DURKHEIM AND DISENGAGEMENT: A CAUSAL MODEL OF AGING SUICIDE

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INTRODUCTION Most people in each age cohort are fairly successful in making the transition from one life stage to the next. However, there remain those who are unable or unwilling to make the transitions smoothly. This paper is concerned with the latter among older persons, called the "high risk" group. Based on a synthesis of Durkheim's egoistic model of suicide, and a modification of the disengagement theory of aging, we will develop a causal model of aging suicide. Of course, causal models of suicide based on anomie, altruism, and fatalism and other theories of aging are not rejected. Here, the goal is to construct a causal model of suicide among aging populations, based on what the authors believe to be the most prevalent cause of suicide among the elderly. It is not an attempt to explain all suicides among older persons.

This model is designed to provide the best explanation for the greatest number of suicides of older persons. The disengagement theory of aging and the egoistic model of suicide offer the highest potential for unidirectionality, and for the potential of fitting the causal model. This approach is not new. Durkheim (1951) recognized the necessity of limiting his study, and he excluded documented cases of suicide by the mentally alienated from his models. Durkheim also recognized the lack of objective data on suicides of sane persons. Even under such limitations, Durkheim was able to evolve causal models of suicide which stand basically intact today.

FOUNDATION According to Durkheim (1951), egoistic suicide is that form carried out by social isolates. Disengagement theory (Cummings 1963) suggests that the aging person and the society of which the person is a part experience a mutual withdrawal, leaving the individual in a state of social isolation. Other problems of old age tend to exacerbate this isolation, and may explain suicides among the elderly (Tallmer & Kutner 1969). The findings of Farberow and Moriwake (1975) support the proposed synthesis of disengagement and egoism, as a cause of suicide among the elderly. Although carried out in institutional settings, their research findings are significant for the study of aging suicides in a broader context. Factors which contribute to suicidal behavior by elderly patients, both in medical facilities, and in mental hospitals, include a weakening and decline of social support, and multiple losses.

Terms used in describing suicidal attitudes have correlates in descriptions of the social isolate in later life (Benson & Brodie 1975; Sendbuchler & Goldstein 1977). Descriptors such as depression, despondency, moodiness, and withdrawal commonly describe both persons identified as high-risk suicidal persons, and the disengaged or socially isolated elderly. These attitudinal evaluations are clearly associated with a single crisis event or multiple crises such as loss of a spouse, retirement, or debilitating illness. Such crises lead to a perceived or real loss of social support, and impel the individual to suicide. A study by Wenz (1976) concluded that persons with deprecatory self-attitudes tend to be higher risks for serious suicide attempts than persons having favorable self-images in agreement with the egoistic model of suicide, and with disengagement theory. The disengaged elderly, due to various social role losses, may hold a low level of self-esteem. Kuypers and Bengtson

(1973) refer to this in their "social reconstruction" syndrome, based on Zusman's "social breakdown" syndrome (1966).

In noting the differences in suicide rates among the various religious systems, Durkheim held a priori, that those religions providing the greatest freedom and the least integration had the highest rates of suicide. The concept of low or reduced social cohesion is the principal element underlying the egoistic model of suicide. It is plausible that loss of the social cohesiveness developed during the working and nuclear family period would contribute to egoistic suicide among the elderly. Breed (1972) found that suicidal persons ranked high on five components of a suicide syndrome. These were: commitment, rigidity, failure, shame, and isolation, all of which are significant factors among the elderly. The extent to which the individual shows high ratings on a scale combining these components could probably measure the extent of suicide risk for the elderly. Older persons tend to rank higher on all five components.

Kobler and Stotland (1964) assert that those with high suicidal intent are frequently those who have developed a sense of helplessness or hopelessness, and that such persons typically try to communicate their plight to others. The response to this communication is thus a determinant of behavior. One could argue that those with serious intent to end their lives seldom communicate this intent to others who might intervene, but those who do communicate their suicidal intent to others may do so in order to manipulate the environment. However, this point supports the idea of egoistic suicide. The social isolate would be the individual least likely to obtain a favorable response to any call for help or understanding. The elderly are unlikely to find a sympathetic ear, especially the extreme isolates, such as widows, the divorced, and never-married persons living alone, who have no primary group relations.

Durkheim also points out that older persons are more likely to terminate their own lives than are younger persons. Single people are also more prone toward suicide than the married of the same age; and the married with children are less likely to engage in suicide than are the childless (Durkheim 1951). The differences in suicide rates, using such variables, is based on the degree of social cohesiveness, or integration found in the life situation of the person. This supports the egoistic model of suicide in that social isolates participate in suicide more than those with a stronger degree of social cohesion and integration. Marshall (1978) highlights the differences in the period 1948-1972.

The concept of egoistic suicide presumes the need of the individual for strong and numerous primary group ties. The tendency toward suicide should be higher for those who fail to develop such close social relations, and for those who lose them, as the elderly do, through retirement, and from the death of loved ones. Recent research on geriatric suicide by Miller (1978a) identified the predisposing influence toward suicide by older people who lacked a confidant. Kalish (1972) also supports the disengagement theory as a factor in egoistic suicide, noting that the disengagemnt theory of aging relates closely to the Kubler-Ross concept of the acceptance of death. The dying person, like the aging individual, seeks to withdraw from close ties. The self-imposed state of isolation is a preparation for death.

