



## Suicide Risk in the Hospitalized Elderly in Turkey and Affecting Factors



Dilek Avci <sup>a,\*</sup>, Kevser Tari Selcuk <sup>a</sup>, Selma Dogan <sup>b</sup>

<sup>a</sup> Bandirma Onyedi Eylul University Faculty of Health Sciences, Balikesir, Turkey

<sup>b</sup> Uskudar University Faculty of Health Sciences, Istanbul, Turkey

### A B S T R A C T

**Objective:** This study aimed to investigate the suicide risk among the elderly hospitalized and treated because of physical illnesses, and the factors affecting the risk.

**Methods:** The study has a cross-sectional design. It was conducted with 459 elderly people hospitalized and treated in a public hospital between May 25, 2015 and December 4, 2015. Data were collected with the Personal Information Form, Suicide Probability Scale and Hospital Anxiety and Depression Scale. For the analysis, descriptive statistics, the chi-square test, Fisher's exact test and logistic regression analysis were used.

**Results:** In the study, 24.0% of the elderly were at high risk for suicide. Suicide risk was even higher among the elderly in the 60–74 age group, living alone, drinking alcohol, perceiving his/her religious beliefs as weak, being treated for cancer, having the diagnosis 11 years or over, having a history of admission to a psychiatry clinic, and being at risk for anxiety and depression.

**Conclusion:** In the study, approximately one out of every four elderly people was at high risk for suicide. Therefore, older people should be assessed for suicide risk and programs targeting to prevent the elderly from committing suicide should be organized.

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Suicide defined as the act of deliberately killing oneself voluntarily has increased in recent years, and thus has become an important public and mental health problem in many countries (Casey et al., 2006; Kellogg, Kaur, & Blank, 2014; WHO, 2014). Every year, about a million people die from suicide in the world. The World Health Organization (WHO) predicts the number of deaths by suicide to reach 1.5 million in 2020 (WHO, 2012).

One of the most important factors affecting the suicide rate in a society is age. Several studies report that the prevalence of elderly suicides is increasing due to the increase in the elderly population (Bilonia, Shah, Baiwa, & Zafer, 2015; Conwell, Van-Orden, & Caine, 2011; Hwang, Park, & Choi, 2016; Lapierre et al., 2011). According to the WHO, age specific suicide rates significantly increase after the age of 45 in the US, being the highest in the 75+ age group. In the UK, 30–40% of suicides are committed by those in the 55+ age group (WHO, 2014). In Turkey where the elderly population is rapidly increasing, the highest rate of suicide attempts is in the 75 and over age group with 8.07 per hundred thousand (Turkish Statistical Institute, 2014). Suicide facts related to elderly people differ from those related to younger people in many ways. Compared to young people, older people share their suicidal ideas with anyone less, underutilize mental health services and use more lethal methods, which makes it difficult to determine the suicide risk in the elderly and thus increases the rate of completed suicides

among them (Chan, Liu, Chau, & Chang, 2011; Conwell et al., 2011; Fässberg et al., 2016).

Although suicide rates among the elderly increase at a serious level, issues such as suicide risk and suicidal behaviors among them are often neglected (Heisel & Duberstein, 2005; Lapierre et al., 2011). However, the most effective way to develop interventions to prevent suicides, and to reduce suicide-related mortality rates is the determination of risks urging people to commit suicide, and protective factors (Conwell et al., 2011; Fässberg et al., 2016; Xu et al., 2016). Functional impairment, hopelessness, economic losses, social isolation, stressful life events, physical illnesses and psychiatric disorders increase the suicide risk in elderly individuals (Bilonia et al., 2015; Chan et al., 2011; Fässberg et al., 2016; Hwang et al., 2016; Lapierre et al., 2011; Xu et al., 2016).

