■ Integrative Review
doi: https://doi.org/10.1590/1983-1447.2018.2017-0120

Nursing diagnosis for Risk of Suicide in elderly: integrative review

Diagnóstico de enfermagem para Risco de Suicídio em idosos: revisão integrativa

Diagnóstico de enfermería para Riesgo de Suicidio en ancianos: revisión integradora

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How to cite this article:
Sousa GS, Perrelli JGA, Botelho ES. Nursing diagnosis for Risk of Suicide in elderly: integrative review. Rev Gaúcha Enferm. 2018;39:e2017-0120. doi: https://doi.org/10.1590/1983-1447.2018.2017-0120.

ABSTRACT

Objective: To analyze the specialized literature regarding the risk factors in nursing diagnosis for suicide risks in elderly.

Method: This is an integrative literature review carried out during June 2015 in the following databases with no time limit: MEDLINE, PsycINFO and CINAHL.

Results: A total of 80 full papers were analyzed. It was suggested the inclusion of 23 risk factors in NANDA-I taxonomy: apathy; unrest; low self esteem; carelessness with medication; Inability to ask for help; Inability to express feelings; suicidal plan; rigidity; functional disability; visual problems; sadness; hostility; anxiety; failure; frustration; unhappiness; dishonor; frequent visits to a physician with unclear symptoms; social deprivation; social devaluation; psychological violence; Interfamilial violence; and financial violence.

Conclusion: The risks for suicide presented in NANDA-I taxonomy need to be refined and adapted to the elderly reality. Furthermore, a review is also recommended for the risk factors not included in this classification.

Keywords: Nursing diagnosis. Suicide. Aged. Review.

RESUMO

Objetivo: Analisar a literatura específica acerca dos fatores de risco do diagnóstico de enfermagem Risco de Suicídio de idosos.

Método: Trata-se de uma revisão integrativa da literatura realizada em junho de 2015 nas bases de dados MEDLINE, PsycINFO e CINAHL, sem limite temporal.

Resultados: Foram analisados 80 artigos. Sugere-se a inclusão de 23 fatores de risco na taxonomia da NANDA-I: apatia; agitação; baixa autoestima; descuido com a medicação; incapacidade de pedir ajuda; incapacidade de expressar sentimentos; plano suicida; rigidez; incapacidade funcional; problemas visuais; tristeza; hostilidade; ansiedade; fracasso; frustração; infelicidade; desonra; frequentes visitas a médico com sintomas vagos; privação social; desvalorização social; violência psicológica; violência intrafamiliar e violência financeira.

Conclusão: O risco de suicídio apresentado na taxonomia da NANDA – I necessita de refinamento e adaptação ao contexto de idosos, sobretudo para averiguação dos fatores de risco que não estão contidos na referida classificação.

Palavras-chave: Diagnóstico de enfermagem. Suicídio. Idoso. Revisão.

RESUMEN

Objetivo: Analizar la literatura específica acerca de los factores de riesgo en el diagnóstico de enfermería sobre los riesgos de suicidio en ancianos.

Método: Revisión completa en la literatura, realizada en junio del 2015, sobre la base de datos MEDLINE, PsycINFO y CINAHL, sin límite de tiempo.

Resultados: Se analizaron 80 artículos. Se sugiere la introducción de 23 factores de riesgo en la Taxonomía de NANDA-I: apatía, agitación, autoestima baja, descuido con la medicación, incapacidad de pedir ayuda, incapacidad de expresar sentimientos, pensamientos suicidas, incapacidad funcional, problemas visuales, tristeza, hostilidad, ansiedad, fracaso, frustración, infelicidad, deshonor, visitas frecuentes al médico con síntomas vagos, comportamientos antisociales, violencia psicológica, actitudes violentas dentro del seno familiar.

Conclusión: El riesgo de suicidio presente en la taxonomía de NANDA-I necesita de mejorías y adaptación para ser aplicado en ancianos, sobre todo para aclarar los factores de riesgo que no se encuentran en esta clasificación.

Palabras clave: Diagnóstico de enfermería. Suicidio. Anciano. Revisión

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INTRODUCTION

Suicide is a serious public health problem, especially in the elderly population that is increasing exponentially worldwide[1-2]. The World Health Organization (WHO) estimates that the suicide rates are higher in people over 70 years old in almost all regions of the world[3]. One fact that stands out is the close relationship between suicide attempts and effective suicide: among young people, this ratio is 100 to 200 attempts for an accomplished death; in the elderly population, every two to three people attempt the act without success, one death occurs[4-5].

