Understanding Why Older People Develop a Wish to Die
A Qualitative Interview Study

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Abstract. Background: Quantitative studies in several European countries showed that 10–20% of older people have or have had a wish to die. Aims: To improve our understanding of why some older people develop a wish to die. Methods: In-depth interviews with people with a wish to die (n = 31) were carried out. Through open coding and inductive analysis, we developed a conceptual framework to describe the development of death wishes. Results: The wish to die had either been triggered suddenly after traumatic life events or had developed gradually after a life full of adversity, as a consequence of aging or illness, or after recurring depression. The respondents were in a situation they considered unacceptable, yet they felt they had no control to change their situation and thus progressively “gave up” trying. Recurring themes included being widowed, feeling lonely, being a victim, being dependent, and wanting to be useful. Developing thoughts about death as a positive thing or a release from problems seemed to them like a way to reclaim control. Conclusions: People who wish to die originally develop thoughts about death as a positive solution to life events or to an adverse situation, and eventually reach a balance of the wish to live and to die.

Keywords: The Netherlands, interviews, death thoughts, life events, framework

Introduction

There are several quantitative studies of the wish to die in older people. These studies consistently found that 10–20% of the older people in different European countries have or have had death thoughts or wishes (Barnow & Linden, 2000; Forsell, Jorm, & Winblad, 1997; Rao, Dening, Brayne, & Huppert, 1997; Rurup, Deeg, Poppeliers, Kerkhof, & Onwuteaka-Philipsen, 2010; Scocco & De Leo, 2002; Skoog et al., 1996). In a large cohort study we found that although people with a wish to die more often had depressive symptoms than people without the wish to die; only a minority of 20% of people with a wish to die actually suffered from a depressive disorder (measured with the Diagnostic Interview Schedule for depression). We found the following factors were also associated with the wish to die in older people: lower perceived mastery, financial problems, loneliness, a small social network, involuntary urine loss, being divorced and having a speech impairment (Rurup et al., 2010). Some of these associated factors had also been found in previous studies (Callahan, Hendrie, Nienaber, & Tierney, 1996; Dennis et al., 2007; Forsell et al., 1997; Jorm et al., 1995; Yip et al., 2003).

These studies, however, do not provide indepth insight into questions such as: How and when do wishes to die develop? What is the background and what are the reasons for their wish to die? To answer these questions, we set up a qualitative study in which indepth interviews were held with older people with a wish to die.

Methods

Data Sources

Respondents were included from two cohort studies, based on selection questions about the wish to live and the wish to die. See Table 1 for an overview of background characteristics of the selected respondents and the intensity of their wish to live and die.

The first cohort stems from the Longitudinal Aging
Table 1. Background characteristics of the respondents

<table>
<thead>
<tr>
<th>Gender</th>
<th>n = 31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>13</td>
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<tr>
<td>Female</td>
<td>18</td>
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<table>
<thead>
<tr>
<th>Age (years) (average 74 years)</th>
<th>n = 31</th>
</tr>
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<tbody>
<tr>
<td>49–60</td>
<td>3</td>
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<tr>
<td>61–70</td>
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<td>71–80</td>
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<tr>
<td>81–90</td>
<td>7</td>
</tr>
<tr>
<td>91–99</td>
<td>3</td>
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<table>
<thead>
<tr>
<th>Partner status</th>
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</thead>
<tbody>
<tr>
<td>Partner (living together)</td>
<td>7</td>
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<tr>
<td>Divorced</td>
<td>6</td>
</tr>
<tr>
<td>Widowed</td>
<td>14</td>
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<tr>
<td>No partner</td>
<td>4</td>
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<table>
<thead>
<tr>
<th>Children</th>
<th>n = 31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good contact with children*</td>
<td>17</td>
</tr>
<tr>
<td>Poor contact with some or all children*</td>
<td>9</td>
</tr>
<tr>
<td>No children</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Housing</th>
<th>n = 31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>23</td>
</tr>
<tr>
<td>Semidependent</td>
<td>5</td>
</tr>
<tr>
<td>Care home</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Beck Scale: the wish to live and die</th>
<th>n = 31</th>
</tr>
</thead>
<tbody>
<tr>
<td>No wish to die and weak wish to live</td>
<td>2</td>
</tr>
<tr>
<td>Weak wish to die and moderate-strong wish to live</td>
<td>2</td>
</tr>
<tr>
<td>Weak wish to die and weak wish to live</td>
<td>5</td>
</tr>
<tr>
<td>Weak wish to die and no wish to live</td>
<td>1</td>
</tr>
<tr>
<td>Moderate-strong wish to die and weak wish to live</td>
<td>5</td>
</tr>
<tr>
<td>Moderate-strong wish to die and no wish to live</td>
<td>16</td>
</tr>
</tbody>
</table>