EXPANSION OF THE THEORY Johnson (1965) suggested that Durkheim went too far in offering four causes of suicide. One can find many similarities in anomie and egoism as these are described by

Durkheim. We believe that anomie and egoism have certain similarities, but that they are not the same. This is indicated by the differences cited by Durkheim (1951) between integration and regulation. With a lack of integration, or a weakened state of social cohesion, egoism is found. When regulation is lacking, an anomic situation prevails.

In the study of suicide, the success rate of the suicidal act is an important factor in correlating age and suicidal intent. The number of suicide attempts is greater for the younger age cohorts but the number of successful suicides is greater for the older age cohorts. Sendbuchler and Goldstein (1977) and Marshall (1978) peg the over-65 white male rate at four times the national average, or about 40 per 100,000, versus 10 per 100,000. This conveys the relative lethality with which the elderly approach suicide (Farberow & Schneidman 1961). This fact can be explained by the lack of intimate contacts available to the elderly to whom they might communicate their intent. Lack of such social supports removes any chance that their frustrations might be rechanneled.

Schneidman and coauthors (1965) provide four main types of suicidal crises which offer an excellent fit for the proposed causal model. These categories are: 1) impulsive self-annihilation following anger, frustration, or disappointment; 2) a feeling that life is no longer worth living; 3) an acute illness; and 4) the communication of suicidal attempts, in order to manipulate the behavior of others.

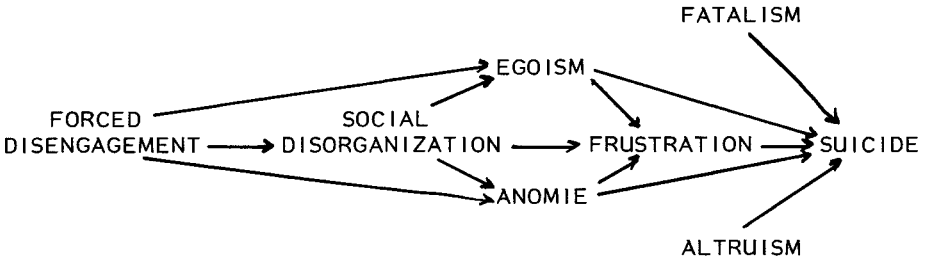
The elderly age cohort is vulnerable to disappointment and frustration. Some may be particularly subject to episodes of anger, directly as a result of disappointment and frustration, which probably aggravates their sense of isolation. The feeling that life is no longer worth living may be a major influence in the attitudes and behavior of the fully disengaged. Upon retirement, and the loss of family and other primary relations, through death or a mutual withdrawal, and isolated from former social contacts such as work, fraternal, and leisure associations, the aging individual may see no meaning in life. The loss of the work role may partly explain the higher proportion of suicides among elderly men, compared to elderly women.

The elderly are most vulnerable to acute and chronic illness. Insofar as the ills of the aged often require institutionalization, the older person may be more subject to feelings of social isolation. Of course, isolation is not determined by the number of social contacts, but rather in relation to primary group contacts, and relations which do not typically occur in institutions. Despite the amount of attention that the individual may receive in the institution, the needed primary relations are lacking. It is these which tend to provide an important factor in reducing the suicidal tendency.

THE CAUSAL MODEL Egoism as a state held by a person in isolation is not the only cause of suicide. As indicated in Figure 1 fatalism and altruism are not connected to disengagment, but exist independently, as conceptual opposites of anomie and egoism. Fatalism and altruism must be incorporated in the causal model for the same reason that it is necessary to include anomie. The disengagement path represents the primary cause or geriatric suicides, but there are other causal elements.

It has been claimed that suicide is closely related to certain ages, when major social or biological changes occur, such as menopause and retirement (Lester & Lester 1971). The tendency toward suicide among the elderly is not high in societies which accord the elderly a high degree of value and social esteem. Societies in which the elderly are not socially

FIGURE 1. A CAUSAL MODEL OF GERONTOLOGICAL SUICIDE



isolated and socially disengaged have few suicides in this age cohort. This appears to establish the egoistic nature of suicide, directly related to the disengagement theory of aging. There is a direct positive correlation between disengagment and the tendency toward egoistic suicide. Bock (1972) finds that elderly widows and widowers often find themselves isolated. When they are suddenly and dramatically deprived of the close, integrated relation of a marriage, and family kinship, there is a dramatic shift of situation, from social cohesion to social isolation and disintegration. It can be assumed that the role differences based on sex, somehow makes the shift less drastic for women than for men.

Figure 1 includes the elements presented thus far, plus frustration. Although frustration may be a direct result of forced disengagement, it is more likely that it occurs as the result of social isolation, or social normlessness brought about through forced disengagement. Miller (1978a) calls this the "level of unbearability". Fatalism and altruism are included in the model as causes of suicide, but are isolated from the paths connecting the components of the body of the model. This is done to show that anomie and fatalism are opposites, as are altruism and egoism. Anomie and fatalism are held as functions of regulation, while altruism and egoism are regarded as functions of integration. Social disorganization is incorporated in the causal model as a more relative and more transitory state than anomie in Figure 1.

Presumably, social norms would be nonexistent in the state of anomie, but the pure state of anomie probably does not exist in actual social settings. Where anomie may be seen as relatively static, social disorganization is presented as relatively more dynamic condition which disrupts a typically stable set of norms. The causal model presented here contains indirect relations between social disorganization and suicide, both through egoism and through anomie. There is no causal relation between egoism and anomie. Isolation, manifested in the environment as egoism, may contribute to a state of normlessness as anomie in the social area, and failure to perceive the norms may aggravate the condition of isolation.

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