In Rio Grande do Sul, Brazil, it was found that 15.9% of the elderly were at risk of suicide[6]. Elderly's suicide is more planned and deliberate than in other age groups[7], which reinforces the nurses' need to be aware of factors related to nursing diagnosis (ND) for *Risk of Suicide* in this population to identify, understand and treat vulnerabilities for this phenomenon.

In this context, the taxonomy of NANDA - I presents the phenomenon *Risk of Suicide* compounded by 47 risk factors and defined as vulnerability to life threatening self-inflicted injury[8]. It is believed that these risk factors suggested by NANDA-I for this diagnosis need to be refined, since some factors are related to the risk of suicide[1-2] and, however, are not included in the taxonomy[8]. Thus, it is aimed to analyze the specific literature about the risk factors of the nursing diagnosis for *Risk of Suicide* of the elderly.

METHOD

This is an integrative review of the literature based on Ganong's proposal[9]. The first phase, related to the conducting question, had the following questioning: what are the factors associated with the nursing diagnosis for *Risk of Suicide* in elderly? Subsequently, the second phase was called: study selection.

The search for articles occurred in the following databases: Medline (International Literature in Health Sciences), Psycinfo (Behavioral and Social Science Research) and Cinahl (Cumulative Index to Nursing and Allied Health Literature). The following descriptors were used: suicide, elderly and nursing. Two search strategies were used with the selected descriptors: the first crossed them using the AND icon and, in the second strategy, the crossings were made through the OR icon. The study was carried out in June 2015. The following inclusion criteria were adopted: articles that respond to the theme, published in Portuguese, Spanish or English, with no time limit and fully available online.

The database search resulted in 2,624 articles, which were pre-selected through the reading of titles and abstracts. At the end of this phase, 119 articles were pre-selected and read in full, resulting in 80 articles. The reasons for the exclusion of 2,544 studies are described in Table 1.

Table 1 – Description of reasons for excluding articles

Reasons for excluding articles	n
Not available in full	9
Editorial Letters and Event Annals	20
Suicide prevention	29
Articles written in French, German and Japanese	241
Epidemiology of suicide in the general population	279
Institutionalized elderly	313
Self-reliance, falls and homicides	323
Ideation and suicide attempt	330
Articles repeated in one or more database	920
Total articles that did not meet the inclusion criteria	2.544

Source: Research data, 2015.

The third phase corresponded to the characterization of the studies. For this, it was extracted from the articles the following information: (1) General data about the article; (2) Methodological characteristics and (3) Description of the risk factors for *Risk of Suicide* ND in elderly. The fourth and fifth phases concern the analysis of the primary data

of the studies included in the integrative review and the interpretation of the data, highlighting the singularities and peculiarities of the articles on the central theme. The sixth phase corresponds to the summarization of the integrative review articulating the factors that led the elderly to die by suicide. In this review, the quality of the studies was evaluated according to the classification of the evidence level of Melnyk, Fineout-Overholt's[10] surveys (Chart 1).

Level	
I	Evidence from relevant systematic reviews or meta-analyzes of all the randomized controlled clinical trials or from clinical guidelines based on systematic reviews of randomized controlled clinical trials.
II	Evidence derived from at least one well-delineated randomized controlled clinical trial.
III	Evidence obtained from well-delineated clinical trials without randomization.
IV	Evidence from well-delineated cohort and case-control studies.
V	Evidence from a systematic review of descriptive and qualitative studies.
VI	Evidence derived from a single descriptive or qualitative study.
VII	Evidence from the opinion of authorities and/or expert committee reports.

Chart 1 – Classification of the evidence levels

Source: Melnyk, Fineout-Overholt[10]

Concomitantly, after exhaustive reading of the articles included in the present review, the data evidenced in the results of the research, the theoretical knowledge in this theme and the implications for the clinical practice of nursing were articulated. Based on the discussion and interpretation of the results, it is argued based on the literature the inclusion of new risk factors for *Risk of Suicide* ND in elderly indexed in NANDA-I taxonomy. The last step corresponds to the synthesis of the knowledge evidenced in the articles analyzed. This way, the evidences of the risk factors were grouped regarding the psychological, demographic, physical, emotional and situational aspects.

RESULTS

The geographical distribution of the selected articles[1-2,4,6,11-85] was concentrated in Europe (47%), the United States (29.3%) and Asia (15%). It is noteworthy that 7.5% were developed in Brazil. In the area of publication, 52.7% were concentrated in psychiatry, 39.9% in geriatrics and 7.4% in public health. In the last five years, a significant number of publications were obtained (39.2%).