*Good contact with children* includes respondents who were in contact with their children, regardless of the frequency of that contact; *Poor contact with some or all children* includes respondents who had lost touch or had a serious conflict with some or all children.

Selection Questions

People were selected from these cohort studies on the basis of their answers to the following two questions about their wish to live or die (derived from the Scale for Suicidal Ideation by Beck, Kovacs, & Weissman, 1979).

- What were your feelings toward living the past week?
  - Did you wish to live, and how strong was this wish?
  - Did you have ... (no wish to live/a weak wish to live/a moderate to strong wish to live)?

- What were your feelings toward dying the past week?
  - Did you wish to die, and how strong was this wish?
  - Did you have ... (no wish to die/a weak wish to die/a moderate to strong wish to die)?

The questions were asked in a context of a questionnaire or interview.

Sampling

We had no prefixed sample size, according to the theory of sequential analysis. We interviewed people until theoretical saturation was reached (n = 31). Two pilot interviews were done in 2004, 29 people were selected from the two cohort studies and interviewed in the period 2006–2008. The time lag between answering the selection questions and the interview was 13 months on average (min 1 month–max 28 months).

We selected people from both cohorts, with a variation in age, gender, reason, background, and Beck intensity of the wish to die. To achieve maximum variation in reasons and background of wish to die, the phases of sampling, interviewing, and analyzing alternated (purposive sampling).

From the 1794 LASA respondents, 1459 indicated they had never had death thoughts, 274 indicated having had death thoughts, 47 indicated having had a weak or no wish to continue living in the past week and/or a weak wish to die in the past week, and 14 indicated having had a moderate or strong wish to die in the past week. We selected 16 respondents for an indepth interview; one person was untraceable, one refused, and one had died before the interview could take place.

From the 3754 ADC respondents who answered the selection questions, 2364 indicated they had never had death thoughts, 984 indicated having had death thoughts, 320 indicated having had a weak or no wish to continue living in the past week and/or a weak wish to die in the past week, and 86 indicated having had a moderate or strong wish to die in the past week. The data from the questionnaires from the ADC respondents are kept separate from the personal data and can be linked only if the respondent has explicitly allowed this, in order to be asked to participate in indepth interviews. About 55% of the ADC respondents gave this permission, leaving 227 eligible respondents with a weak
or no wish to live in the past week, or a weak/moderate/strong wish to die in the past week. All 16 respondents selected for the indepth interview agreed to participate in an interview.

The Interview

The interviews were done by two interviewers (MLR and JG), in 30 cases at the place of residence of the respondent, in 1 case in a conference room. All respondents were living in the Netherlands. All were informed about the purpose of the study, and they all signed an informed consent form or gave oral consent on tape if they were unable to read or write, in accordance with the procedure approved by the Ethical Committee of the VU University Medical Center. The interviews lasted between 30 minutes and 2½ hours.

