made in the present analysis, it would be interesting to compare individuals who made their first suicide attempt in later life with those who had made earlier attempts, to see whether their experience of ageing differed. Comparing the present sample's experience of ageing with a depressed but not actively suicidal group of patients might also be useful. Finally, it would be interesting to explore MHCOP staff perceptions of older people who make a suicide attempt and how they inform their clinical practice, given the stereotypes that seemed to circulate within the teams. It would also be interesting to explore staff perceptions outside of MHCOP given the number of participants who were seen in medical settings prior to their suicide attempt.

#### **4.4. Clinical Implications of the Findings**

This section will outline clinical implications from the present findings. The principal implication of the current findings is that although three main themes have emerged from the interview data, there appears to be no set pattern or 'profile' of experience prior to the suicide attempt. This suggests that drawing on stereotypes of older people who make suicide attempts in clinical practice is not always helpful. Risk factors are not always present or salient to the individual prior to their suicide attempt. It is therefore important for clinicians to focus on the subjective meaning of any losses and changes, and the influence of the social context on the pathway to suicide to better understand this experience in later life.

Participants discussed various turning points in which their lives took a turn for the worse. These may have been points at which they would have been amenable to

therapeutic intervention (e.g. problem-solving techniques and referrals to day centres) or practical assistance (e.g. home-help and appropriate medical treatment), which may have helped avert a suicide attempt. Following a suicide attempt, an in-depth interview could be used therapeutically to help identify problems that could hinder recovery and precipitate another attempt in the future. It could also be a way of offering participants relief and a way of working towards resolution. This would go against some of the earlier concerns voiced by staff (and indeed the Ethics Committee) that talking about suicidal feelings close to an attempt can be distressing and can encourage people to act upon them.

The current findings highlight the difficulty in preventing suicidal behaviour in older people, as there appears to be no set pathway to a suicide attempt. Many participants who were not in contact with MHCOP services prior to their attempt, had contact with other health professionals who they felt could have played a part in the prevention of their suicide attempt, for example when they complained of physical ailments and did not feel believed. However, it is possible that some participants did not articulate their distress in emotional language, focusing more on their physical health concerns or practical problems rather than their inner turmoil. Furthermore, obtaining an accurate assessment of an individual's experience prior to their suicide attempt in a general medical setting is likely to prove challenging, given the brief consultations that are offered.

Some participants experienced becoming visible as a burden after the suicide attempt, which resulted in feelings of shame and isolation. Some reported unsympathetic

attitudes from staff at this time, particularly those in a medical setting which compounded their feelings of distress. This may be a point for future staff training.

The findings from this research also suggest that assessing the individual's intent to die is more meaningful than focusing on the quantity of medication they have taken in overdose, as some participants were confused over the amount of medications needed to make a fatal suicide attempt.

Finally, almost half of the sample reported the experience of having a fall as contributing to feelings of helplessness prior to their suicide attempt, in fact for many it symbolised a 'turning point' that brought them closer to the suicide attempt. This has implications for medical services treating these patients who may need to offer additional support to facilitate adjustment to reduced mobility i.e. fall groups. This is timely given the governments emphasis on falls in the current National Service Framework for Older People (D.O.H., 2001).

#### **4.5. Closing Summary**

This study aimed to explore how older people who have recently acted on their suicidal feelings experience the pathway to their suicide attempt, including their subjective experience in relation to 'risk factors'. It also aimed to capture their experience of ageing. The findings have demonstrated that the pathway to suicide in old age is extremely complex, and that no set pattern or 'profile' of experience has appeared in the results, despite the emergence of the three broad themes. Different losses and changes were seen as being important to participants around the time of their suicide attempt and

these were not always 'risk factors' identified in the existing literature. This raises the question of whether a set pattern should be expected at all, given the diversity of experience prior to the suicide attempt. It also highlights the importance of considering the way in which an individual makes sense of their experience prior to their suicide attempt, and indeed the social context within which the individual operates at this time. The findings suggest that a risk factor approach is not only limited in predicting attempted suicide, but also in furthering understanding the phenomenon of suicide.

The experience of losing control, becoming less visible due to loneliness, and feeling trapped and helpless immediately prior to the suicide attempt were not surprising findings given the existing literature available on suicidal thinking, whereas the struggle that many participants encountered before acting on their suicidal thoughts, was less expected. Participants were not as 'helpless' as one might expect in the pathway to their suicide attempt and tried hard to fight against some of the changes and losses they experienced, even though many of these efforts were in vain. The themes that emerged following the suicide attempt were also less expected and highlight the vulnerability as well as the strengths and resources of older people at this time. Another more surprising finding was the extent to which participants felt marginalised and overlooked by others in society because of their age, and the difficulty they had in trying to come to terms with their identity as older people. Indeed, several participants made an explicit link between their difficulty in adjusting to growing older and their motivations for attempting suicide. However, as the relationship between adjustment to ageing and attempted suicide has been somewhat neglected in the existing literature, and the present

findings are based on a small sample in which differences were apparent, further research is necessary before any firm conclusions can be drawn.