In several epidemiological studies and psychological autopsies, illnesses are stated as the most common cause of suicides (Beautrais, 2002; Conwell et al., 2011; Gumus, Ozer, Yildirim, & Cetin, 2010; Phillips et al., 2002; Préville, Hebert, Boyer, Bravo, & Seguin, 2005). The prevalence of physical illnesses in suicide cases varies between 23% and 72% (Beautrais, 2002; Chan et al., 2011; Qin, Webb, Kapur, & Sørensen, 2013; Turvey et al., 2002; Xu et al., 2016). Among the causes of suicide in Turkey, physical illnesses rank the first. According to the Turkish Statistical Institute's report released in 2014, although the cause of 52.9% of the suicides was not known, in 17.9% of the remaining suicide cases, the cause was illnesses. The report also states that most of the suicides were committed by people in the 75 and over age group (Turkish Statistical Institute, 2014). In addition, studies show that the drugs used in the treatment of physical illnesses, age-related physical and mental

\* Corresponding Author: Dr. Dilek Avci, Assistant Prof. PhD, RN, Bandirma Onyedi Eylul University, Faculty of Health Sciences, Kurtulus Street, 10200 Bandirma/Balikesir, Turkey.  
E-mail address: [daydinenator@gmail.com](mailto:daydinenator@gmail.com) (D. Avci).

disabilities, and changes in the life style cause despair in the elderly, which consequently makes them more susceptible to depression, and this increases the suicide risk among them (Conwell et al., 2011; Kim, Lee, & Park, 2015; Liu et al., 2016; Wang, Li, Zhang, Phillips, & Yang, 2007; Xu et al., 2016). In their study conducted with elderly individuals who had attempted suicide, Suominen et al. determined that depression was an important risk factor for suicides, but that the presence of depression was mostly realized after the person attempted suicide, and they emphasized that the elderly should be monitored for depression (Suominen, Isometsä, & Lönnqvist, 2004).

Suicide risk is a threat for patient safety, and suicide is a cause of death that could be detected and prevented in advance. Nurses who are responsible for patients' care play an active and important role in the prevention of suicide (Garand, Mitchell, & Dietrick, 2006; Kellogg et al., 2014). Determination of the elderly at risk for suicide is of vital importance in preventing elderly suicide (Chan et al., 2011; Lapierre et al., 2011). In addition, encouraging the elderly to hold onto life, enabling them to continue their productivity and the efficient implementation of home care services for the elderly will reduce the likelihood of committing suicides among them (Fässberg et al., 2016; Garand et al., 2006; Oslin et al., 2004). On the other hand, in Turkey, there are few if any studies investigating suicide risk in the elderly (Kizil, Yarpuz, Ekinci, Sorgun, & Turan, 2007). Most of the studies investigate the factors affecting the completed suicide (Ekici, Savas, & Citak, 2001; Gumus et al., 2010; Yavuz, Yurumez, Kucuker, Demirel, & Kucuk, 2006). Determination of suicide risk considered as one of the most important factors threatening patient safety in general medicine and factors affecting suicidal ideation will significantly contribute to the development of approaches to prevent suicides and the effectiveness of treatment. Therefore, this present study was aimed at investigating the suicide risk among the elderly hospitalized and treated because of a physical illness and the factors affecting the risk.

The main research questions of this present study are as follows:  
1) What is the prevalence of suicide risk in the hospitalized elderly?  
2) What are the factors that affect the suicide risk in the hospitalized elderly?

## METHODS

### Study Design

This cross-sectional study was conducted in a State Hospital in Bandirma, a district of Balıkesir Province.

### Participants

The minimum sample size was calculated with the PASS 11 software. The sample size was calculated according to the frequency of an event when the population size is unknown. No nationwide and regional study has been conducted to determine the prevalence of suicide risk in the hospitalized elderly in Turkey. On the other hand, in studies carried out abroad, the rate of suicide risk in the elderly ranges between about 6.0% and 29% (Chan et al., 2011; Heisel, Duberstein, Lyness, & Feldman, 2010; Vasiliadis, Gagné, Jozwiak, & Préville, 2013; Xu et al., 2016; Yen et al., 2005). Based on this, the minimum sample size was calculated as  $n = 450$  by using  $p = 0.10$ – $0.25$  and  $\beta = 0.84$  (power) for the prevalence of suicide risk. In order to achieve the minimum sample size, of the 726 elderly patients who were treated in the internal medicine and surgery clinics of Bandirma State Hospital, who were hospitalized between May 25, 2015 and December 4, 2015, and who met the inclusion criteria, 459 were included in the study. The inclusion criteria were as follows: having diagnosis of a physical illness, having been hospitalized at least 5 days, agreeing to participate in the study, being older than 60 years. Fifty-three patients who refused to participate were excluded from the study. The exclusion criteria were as follows: having perception disorders, having mental disorders.