The purpose of the interview was to learn more about the wish of the respondent to die. The following opening question was used: “In a previous interview/questionnaire questions were asked about your feelings concerning living and dying. You then indicated that you sometimes felt life was not worth living, and that you had a [use score Beck scale] wish to die. Have those feeling changed since that time?” After this opening question, the questions were based on what the respondent said. A topic list was used as a reminder of the issues that should be addressed in the interview. Topics that were included were: the reasons for their wish to die, when their wish to die developed, the intensity of this wish, their thoughts about death and dying, and the most important thing in their life.

Analysis

The interviews were recorded and fully transcribed. Interviews were analyzed using atlas.ti. We used open, inductive coding to identify recurring themes in the interviews; codes were made based on the content of the interviews, and no prior theory or framework was used in the analysis initially. The codelist extended as more interviews were analyzed, codes were grouped and regrouped in the process of analysis, most codes were
created in the analysis of the first 15 interviews. Appendix 1 shows an overview of the codes that were created in relation to the background and reasons for their wish to die and the intensity of the wish die.

Then, to better understand the reasons why a wish to die had developed, an overview was made of how the wish to die had developed per respondent (not given in a table for reasons of anonymity). We found that the triggers for why the wish to die had developed could be categorized in five main groups, but for each respondent many other aspects had also played a role. To illustrate this we developed a conceptual framework (Figure 1).

**Results**

Figure 1 shows a framework we developed to describe the origination and development of a wish to die. First, we describe the life events and/or problems that were the original trigger in the development of the wish to die. We then describe some recurring themes related to personal character, coping strategies, and social support that played a role in the way the respondents dealt with these events or situations. Finally, we describe how respondents – once their thoughts about death as a way out had developed – considered positive and negative sides of living and dying, and formed a balance of feelings toward living and dying.

**Original Trigger of the Development of the Wish to Die (Table 2)**

**Traumatic Life Event(s) at a Young Age**

Four respondents had developed serious thoughts about death at a very young age. This had to do with very traumatic experiences, e.g., experiences in a Japanese concentration camp or (sexual) abuse. In each of these respondents their wish to die had been present (at least in the background) throughout their entire life and had become more pronounced after a negative life event later in life (death of partner, divorce, illness) and/or when certain roles they had performed in their life, such as raising children or working, had ceased.

A case description of one of these four respondents is given in Appendix 2.

**Traumatic Life Event(s) Late in Life**

Eight respondents had developed thoughts about death after a traumatic life event late in life. Most often this was the loss of the partner (death or divorce), but in two cases it was the loss of job (retirement or because of illness), which meant a drastic change in lifestyle. The respondent who retired had also lost his wife during the same period.

<table>
<thead>
<tr>
<th>Trigger of the development of a wish to die</th>
<th>(combined in some respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traumatic life event at a young age</strong></td>
<td>War experiences as a child</td>
</tr>
<tr>
<td></td>
<td>(Sexual) abuse as a child</td>
</tr>
<tr>
<td><strong>Traumatic life event at a senior age</strong></td>
<td>Death of the partner</td>
</tr>
<tr>
<td></td>
<td>Divorce of the partner</td>
</tr>
<tr>
<td></td>
<td>Loss of a job</td>
</tr>
<tr>
<td><strong>A life of adversity and distress</strong></td>
<td>Illness and loss of multiple partners</td>
</tr>
<tr>
<td></td>
<td>Combination of unrelated problems (e.g., multiple road accidents, financial problems, pedophilic sexual inclination)</td>
</tr>
<tr>
<td><strong>Poor quality of life as a consequence of aging and/or illness</strong></td>
<td>Usually a combination of consequences of aging and/or illness, such as dependence, impairments in hearing, seeing, etc.</td>
</tr>
<tr>
<td><strong>Recurring depression</strong></td>
<td>Recurring depression/burnout</td>
</tr>
</tbody>
</table>

**A Life of Adversity and Distress**

Six people described a life of adversity and distress, which had at some point led to thoughts about death and then, gradually, to a wish to die. They did not describe one single event that had led to their wish to die, but rather that their wish to die had developed as a result of many reasons accumulating over time. These people had uncommon experiences or illnesses, or had unusual life stories. Some of them seemed to have had unlikely amounts of bad luck in their life. One respondent, who suffered from his inability to have a lasting relationship because of his pedophilic sexual inclination, quotes from a novel to explain his experience of his fate: "My life is a story imagined by a madman." He explained that in his vision people often pretend that everything in life fits beautifully, only that something goes wrong every now and then. But in his life many things were not right or as they should have been, and these things were not under his control.