Finally, the current findings have implications that go beyond the boundaries of health services. Many participants experienced ageist attitudes from wider society, which left them feeling overlooked and marginalised. It is hoped that as the proportion of older people increases in the UK, and they become less of a minority group that they will be become more empowered within society and will begin to feel more valued and integrated as a result. Later life might then be seen as a period of development rather than inevitable decline, making the prospect of growing older far less daunting. This may in turn help reduce attempted and completed elderly suicide rates.

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## **Appendices**

**Appendix 1: Ethics Approval Letter**

**Appendix 2: Patient Information Sheet**

**Appendix 3: Patient Consent Form**

**Appendix 4: Interview Schedule**

**Appendix 5: Figure 4.1. Diagram of The Experience of the Pathway to & from  
Attempted Suicide in Later Life**

**Appendix 6: Summary of the points from the 'Resonating with the reader check'**

# Camden and Islington Community LOCAL RESEARCH ETHICS COMMITTEE

Research & Development Unit, 3<sup>rd</sup> Floor, West Wing, St. Pancras Conference Centre  
St Pancras Hospital, London NW1 0PE  
tel: 020 7530 3376 fax: 020 7530 3235  
e-mail: ayse.ali@cichs-tr.nthames.nhs.uk  
Chair: *Stephanie Ellis* Administrator: *Ayse Ali*

03 May 2001

Ms Louise Crocker  
Sub-Department of Clinical Health Psychology  
University College London  
Gower Street  
London  
WC1E 6BT

Dear Ms Crocker

**LREC Ref: 01/25**(please quote in all further correspondence)

**Title: Giving Up: A qualitative study of suicidal thinking in older people**

Thank you for your letter dated 20 April 2001 addressing the concerns raised by the ethics committee. I am pleased to inform you that the Local Research Ethics Committee has recommended that ethical approval be granted for your study.

## **THIS APPROVAL ALONE DOES NOT ENTITLE YOU TO BEGIN RESEARCH.**

Camden and Islington LREC considers the ethics of proposed research projects and provides advice to NHS bodies under the auspices of which the research is intended to take place. It is that NHS body which has the responsibility to decide whether or not the project should go ahead, taking into account the ethical advice of the LREC<sup>1</sup>. Where these procedures take place on NHS premises or using NHS patients, the researcher must obtain the agreement of local NHS management, who will need to be assured that the researcher holds an appropriate NHS contract, and that indemnity issues have been adequately addressed.

**Note:** Camden and Islington Community LREC is an independent body providing advice to Camden and Islington Community Health Services NHS Trust and others. Approval from the LREC and approval from the Trust to commence research on Trust premises or patients are **NOT** one and the same. Trust approval is notified through the Research & Development Unit.

## **The following conditions apply to this (ethical) approval:**

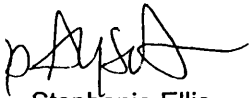
- ♦ You must write and inform the committee of the start date of your project. The Committee (via the Local Research Ethics Committee Administrator or the chair at the above address) **must** also receive notification:
  - a) when the study is complete;
  - b) if it fails to start or is abandoned;
  - c) if the investigator/s change and
  - d) if any amendments to the study are made.
- ♦ The Committee **must** receive immediate notification of any adverse or unforeseen circumstances arising out of the project.
- ♦ It is the responsibility of the investigators to ensure that all associated staff including nursing staff are informed of research projects and are told that they have the approval of the Ethics Committee and management approval from the body hosting the research.

<sup>1</sup> Local Research Ethics Committees Health Service Guidelines (91)5, NHS Management Executive, 19 August 1991 (*commonly known as The Red Book*).

- ♦ The Committee will require a copy of the report on completion of the project and may request details of the progress of the research project periodically (i.e. annually for longer projects).
- ♦ If data are to be stored on a computer in such a way as to make it possible to identify individuals then the project must be registered under the Data Protection Act 1998. Please consult your department data protection officer for advice.

