Chapter 1

Durkheim's *Suicide* in the 21st Century

> Science cannot describe individuals, but only types. If
> human societies cannot be classified, they must remain
> inaccessible to scientific description.
>
> —Emile Durkheim, "Montesquieu's Contribution
> to the Rise of Social Science*"*

Theory helps us organize our thoughts and establish causal relationships as we work with clients. It helps us understand the actions of people, and because of our understanding we can respond in ways that are helpful. As addressed in the preface, research in gerontology tends to be theory weak. Thus, when gerontologists conducted research on suicide rates in nursing homes, they learned that at the time of admission to a nursing home, residents have a high suicide rate. They made this discovery without a theory to guide them. Durkheim's theory predicts high suicide rates during periods of major life or social change. Durkheim made this discovery over 100 years ago—prior to the existence of nursing homes. Durkheim made a number of important predictions about suicide that provide a good fit for suicide data of elderly people today.

Using Durkheim's theory of suicide helps us look for signs of suicide potential among elderly clients and residents. However, it does much more. Once a practitioner has identified high suicide potential, Durkheim's theory guides the practitioner to a particular type of intervention. For Durkheim, all suicide potentials are not the same. Each type of suicide potential requires a unique intervention strategy. Thus, once a practitioner uses Durkheim's theory to identify suicide potential, the suicide category may be determined. When one identifies the type of suicide, the practitioners can provide the best

intervention to address the social problems that are propelling the elderly person toward suicide.

Durkheim discovered that the social environment is the springboard for many suicides. In particular, he uncovered four environments that create suicide potential. These social environments include the fatalistic, anomic, egoistic, and altruistic. Chapters 2 to 5 each address one of these four types of suicidal environment. Each chapter includes gerontological research addressing the type of environment and a social history that illustrates the research evidence. After each social history, there is a synthesis of all the material that includes various intervention strategies.

Social histories are an important component for applying theory to real practice situations. The examples within each social history provide a backdrop for making the theory come alive. Studying and learning theory can be dry and boring. Using social histories creates a connection between abstract thinking and humanitarian action needed to create an environment that provides comfort for individuals during their elder years.

Our first social history is of Mr. John Smith (a pseudonym). His social history will be used as a springboard for understanding the foundation of Durkheim's theory. In chapter 2, we will come to understand that Mr. Smith's suicide was in an anomic social environment. The question becomes: Could the practitioner have acted in a manner to prevent this suicide?

A STORY OF SUICIDE

During the Great Depression, John Smith (a pseudonym) completed a degree in engineering at a prestigious university in the South. When Mr. Smith attended college, most men were not sure that a high school degree was necessary to get a worthwhile job. After graduation, he and his young wife prospered both economically and socially. They were living the American dream.

Mr. Smith loved his work and retired in his late sixties. At that point, the couple decided to purchase a condominium on the campus of a comprehensive care facility. The facility ranged from total independent living in a condominium to skilled care services. Once a person purchased a condominium, the comprehensive care facility was contractually obligated to provide health and social services for the rest of the resident's life. The contract was comforting for those who signed it. It afforded this couple and others a sense of security.

During his early eighties, Mr. Smith gradually was losing his mental capacity. He had early signs of dementia. In his mid- to late eighties, his inability to think and remember became more and more pronounced. On a beautiful spring morning, Mr. Smith woke and discovered his wife was gone. He dressed and went for a walk to search for her. Because he was living in

an independent condo, the staff did not know of his whereabouts. His walk ended at a bank approximately a half mile away from the comprehensive care facility. He asked various staff members if they had seen his wife. By the way he was dressed, it was abundantly clear to the banking staff that Mr. Smith was a man of means. Eventually, the bank manager invited Mr. Smith into his office, where the story unfolded: Mr. Smith was a resident of the comprehensive care facility. The thoughtful bank manager called the facility and reported that Mr. Smith was at his bank looking for his wife.

Within minutes after receiving the phone call, the facility's social worker arrived at the bank and drove Mr. Smith to his condo, where they had a talk. The social worker had established a strong rapport with Mr. Smith, now a long-term resident of the facility, years ago. In a sensitive and compassionate manner, the social worker gently reminded Mr. Smith that his wife had passed away five years prior. Mr. Smith sat in silence for a few seconds and slowly said, "The memory in the mind forgets, but the memory in the heart cannot." The social worker continued to reassure him.