**Poor Quality of Life as a Consequence of Aging and/or Illness**

Ten people described how their thoughts about death had developed as a result of their poor quality of life, a consequence of aging and/or illness (illustrated in Box 1). Most often respondents talked about how they used to be able to do everything for themselves, and now they were unable to do that anymore; they talked about being dependent, not being able to perform activities of daily living, not being able to go places. Some talked about specific physical impairments, such as impairments in hearing, seeing, speaking, walking, reading, eating, incontinence, impotence, memory, and concentration.
Recurring Depression

Three respondents suffered from recurring episodes of depression or burnout, and had developed thoughts about death as well as a wish to die in such an episode. All three described the ups and downs in their feelings toward living and dying.

Desired Situation vs. Real Situation

After these original triggers the respondents were in a situation they did not want to be in. Many respondents described that they felt they were not in control of their life, they felt like a victim of their situation. In their situation, or with their experiences, it was impossible to be satisfied with their life, even if there were also positive sides to their life. Their life was below the norm of what they considered acceptable, even if they did realize they had no choice but to accept it.

Recurring Themes: Personal Character, Coping Strategies and Social Support

Intolerance to Dependence

Respondents had difficulties coping with their new situation of dependence. People who were grieving over a loss, whether it was their partner, their health, or something else, sometimes felt that their impairments prevented them from overcoming their loss, because they were too old, too sick, or too impaired to find a new purpose in their life.

Being Useful

Respondents described the difficulty of not being able to be useful anymore because of impairments or because they did not work anymore, and feeling that it was difficult to find a reason to want to continue living because of this (illustrated in Box 2). Some respondents also talked about not wanting to be a burden. Usually they referred to the financial burden of old people on society; sometimes they referred to not wanting to be a burden to relatives or other people around them, like health-care professionals or volunteers.

High Expectations

Many respondents also seemed to have high expectations of other people. They had taken care of their own parents or other relatives when they were old, sick, or dying, and some had always been or still were very helpful toward people around them. Many respondents expected that other people would likewise help them if they needed it—only to visit them regularly—and were disappointed that they did not do this. Some were very hurt by the apparent disinterest of their children, although most blamed it on the fact that these were different times, and everyone simply was always very busy nowadays. It was noticeable that some respondents had not told their relatives or friends that their help or company was very important to them. They expected these people to understand that without telling them explicitly, but did not really know whether they actually did understand.
Box 2. Quotations from the interviews about wanting to be useful, not having work anymore, feeling like a burden on society or loved ones (I = interviewer, R = respondent)

Respondent 3, woman, divorced, age group 65–70 years, no medical problems [about wanting to be useful]

R: Well, that you feel that you’re no longer useful. I mean, I’ve put my name down for various projects, but nothing’s happening. And, for instance, yes, well that’s not really in my line, like helping the dying and things like that. But, yes, whereas you, yes, well I often had that when I was a nurse, that you do things that you don’t really intend to do, comfort people when you were thinking to yourself, that’s not my work at all. But then I think that somehow it comes from above, or something like that. Even though I’m not religious.
I: Yes. So really, also the fact that you are no longer working makes it worse some how.
R: Yes, yes, yes. That’s what I’m saying, that you’re not needed any more. Because if you’re needed, then in some way there’s a reason for being here.