Regarding the classification of the evidence level of the studies and their methodological designs, 61.8% were level IV, that is, they are cohort and case-control studies, followed by 22.3% of level VI, which corresponds to single descriptive or qualitative study, and 15.9% were level V, characterized by a systematic review of descriptive and qualitative studies.

Regarding the psychological risk factors (table 2), it is suggested the increase of new risk factors to the NANDA I taxonomy: apathy, agitation, low self-esteem, carelessness with the medication, inability to ask for help, inability to express feelings, suicidal plan and behavioral rigidity. In addition, it is suggested to change three existing factors: from an euphoric recovery from a deep depression to a sudden recovery from a deep depression; of psychiatric disorder to mental disorder; and the conjunction of threats of killing themselves and verbalization of the desire to die for suicidal ideation.

Regarding the physical risks contained in table 3, it is suggested the increase of the functional disability and visual problems in NANDA I, as well as the use of expressions from chronic-degenerative diseases and terminal diseases to refer, respectively, to physical illnesses and terminal illnesses.

Regarding the feelings experienced by the elderly who have committed suicide (Table 4), it should be noted that the factors related to sadness, hostility, anxiety, failure, frustration, misery and dishonor are not present in NANDA-I. This way, it is suggested to include them in the taxonomy.

Regarding the situational risk factors (Table 5), NANDA I divides them into: situational and social risks. It is suggested the use of a single nomenclature: situational risk factors. In addition, they are not included in the mentioned taxonomy: frequent visits to doctor with vague symptoms, social deprivation, social devaluation, psychological violence, interfamily violence, financial violence and self-neglect.

Table 2 - Psychological risk factors found in the revised publications

Psychological factors	n	%
Depression[1-2,4,6-7,11-61,80]	55	68.5
Mental disorder[1-3,6,14-19,21-22,24,28-29,33-34,37,39,41,43,45,47-48,59-64,66-68]	37	46.2
Suicidal ideation[1,4,6,12,14,25,29,34-35,37,41-43,45-46,48,51-54,59-61,65,69-72,78-79]	27	33.7
History of attempted suicide[1,4,6,15,19,22,25,38,44,47,49,53-55,62-63,66,69-71,74-76]	20	25.0
Inability to ask for help[1-2,12-14,19,22,35,39,41,50,73-78]	14	17.5
Behavioral rigidity[1-2,7,12,22-25,37,43,59,62,76,78]	12	15.0
Primary psychotic diseases (schizophrenia and schizoaffective disorder)[1,4,16,19,23,25,28,33,37,39,43,47,53]	11	13.7
Inability to express feelings[2,12-14,22,37,45,52,75,78-79]	11	13.7
Bipolar disorder[1,6,17-18,23,28,37,43,45]	9	11.2
Suicidal plan[1,4,48,53-54,65,69-70]	8	10.0
Child abuse[53,55,67,76,78-79,81,85]	8	10.0
Low self-esteem[1,4,7,24,43,45,64]	7	8.7
Carelessness with medication[1,48,53,62,66]	5	6.2
Personality disorder[4,16,34,42]	4	5.0
Apathy[1,41,43,52]	4	5.0
Medication storage[37,43,62,66]	4	5.0
Writing a will[2,53,54,63]	4	5.0
Agitation[1-2,48]	3	3.7
Sharp change of attitude[1,48]	2	2.5
Sudden recovery from a deep depression[1]	1	1.2

Source: Research data, 2015.

Table 3 - Physical and demographic risk factors found in the revised publications

Physical risk factors	n	%
Chronic-degenerative diseases[1-3,6-7,11-13,19-21,22,24-27,31-33,36-39,41,43-46,48,50,58-60,62-65,67,69,71,73,76-82]	49	61.2
Functional disability[1-2,4,7,11,13,22,24-27,29,31,36-37,39,41,43,45-48,52-53,59-60,69,73,76,78-79]	28	35.0
Terminal illnesses[1,7,21-22,25-26,29-31,37,41,43,45-48,52-54,58,62,69,78-79]	23	28.7
Chronic pain[1,7,13,22,24,28,32,37,41,43,45-48,53,69,76,78-79]	18	22.5
Visual problems[1,13,37,41,46,82]	6	7.5
Demographic risk factors	**n**	**%**
Male gender[1-2,13,19-22,24-27,29,32-34,37-39,42,45,49,54,57,60,62,64,67,69,78-81]	28	35.0
Widowhood[1,4,7,19,22-25,29,36-38,39,42-43,45-46,49,51-55,58,60,62-63,69,72]	26	32.5
Divorce[1,4,6,7,21,24-27,37,39,42-43,45-47,53-55,60-63,65,68-69,71,72]	25	31.2

Source: Research data, 2015.