**Please forward any additional information/amendments regarding your study to the Local Research Ethics Committee Administrator or the chair at the above address.**

Yours sincerely



Stephanie Ellis  
Chair, LREC

Camden and Islington  
Community Health Services NHS Trust



Dr Paul Fox  
Research & Development Unit  
3<sup>rd</sup> Floor West Wing  
Camden & Islington Community Health Services NHS Trust  
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Phone 020 7530 5375  
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03 May 2001

Ms Louise Crocker  
Sub-department of Clinical Health Psychology  
University College London  
Gower Street  
London  
WC1E 6BT

Dear Ms Crocker

LREC Ref: 01/25

Title: Giving up: A qualitative study of suicidal thinking in older people

I am pleased to note that the Local Research Ethics Committee has recommended to the Trust that there are no ethical reasons why your study should not proceed.

On the basis of the documentation supplied to us, your study has the support of the clinical service manager/assistant locality director of the service in which it will be based.

This Trust therefore grants permission to undertake the research, as stated in the study protocol. This permission is only valid concurrently with ethical approval for this study. Ethical approval issued by Camden and Islington Community LREC is issued subject to a number of conditions (see ethics approval letter). Should your ethical approval be invalidated for failure to adhere to these conditions, then the Trust would also consider this approval to be withdrawn.

Please make all members of the research team aware of the contents of this approval. I wish you every success with your research.

Yours sincerely,

Dr Paul Fox  
Head of Research & Development



**CONFIDENTIAL**

**INFORMATION SHEET ABOUT THE STUDY OF SUICIDAL THINKING IN OLDER PEOPLE**

You are being invited to take part in a postgraduate doctoral research study. Before you decide, it is important for you to take time to read the following information carefully and feel free to ask questions at any time.

***What is the study trying to find out?***

This study is interested in finding out more about suicidal thinking in older people. We know that older people can feel suicidal for a variety of reasons but need to develop a greater understanding of the kind of thoughts and feelings individuals might be having at this difficult time. To help find this out, interviews are being carried out with approximately 20 people aged over sixty-five who have recently acted on their suicidal feelings and have come into contact with local services.

***What does the study involve?***

The study involves a one-off interview with Louise Crocker that lasts approximately one hour. During the interview you will be asked about your experience of feeling suicidal both in terms of the kind of thoughts you were having on a day-to-day basis and how your thinking might have changed over time. Lastly, you will be asked about what it is like to be growing older. All of the interviews will be tape-recorded and typed-up afterwards. The tape will then be destroyed and the typed-up interviews will be kept anonymous so that confidentiality is ensured.

***Do I have to take part?***

You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason. Your decision whether to take part or not will not affect your care and management in any way.

***Are there any possible risks of taking part?***

Talking about recent suicidal thoughts and feelings may well be distressing, but people can also find it a relief to talk about how they have felt. You can stop the interview should you feel it necessary and your keyworker or somebody close to you could be contacted with your permission. The interviewer will be speaking to your keyworker after the interview and if necessary will inform them of any concerns they have about you.

***Who do I contact for more information?***

The main investigator for this study is Louise Crocker, Trainee Clinical Psychologist who may be contacted at the Sub-Department of Clinical Health Psychology, University College London, Gower Street, London, WC1E 6BT (Tel no. 07957 692 574 during office hours only). The other two investigators are Dr. Linda Clare, Lecturer in Clinical Psychology at the above address and Dr. Kathryn Evans, Clinical Psychologist in Mental Health Care for Older People, Camden and Islington Mental Health NHS Trust.

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the Camden and Islington Mental Health NHS Trust local research ethics committee.

**CONFIDENTIAL**

Centre Number:

Participant Identification Number:

**CONSENT FORM**

A study of suicidal thinking in older people

Louise Crocker, Trainee Clinical Psychologist, University College London

**To be completed by the participant**

- 1. I have read the information sheet about this postgraduate doctoral research study YES/NO
- 2. I have had an opportunity to ask questions and discuss this study YES/NO
- 3. I have received satisfactory answers to all my questions YES/NO
- 4. I have received sufficient information about this study YES/NO
- 5. I have spoken to Louise Crocker about this study. YES/NO
- 6. I understand that I am free to withdraw from this study:-
  - at any time
  - without giving a reason for withdrawing
  - without affecting my future medical care YES/NO
- 7. Do you agree to take part in this study? YES/NO

Signed..... Date.....

Name in Block Letters .....

Signature of Investigator .....

## Semi-Structured Interview Schedule

### Background information and orientation to interview

1. Can you tell me a bit about yourself? *Prompts:* Can you give me an idea of how your **health** has been in recent years, whether you are quite **active and independent**, whether you have **family and friends** around you, consider yourself to have a **stressful life**, have had any **losses in recent years**?