Respondent 14, man, age group 65–70 years, schizophrenia affective disorder [about feeling like a burden on society]

R: And don’t forget, it was wartime. I’ve also learned: give us this day our daily bread. And I mean bread, nothing else, but that is all you can ask God for. You mustn’t bother people by asking for such things. I’ve always had enough to eat and I’m ashamed that I’ve got food. I shouldn’t have any food because I’m not working am I. At least, I don’t do anything useful.

I: I just heard you say. I don’t want the whole “old people problem.” What did you mean by that? Just imagine that you’re older, you can no longer function at home, you should go to a care home – is that what you don’t want, or do you mean something else?
R: I don’t want to go to a care home. I think that’s much too expensive. I haven’t made any contribution. I mean money. Economy.
I: So you think you are too much of a burden on society?
R: Yes, if you don’t work, you don’t eat.

Lack of Social Contacts

Another recurring theme was that many respondents experienced a lack of social contacts (illustrated in Box 3).

Box 3. Quotations from the interviews about problems of a social nature: loneliness, being widowed and contact with their children (I = interviewer, R = respondent)

Respondent 23, woman, widowed, age group 80–85 years, small physical impairments, had a brain infarct [about loneliness, contact with (grand)children]

R: A few years ago, your children go their own way, and that’s good, but then they start forgetting you, and I’ve got [number] grandchildren between 32 and 13, and you notice more and more that the older they get the less interesting you are for them. You want to have contact with them, but they don’t want that. So at a certain moment I thought what am I really any good for, I live in [place], I don’t come from [place-name] and there’s hardly anybody else that I know there, so then you really do get lonely don’t you. And then you think, well, I might just as well not be here, and yes, that’s when things happen. Then you think, well, why do I really have to stay here.

Respondent 9, woman, widowed, age group 70–75, back problems and had surgeries for vascular disease [about being widowed]

I: And how long ago did your husband die?
R: Well, that was 5 years ago this January.
I: 5 years, yes, yes. And you’re still finding it so difficult?
R: Yes.
I: Yes. And it doesn’t get any less difficult? [respondent is crying and shakes her head] No.
R: I miss him in the evenings too. I had such a lovely husband. Some days it’s not so bad, and other days I think all I do is a bit of work.

I: That’s the problem, it’s not nice to be on your own, it’s terrible. I could never have imagined that it was so bad. If you think more about how my mother lived, I never realized that it was so bad because it happens to so many people, doesn’t it.

Loneliness was often mentioned, most often in relation to being widowed, the death of friends, family, and acquaintances, and having a small network as a result, or having contacts but not being as close as with them as with those who had passed away. Many people described that they were often alone, bored, and lonely, and some thought about their situation a lot at those times. Furthermore, not having a partner to share their life with, especially if they had had a long-time partner, gave many respondents a sense of uselessness. Respondents also often talked about how they understood that their children did not have time to visit
them more often, although they would have liked it to be different.

Some respondents also talked about how they had only a small network because they had always had problems in making friends, or how they always felt excluded; and some did not have contact with some or all of their children because of conflicts or a divorce.

Lack of Control to Realize the Desired Situation and Developing Thoughts About Death as a Positive Thing

Lack of Control to Realize the Desired Situation

Some respondents talked about feelings of inferiority, and that maybe other people could have handled their situation, but they were not able to change their lives in a meaningful way. Some described that they felt that people around them decided everything for them, or they thought it was “fate” or a power outside of them that decided about their lives.

They were unable to be satisfied with their life, but they also felt unable to change their situation. For example, if they had lost their partner, they were not able to enjoy life without a partner, or were unwilling to look for another partner; they felt they could only enjoy life if their deceased partner were still alive. Also respondents who seemed to have a more feasible need felt they did not have control to attain this, which hampered them in finding ways to deal with problems that played a prominent role in their current lives. This lack of control seemed the result of various causes, ideas, and beliefs, the most important of which were that they (1) were unable to manage problems because of physical impairments and limitations, (2) were reluctant to ask other people for help, and (3) were not convinced that it would make much difference anyway.