Table 4 - Emotional risk factors found in the reviewed publications

Emotional risk factors	n	%
Loneliness[1-2,11,13,20,24,26-28,29-31,37,39,41,43,45-46,48,49,52,55,67,71,76,78-79,83]	26	32.5
Hopelessness[1-2,4,11,13,27,30,35,37,41-43,52-53,55,60,62,74-76,78,80]	22	27.5
Sadness[1,13,14,24,29,41,43,45-46,48,52-55,64,71,74,78-80]	20	25.0

Hostility[2,7,12-13,14,24,34,39,42-44,48,59-61,62,70,73,78-79]	18	22.5
Anxiety[1-2,12,14,16,24,32,37,41,43,46,51-52,59,70,73]	16	20.0
Failure[1,37,41-43,45,52-54,59,64,76,78-80,83]	16	20.0
Frustration[1,25,36-38,41,44,51,63,79]	8	10.0
Guilty[1,14,25,41,55,78]	6	6.2
Unhappiness[1,39,41,43,60]	5	7.5
Dishonor[25,52,78-79]	4	5.0

Source: Research data, 2015.

Table 5 - Situational risk factors found in the reviewed publications

Situational risk factors	n	%
Alcohol abuse[1,4,7,13-15,17-19,21,23-26,31-33,37,40-41,43,45-46,48,51,60-61,67-68,73,75,81]	33	41.2
Family conflict[1-3,7,21,22,27,29,36-39,43,45-46,48,51,53,63,65,71-73,76-77,81]	27	33.7
Insufficient social support[1-3,7,13,22,26-28,35-37,43,45-47,48,52-54,62-63,65,71,73,7,81-83]	26	32.5
Financial problems[1-2,13,21,22-25,27,36,38,45-46,48,51,53,63-64,71-73,77-78,80-81,85]	25	31.2
Functional dependence[1-3,7,13,21,22-27,29,36-38,43,45-47,53,59,68-69,71,73,76,78]	24	30
Frequent visits to the doctor with vague symptoms[1,7,13-14,27-28,31,33,37,41,48,56-57,61,69,71,80-82,85]	19	23.7
Living alone[1-3,6,11,13,19,22,37,41,43,48-49,55,57,59-61,67,79]	20	25
Significant loss of relationships[1,6,7,22-24,37,43,45,48,52-54,63,65,71,74,76,81]	18	22.5
Social isolation[1,3,7,11,24,41,43,45,48-49,51,54,68,71,74,77,81,83]	18	22.5
Loss of autonomy[1-2,13,24,29,36-38,43,45-46,48,52,78-79]	15	18.7
Retirement[1,4,36,41,45-46,49,53,65,76,78-79,84]	13	16.2
Social deprivation[1,19,45-46,48,53,60,72,78-79]	10	12.5
Social devaluation[1,41,45-47,48,53,74,76,78-79]	10	12.5
Grief[1,7,37,45-46,52-53,72,74,79]	10	12.5
Abandonment[1,22,45,48,52,78,79]	7	8.7
Access to lethal means[1-2,22,37,47-48]	6	7.5
Psychological violence[46,48,52-53,55,77]	6	7.5
Domestic Violence[46,48,53,55,60,79]	6	7.5
Financial Violence[48,52-53,60,79]	5	6.2
Self-neglect[48,53]	2	2.5

Source: Research data, 2015.

DISCUSSION

It was detected the shortage of studies in the nursing area focused on the subject of suicide of the elderly. In this sense, the scarcity of research in Latin America, specifically in the Brazilian context, is also reinforced.

The literature emphasizes that among the psychological factors related to the ND *Risk of Suicide* in the elderly, the most frequent are the mental disorders. The exception is in China, where mental disorders in elderly people who committed suicide are rare[38].

A study conducted in Canada[22] found that elderly people with depression may present up to seven times more chance of committing suicide than those without depression. A cohort study in Hong Kong[50] revealed that depression has been associated in 21.9% of the cases of suicide death in women and 15.5% in men. Studies in Brazil[52], Australia[25] and Europe[82] found that depression assumes multiple faces in the suicide of the elderly, it appears as a primary or secondary diagnosis, as a symptom associated with other morbidities[12,20,22, 25-26,31-32,36,38,59-60,64,67-69,71,73,77-78,81-82] or as a reaction to social stressors.