### Area 1: The psychological pathway to a suicide attempt: How the decision to 'give-up' evolved over time.

1. Thinking about how low you have feeling, I'm wondering when you first thought about ending your life / acting on these feelings<sup>1</sup>? *Prompt:* How old were you? Was this the first time that you had felt like this?

2 Can you tell me a bit about how your thoughts about acting on your suicidal feelings changed/evolved over time. *Prompt:* A brief history of your thinking before your attempt (starting with the day, day before, week before, month before, year/s). Or was it a quick decision?

### Area 2: How possible risk factors came together in and/or contributed to, the respondent's decision to 'give-up'?

1. What sorts of things were on your mind during the **week before** you came to hospital?

2. If one night whilst you were asleep before you came to hospital/A&E etc. there had been a miracle that had taken your suicidal feelings away, what would you have noticed to be different in your life when you woke up? *Prompt:* How would you know things were better? Looking back, what do you think needed to be different to have stopped you doing what you did? How did you feel immediately after the attempt (e.g. when you first regained consciousness/ realised what had happened)? What were your first thoughts?

3. (*Acknowledge struggle etc.*) How would you explain how you were thinking and feeling in the weeks before you came to hospital to someone who had never felt that way before? How are you feeling about it now?

### Area 3: Adjustment to ageing and the role this might have played in 'giving up'

1. What words come to mind when I say 'growing old'? *Prompt:* Images?

2. What do you think are the advantages (good things) and disadvantages (bad things) of (about) growing old today? *Prompt:* Generally, what do you think most people think of older people today? What do you think people in Islington/Camden? Hampstead etc. think of older people?

3. Do you think of yourself as getting old? *Prompt:* What is it like to be an older person in 2001? Good things and bad things about it for you.

4. When would you say that you became, or made the transition to, being an older adult? *Prompt:* What changes took place (e.g. retirement, physical changes etc.) and how did you manage them/ get used to it? How was this process? Was it a smooth transition?

5. What are your first memories of older people? Did these change much as you became an adult / across your lifespan? What were your views on older people twenty years ago? What are your views of older people today? *Internalised ageism.* Media representations.



Additional area to focus on throughout the interview: The beliefs that the respondent holds about suicide that may or may not have changed over their lifespan.

1. What was your first experience of hearing about someone who was suicidal or who had committed suicide? *Prompt:* Childhood experience, your view of this act - honourable or sinful?

2. If I'd asked you your views on suicide twenty or thirty years ago, or even longer what might you have said they were? *Prompt:* Views of friends, family and even culture and religion over the years. Media representations.

Ending discussion and debriefing:

- Discuss strengths of respondent, given above history.
- Debrief and obtain feedback on how they found the interview.
- Discuss support on offer from statutory and voluntary services (e.g. Islington Mind, Samaritans etc.).

<sup>1</sup> Note: The interviewer will try to incorporate the participant's choice of terminology used to describe the suicide attempt and will modify the questions accordingly.



## Appendix Six

### Summary of points from the 'Resonating with the reader' check

The following summary outlines the main points raised in relation to the four questions asked as part of the 'Resonating with the reader check':

*1. Do the descriptions of themes match up with the quotations provided to illustrate them?*

The reader reported that on the whole, the descriptions were clear and 'matched up' well with the quotations provided. She did feel that one excerpt used in the account of the findings to illustrate a subordinate theme was too long as it seemed to be illustrating two themes rather than one, making it potentially confusing to readers. I therefore refined the quotation to ensure that it better captured the full essence of the theme.

*2. Has the author managed to find client language for 'difficult-to-express' experiences?*

The reader liked the use of participant language to illustrate the themes, remarking that it "brought them to life" and made the processes underlying them clearer. She particularly liked the use of quotations in the theme labelling.

*3. Do the results seem to be an accurate representation of the subject matter?*

The reader felt that the findings were an accurate representation of the topic. She was not surprised to hear that participants felt trapped and hopeless prior to their suicide attempt, but she was surprised that more participants did not report feeling helpless and "in the depths of despair" earlier on in the pathway to their suicide attempt.

*4. Do the results enhance your appreciation of this topic in any way?*

The reader was struck by the diversity of participant experience prior to the suicide attempt, which seemed to challenge her expectations about the type of older people that make suicide attempts. Coming from a solution-focused perspective, she was particularly interested in and encouraged by the resources participants were able to draw on to experience 'regaining control' and 'becoming visible again'. She also wondered whether the 'opiate like state' that accompanied 'finding a solution' could be picked up clinically to avert a suicide attempt. Finally, she was struck by the richness of the descriptions given by participants and felt that some of the detailed information they described about their experience of ageing would often be missed clinically.