Reclaiming Control by Developing Thoughts About Death as a Positive Thing

The development of thoughts about death as a positive thing or as a release of problems was a way to reclaim control. By developing the wish to die, the real situation would be implicitly or explicitly labeled as unacceptable. They might not be able to transform their life in the desired direction, but the real situation will at least end when death comes. Some respondents explicitly regarded the option to end their life as something positive in itself, because it was a decision only they had control over.

Once thoughts about death as a positive thing had developed, considerations of the reasons and feelings for wanting to live or die were usually much broader than the original reasons why they had developed thoughts about death. It seemed that there were four dynamic aspects that were weighed against each other: (1) negative sides of living, (2) positive sides of dying, (3) negative sides of dying, and (4) positive sides of living (see also Figure 1).

Considering the Negative Sides of Living

The list of the negative sides of living was the longest with most respondents. Many previously described themes were considered, e.g., the impact of growing dependency and impairments was described by many respondents, even if this was not the original trigger of their thoughts. There were also other aspects of life that were considered negative sides by one or more respondents, such as having financial problems, having bad health, living by the rules of the care home, being in pain, being disappointed, and having lost faith in other people.

Considering the Positive Sides of Dying

The reason most people had a wish to die was to be rid of their problems. Some respondents also had positive ideas about dying because they believed in an afterlife and were looking forward to being reunited with loved ones. Some people viewed death as something beautiful, although they did not believe in an afterlife. They associated it with peace and quiet, an end to their suffering, and some longed for a dignified death such as they had experienced with someone close to them.

Considering the Negative Sides of Dying

Most respondents considered the practical side of dying as the most negative. Most had rejected suicide as an option, either because they thought this was just unacceptable, or because they were afraid of doing it or surviving with injuries. And most had concerns for their loved ones and/or people who would see them or find them. Some were scared of death or dying, or were afraid of “not existing” or described an “instinct” to want to continue living despite problems. Some were scared about not being found soon after death, although others did not care at all about the how and when and simply longed for death, but did not end their life for their children or other relatives.

Considering the Positive Sides of Living

If people had a partner or (grand)children with whom they had good contact, they often mentioned this as a very important positive thing in their life and as something to live for. Other things mentioned by one or more respondents were enjoying nature, going to the shopping center, surfing on the internet, having nice neighbors, work, leisure activities, listening to music, pets, traveling, reading, or going to a pub. Many respondents actively sought out these things.
they liked, to keep their life worth living. Some respondents also mentioned that they hoped to live to see a certain event, usually related to their grandchildren, or to finish something they were working on.

Balance

Taken together, these four dynamic aspects of negative and positive sides of living and dying formed a balance of feelings toward living and dying. Some respondents said this balance was stable and their feelings would not change, e.g., they wished to be dead, but they were not going to commit suicide. Most experienced this balance as less stable, or had already experienced changes for the better or the worse when things in their life had changed. Some anticipated losing something positive in their life, such as a loved one, or anticipated losing their independence further, and they either were not sure what they would do at that point or said they had decided to end their life then.

The majority of the respondents said they had a moderate or strong wish to die and no or only a weak wish to live. Nevertheless, when asked about the most important thing in their current life, many mentioned something positive. Some explained this by saying this was the only thing they still lived for, or they explained their hobbies were just a way to try to make their life worthwhile, although that did not really work. Other respondents did mention something negative as an answer to this question such as pain; or they mentioned something they did not have anymore, such as a partner, work, or independence; or they said that nothing was important anymore, they were just waiting out their time.