### Instrument

Data were collected with the Personal Information Form, Suicide Probability Scale and Hospital Anxiety and Depression Scale.

**Personal Information Form:** The form developed by the researchers through a literature review that consists of 19 items that question some sociodemographic and clinical characteristics of the elderly (Bilonia et al., 2015; Chan et al., 2011; Fässberg et al., 2016; Hwang et al., 2016; Lapierre et al., 2011; Xu et al., 2016).

**Suicide Probability Scale (SPS):** The scale was developed by Cull and Gill in order to evaluate the suicide risk (Cull & Gill, 1988). The validity and reliability of the Turkish version of the scale was conducted by Atli et al. in 2009. The Cronbach alpha for the total Suicide Probability Scale was 0.89. Responses are rated on a 4-point Likert scale ranging from 1 to 4. The scale has 36 items. The scale has 4 sub-dimensions: hopelessness, suicide ideation, negative self-evaluation and hostility. The sum of the total scores for each subscale gives the possibility of suicide. The lowest and highest possible scores to be obtained from the scale were 36 and 144 respectively. The higher the score is the higher the suicide risk is. To assess the suicide risk, the scores obtained from the scale are categorized into four groups: 0–24 = no risk, 25–49 = slight risk, 50–74 = moderate risk, 75–100 = high risk (Atli, Eskin, & Dereboy, 2009). The Cronbach alpha reliability coefficient of the scale was calculated as 0.86 in the present study.

**Hospital Anxiety and Depression Scale (HADS):** The scale developed by Zigmond and Snaith is a self-rating scale used to determine the risk of depression and anxiety in people with a physical illness (Zigmond & Snaith, 1983). The validity and reliability study of the Turkish version of the scale was performed by Aydemir et al. The scale has two subscales: Anxiety (HADS-A) and Depression (HADS-D). The Cronbach alpha was 0.85 for anxiety and 0.77 for depression. Responses are rated on a 4-point Likert scale ranging from 0 to 3. The scale has 14 items. While 7 of them (odd numbers) assess anxiety, the remaining 7 (even numbers) assess depression. The lowest and highest possible scores to be obtained from each subscale are 0 and 21 respectively. While the cut-off point for the anxiety subscale is 11, it is 8 for the depression subscale. Those whose scores are above the cut-off point are considered in the at-risk group (Aydemir, Guvenir, & Kuey, 1997). Cronbach alpha reliability coefficient of the scale was calculated as 0.87 for anxiety and 0.82 for depression in this present study.

### Ethical Considerations

This study was conducted in compliance with the principles of the Helsinki Declaration. Necessary permission was obtained from Balıkesir General Secretariat of the Association of Public Hospitals. The ethics committee approval was received from Balıkesir University Clinical Research Ethics Committee (Decision date and no. 2015/16).

### Procedure

Prior to data collection, the elderly were informed about the purpose and scope of the study, and then their verbal consent indicating they agreed to participate in the survey was obtained. Two nurses from each clinic who assumed the primary care of patients were trained by the researchers and the data collection tools were administered to the elderly included in the study by the nurses through face-to-face interviews. In the hospital where the study was conducted, all the patient rooms have two beds, but there is no interview room in the clinics. Therefore, the data were collected in the patient rooms. To ensure the continuity of the interviews, data were not collected during visit, treatment or meal hours. The administration of the data collection tools took about 30 minutes.

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