When the social worker returned to the main building, she completed an incident report, which in turn triggered a meeting of the interdisciplinary care committee. The committee concluded that for Mr. Smith's own safety, he needed to move out of the condo and into the main building. The social worker was assigned the task of explaining the move to Mr. Smith and organizing the staff to move his personal possessions. Because he was moving from a two-bedroom condo with a garage to living quarters consisting of one room, he could not keep all his personal items. They had to be stored, thrown out, or given away.

The social worker paid a visit to Mr. Smith at his condo. Using her social work skills, she tenderly explained to him that he needed to move into the main building. They talked about his adventure at the bank, which he did not seem to recall but pretended he remembered. He acknowledged that he knew this day would come and felt good that he and his wife had a contract with the facility for lifetime care. The social worker had to remind him that his wife had passed away five years earlier.

On the day of the move, Mr. Smith woke at 4:30 A.M. and dressed in his very best suit with freshly shined black shoes. He walked into the bathroom, where he laid out clean towels in the tub, the walls of the tub, and the floor adjacent to the tub. He entered the tub and sat as comfortably as possible. He placed the barrel of his revolver into his mouth and pulled the trigger. The note he left behind read: "I have had a good life but my heart aches. It is time for me to leave. I am sorry for any mess that I made but did my best by laying out towels to make it as easy as possible for the housekeeping crew. Bye."

The experienced social worker and members of the interdisciplinary care committee saw no symptoms that Mr. Smith was depressed or other signs of suicidal ideation. The shock of Mr. Smith's suicide has remained in the institutional memory of the comprehensive care facility for decades. The staff continue to replay all the events and wonder what actions they could have taken to prevent the suicide. The aftermath of Mr. Smith's suicide highlights the central insight of Durkheim's work. Mr. Smith's daily activities were not indicative of the need for therapy.

Durkheim's theory does not address therapy. The heart of Durkheim's theory is congruent to social work values. Durkheim provides insight on how to facilitate a social environment that prevents a person from contemplating suicide. Practitioners must strive to create humane social environments that eliminate the need for therapy. Once a practitioner concludes that therapy is needed, it is too late for successful intervention. The current data demonstrate that once an elderly person is determined to commit suicide, little can be done to prevent such an action. Once Mr. Smith decided on suicide, he did not discuss it—he just did it. Some elders contend that Mr. Smith had every right to commit suicide and that practitioners have no right to intervene.

RIGHT TO SELF-DETERMINATION

While I was making arrangements to find a sample of subjects older than 65 for my suicide research, a chapter president of the American Association of Retired Persons (AARP) expressed a level of distress. She was particularly incensed with the work of Dennis and Owens (2012) and H. L. Field and Waldfogel (1995). As a social scientist, I found these works unobjectionable, but as I considered the articles from the chapter president's perspective, I understood how she could envision their work as ageist. Her interpretation was to summarize the work of Dennis and Owens (2012) and H. L. Field and Waldfogel (1995) as "Like it or not, we're going to fix things so you can't kill yourself." In essence, she acknowledged that the action of suicide was worthy of research but asked insightful and tactful ethical questions:

- Does anyone have the right to stop an elderly person from "accelerating the ultimate"?
- If someone is in pain for which there is no medical hope of reversal, does anyone have the right to create roadblocks?
- Why can't a person with vast life experience make a decision regarding the end of life?
- Other than the person whose life is at stake, who has the right to usurp a person's most private decision?

In the United States, we believe in privacy. We believe in the right to self-determination. I suspect that the AARP chapter president will wonder if it would have been appropriate for the social worker to prevent Mr. Smith's suicide. She might believe that Mr. Smith was old and wise enough to make his own decision and that the well-meaning social workers should stay away (Kellehear, 2009). Will suicide research help prevent an elderly person from self-destructive decision making about the most private aspect of his or her being?