Discussion

Strengths and Limitations of the Study

This study used qualitative methods, which implies that it provides insight into reasons and processes but does not provide insight into frequencies of occurrence of the wish to die and associated factors. In previous quantitative studies, a wide range of factors was found to be associated with the wish to die in older people, such as increased disability in daily living, visual/hearing impairment, being widowed and lower (perceived) social support (Dennis et al., 2007; Forsell et al., 1997; Jorm et al., 1995; Runup et al., 2010; Yip et al., 2003). In the present qualitative study, each of these factors emerged as well, but the additional value of this study is that it provides a better understanding of how these factors affect people in such a way that they develop a wish to die.

There was no previous framework of the development of the wish to die. We developed a framework that can serve as a basis for analysis in future quantitative and qualitative studies.

A limitation of this study is that only persons who had at least a weak wish to die were interviewed, so that we were unable to compare people who had a wish to die with people who had similar experiences but had not developed a wish to die, which might have given a better insight into the importance of life events and/or problems of aging or illness versus personal character, coping strategies, and social support in the development of thoughts about death as a positive thing.

Development of Thoughts About Death

This study shows that older people with a wish to die have very diverse reasons for that wish. Some respondents had had it since childhood, others had developed it very recently. The respondents had in common that, following certain life events or because of increasing physical impairments due to aging and/or illness, they realized they were in a situation they did not want to be in. Many respondents described feeling they were not in control of their life, they felt victimized by their situation, they felt it was impossible to be satisfied with their life. It seemed likely that some of these traumatic events or situations would lead many people at some point in time to at least think about death as a way out. In other cases it seemed less likely that thoughts about death would develop similarly in others, and especially in these cases could the development of a death wish be understood only in the context of their personal character, coping strategies, and social support.

The notion of the real situation not matching the desired situation shows similarities with the finding by Ronningstam, Weinberg, and Maltzberger (2008) that a gap between an “ideal self-state” and the contrasting unfolding development of life can force someone into powerlessness and worthlessness, and when self-esteem depends on being in the “ideal self-state,” this may lead someone to commit suicide.

Social Worth of Older People

The recurring themes were feeling useless, not feeling needed anymore, feeling redundant, and feeling a burden to loved ones. These issues were related to the changing role people had in life; they were not working anymore, and they felt they needed their children more often than the other way around. This changing role is to some extent inevitable in old age, but some of the people who experienced these feelings were physically healthy and wanted to put their abilities to use in some way. For them this changing role seemed imposed rather by the way society functions than being required by their diminishing abilities.
Mental Health Issues

Previous quantitative studies showed that only a minority of people with a wish to die qualify for a diagnosis of a depressive disorder (Callahan et al., 1996; Jorm et al., 1995; Rurup et al., 2010). This study adds that most people with a wish to die did not perceive depression as the primary cause of their wish to die either.

Other mental health issues that surfaced were coping with traumatic life events and with losses. In the qualitative study we found that posttraumatic stress disorder (PTSD) was associated with having a wish to die (Rurup et al., 2010). In this qualitative study, traumatic life events were often discussed with respect to the development of the wish to die, but we did not measure whether individual respondents suffered from PTSD. However, the traumatic life events were most often described as having led to a situation that was unacceptable, and it was only seldomly described that it was this event itself that was so traumatic as to be the cause of the wish to die. For example, one respondent whose partner had died had developed a wish to die because she thought her life was not worth living without her partner. It was not the event of the death that was very traumatic in itself. On the other hand, especially those respondents who described traumatic events during the war at a young age described that they were bothered by the images of that event, which they still saw in their mind.

Balance Versus Crisis

The respondents in this study had arrived at a balance of feelings toward living and dying. The length of the time lag between answering the selection questions and the interview appeared to have no effect on their accounts. Although the respondents did not always experience their balance of feelings toward living and dying as stable, apparently it was relatively stable in the sense that most had in fact not committed suicide between the two measurements — and most confirmed their previous Beck rating.

Most respondents had had a wish to die for many years. They did struggle with the original trigger, which had led them to be in a situation they found unacceptable; but it seemed their wish to die had not lead them to a constant struggle with the question whether or not to end their life, nor did they seem bothered by the fact that they had a wish to die in itself.