A study in Australia[72] revealed that 42% of the elderly who committed suicide verbally expressed their desire to die, 25% had the thought that life was not worthy anymore, 21% thought about taking their own lives and 7% planned suicide. A study in Brazil[45-47,52] revealed that the elderly voiced the desire to die; however, relatives and friends did not take the problem seriously or did not recognize these verbal cues as suicidal ideations[45-47,52].

Still in this context, it calls attention the inexistence of a suicidal ideation in NANDA-I, which we think is pertinent to think about the planning and implementation of nursing actions with a focus on suicide prevention.

Older people who died by suicide had a history of attempted suicide. This proportion ranged from 11% to 52%[20,29,31,33,62,69,72,73,81]. About 11 to 27%[19-21,62,70,73,80] of these elderly repeated the act within less than one year, using more violent methods[80].

Traumatic events in childhood are associated with suicide. They are life experiences marked by the father's grief in childhood[80], insufficient and inadequate provision of maternal and paternal care[67,75,78], history of sexual abuse[67] and interfamily violence[84]. These events may reflect on the mechanisms of coping with stressful events in the lives of these individuals.

Regarding the physical factors, investigations on chronic-degenerative diseases and suicide of the elderly[22,26,28,39,38,60,68-69,82] reported significant associations of the self-destructive action with cardiovascular diseases; chronic lung disease; vision problems; diabetes mellitus; urinary incontinence; rheumatoid and terminal illnesses, especially prostate and lung cancer in man and breast cancer in women. In Brazil[45-46,78-79], sexual impotence was associated with the suicide of men.

Elderly people diagnosed with seven or more diseases had nine times a higher risk of suicide compared to those who did not have these diagnoses[29]. In addition to these diseases, the occurrence of severe pain for more than six months increases the risk of suicide[28,32,68].

Among the factors related to feelings, the studies[7,12,14,22,39,43,59,78] showed that these elderly individuals had personality traits for low self-awareness, emotional instability, manifested by feelings such as anxiety, melancholy and sadness, little openness to experience, inflexibility, and hostility. A qualitative study[78] showed that the elderly were intolerant, controlling, rigid and introverted. Such characteristics make it difficult for the elderly to manage the challenges of aging.

More than half of the elderly who committed suicide were living alone[1-3,6,11,13,21,23,37,41,43,48-49,55,57,59-61,67,79]. Feelings of solitude and lack of connectivity with the society are predictive of suicide[1,12,26,30,37,39,43,57,63,74,83]. Inadequate social support widens the horizon of helplessness and the elderly are weakened by having few friends and family they can trust[20,26,29-31,41,45,51-53,67-69,73,78-79]. A study in New Zealand[67] showed that 27% of the suicide cases could be avoided with adequate social support.

The studies show situational and demographic factors that are not included in NANDA-I: retirement in which the elderly person loses their social identity; economic burden, in which the duty to be the provider of the family makes him feel he is failing in the task; social deprivation and loss of autonomy, situations in which the elderly person lives with their children and loses their social space; financial, psychological and interfamily violence, in which the elderly are humiliated and despised by the family[1-2,37,39,41,43,45,48,52-53,55,62,67,73,78-79].

CONCLUSION

It is pointed out the existence of gaps between risk factors for ND for *Risk of Suicide*, which may weaken the decision of the nurse regarding the attribution of the presence or absence of this phenomenon. It is suggested the inclusion of 23 new risk factors for the ND for *Risk of Suicide*: apathy; agitation; low self esteem; carelessness with medication; inability to ask for help; inability to express feelings; suicidal plan; rigidity; functional disability; visual problems; sadness; hostility; anxiety; failure; frustration; unhappiness; dishonor; frequent visits to a physician with vague symptoms; social deprivation; social devaluation; psychological violence; interfamily violence; and financial violence. It is recommended, for greater accuracy, the conduction of new studies for the deepening on this subject and for the production of knowledge about this diagnosis. In addition, it is fundamental to carry out the validation by specialists and a clinical validation to confirm these results.

As limitations of the study, it is possible to mention: the search for the articles was performed by a single researcher, when it is directed to be done in pairs; and the scarcity of Brazilian studies on suicide risk as an ND, which restricted the data discussion and the comparison with other countries.

By amplifying and inserting new risk factors to ND *Risk of Suicide*, this study builds ways for suicide prevention in the elderly population, because by producing new knowledge in order to decipher this phenomenon, it creates new possibilities for nursing care regarding the promotion of the elderly's good mental health and the improvement of their quality of life.

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Received: 06.17.2017
Approved: 10.06.2017