It is likely that these respondents are very different in that way from people who are usually seen by health-care providers who deal with patients who are in the midst of a suicidal crisis. This study shows how the wish to die can be counterbalanced by the wish to live, which can explain how so many people can live with a wish to die (Barnow & Linden, 2000; Forsell et al., 1997; Rao et al., 1997; Rurup et al., 2010; Scocco & De Leo, 2002; Skoog et al., 1996).

Presence and Intensity of Wishes to Die, the Beck Scale

We included respondents with varying strengths of wishes according to Beck’s scale to see what the quantitative measures of a “strong” or a “weak” wish to die implied. Most respondents confirmed their previous rating at the time of the interview: Once thoughts about death had developed, people discerned positive and negative sides of living and positive and negative sides of dying. They were able to make separate statements about the strength of the wish to live, on the one hand, and the strength of the wish to die on the other, as is reflected in the Beck’s scale. However, not everyone used the same rationale to classify their the wish to live or die as strong, moderate, weak, or absent. Some people “toned down” their wish to die and reported having a weak wish to die instead of a strong wish to die, either explicitly because they had decided not to commit suicide, or because motives of social desirability or denial had seemingly played a role, either for the interviewee or for themselves. It seems likely this effect can also be found in people who have a wish to die, but are not willing to admit that at all. That would mean that the prevalence rates from the quantitative studies are an underestimate of the wish to die.

Conclusion and Practical Implications

Although the reasons why people had developed thoughts about death varied widely, we also found many similarities, and we were able to develop a framework of the development of a wish to die. Similiries were found in the way a life event or a situation had exceeded the resilience of the respondent, and the recurrence of themes such as a low perceived control and lack of social support was striking. Similarities were also found in the way people balanced the wish to live and the wish to die. The balance of the wishes to live and die seemed more stable in some than in other respondents, but could change in most respondents e.g., if their physical condition changed or if certain loved ones would die. Some respondents were explicitly aware of this.

The practical implications of this study are that clinicians should realize that only a minority of people with a wish to die have a depressive disorder, and most people with a wish to die do not perceive depression as the primary cause of their wish to die. It is also important to realize that, following the loss of a partner or another traumatic life event, some people can develop a wish to die. It is not yet known whether treatment of the wish to die as such is desired by those older people with a wish to die, but is was apparent from this study that some people feel they are not in control of their problems, which might be a starting point for interventions. There are effective treatments available for common mental disorders in the elderly such as depression, anxiety, PTSD, and sleeping.

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problems (Woods, 1999). There is the possibility of family therapy for suicidal elderly if needed (Richman, 1994). Some of our respondents have had proper treatment. And the late effects of traumatic stress might still be relieved by proper treatment even in this old to very old group (Woods, 1999). But our results indicate that, even when depression or traumatic stress or family discord have been treated or would be treated properly, death wishes may sometimes continue unaffected. In adult samples death wishes may be conceived as independent identities, partially related to, but also partially unrelated to DSM-IV disorders or dimensions (Oquendo & Currier, 2009). This certainly holds for the death wishes in our respondents as well. Death wishes among the elderly, even the depressed elderly, need not be related to suicide risk. Most elderly who ruminate on death wishes do not commit suicide. Only when hopelessness and despair, and perhaps feeling lonely, are added to the death wishes does the suicide risk increase. Satisfactory interpersonal relationships and support can decrease this risk, as can religious support (De Leo, Draper, & Krysinska, 2010). In clinical practice this means that caregivers need to have an open mind in order to both assess psychological and social to the interface in the context of death wishes, as to the independent nature of death wishes reflecting legitimate evaluations of the quality of life. Our results also point at the self-protective nature of death wishes: When everything else is not under control anymore, the wish to stop living is the final autonomous protection against the threat of continued living, feeling, and thinking. In this respect death wishes are a form of self-protection and comfort during prolonged periods of time.

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