Physician aid in dying (PAD) in the United States is becoming increasingly legal in various states (Rose, 2007). Because in most states at this point, PAD is against the law, personal attempts at killing oneself may lead to an outcome that will be worse than jail time. An elderly person who makes an unsuccessful attempt at suicide will most likely be deemed mentally incompetent and forfeit a wide range of constitutional rights. Yet as one reads this, thousands of elderly people each day accept PAD in every state. Of course, we do not call it PAD. Catholic physicians and nurses are involved in this activity on a daily basis. In medical circles, it is known as the double-edged sword. When someone who is bedridden and experiencing hopeless pain, the drug of choice is morphine. However, overdosing on morphine accelerates the ultimate. When a cancer patient is facing a painful and medically hopeless diagnosis, the greater the dosage of morphine (reducing the pain), the quicker death will come. Thus, obituaries that report that an elderly person died of cancer or another painful disease might be inaccurate. Many of these people might have lived longer if they were not subjected to high morphine doses or overdosing morphine as a pain reduction intervention. To be uncompromisingly honest, the use of morphine can open the door for PAD (Rys, Deschepper, Mortier, Deliens, & Bilsen, 2015). However, the use of morphine does not accelerate death, except when taken in high doses (Roxburgh, Pilgrim, Hall, Burns, & Degenhardt, 2018). In fact, when morphine is administered with an *experienced medical practitioner* (physician or pharmacist), the drug reduces pain without killing (Azoulay, Jacobs, Cialic, Mor, & Stessman, 2011; Gallagher, 2010; Lopez-Saca, Guzman, & Centeno, 2013; Portenoy et al., 2006; Sathonrviriyapong, Nagaviroj, & Anothaisintawee, 2016).

The question becomes, "How much morphine is too much?" From this question emerges several medical research facts:

- All pharmaceutical research includes the determination of the optimum dosage. Such research is required but expensive.
- Elderly research subjects are excluded from dosage research. Institutional research boards have concluded that elderly subjects are "high risk" and therefore it is unethical to include them in dosage research.

- Aging produces change in metabolism. Within an individual, the correct morphine dosage at middle age is much different than the dosage within the same individual at old age.
- The tolerance for morphine is highly variable. Statistically, the tails of the morphine tolerance distribution are spread out. In practical terms, this means that predicting the optimum dosage is difficult for medical practitioners.

All of these factors make the selection of the correct dosage of morphine for older patients more complex than for other adult cohorts.

For patients within the elderly cohort, medical professionals must extrapolate from the research and experience. Thus, each patient who is elderly is subjected to a quasi-experiment. Morphine is administered, and the patient is monitored for the degree of pain relief and physical euphoria. Passing the euphoria threshold indicates an overdose. The complexity emerges from the fact that the identification of euphoria is more demanding with frail patients then younger ones. Thus, the ethical (but not legally mandated) administration of morphine must be overseen by a medical practitioner with vast supervised experience. The key point is that the morphine administrator should not merely be a licensed medical practitioner but a morphine experienced practitioner. Otherwise, the death certificate would report cancer as the cause of death rather than morphine. In addition, an inexperienced physician can easily be bamboozled into participating in PAD. Such action would be endorsed by our militant elders as addressed earlier.

In considering the concerns of the AARP chapter president, it is critical to note that Durkheim's theory of suicide does not directly address suicide prevention but rather offers a model that improves the quality of one's life (addressed at the end of this chapter). Ultimately, such intervention creates an environment that decreases the probability that one will want to pursue suicide. Durkheim's theory of suicide is a *social theory*. It does not address the morphine issue and other dimensions of medical decision making. When Durkheim's work is applied by professionals, the right to self-determination is enhanced. Durkheim's model can facilitate an environment that increases the number of social options an elderly person has. Alternatives to suicide emerge.

SO WHAT? AND WHY?

Elder abuse is generally divided into three broad categories: self-mistreatment, elder mistreatment, and crimes committed by a stranger. Of these three, the greatest focus in the academic and popular press is placed on elder mistreatment and crimes of a stranger—not self-mistreatment. Although

studies (for example, Burnett et al., 2014; Dyer et al., 2008; Franzini & Dyer, 2008; Fulmer, Paveza, Abraham, & Fairchild, 2000; Lach, Williams, O'Brien, Hurst, & Horwita, 1997; Naik, Burnett, Pickens-Pace, & Dyer, 2008; Paveza, VandeWeerd, & Laumann, 2008; Pavlik, Hyman, Festa, & Dyer, 2001) consistently show that over the past several decades the greatest percentage of abuse is self-mistreatment, it is the least studied aspect of elder abuse. All these studies demonstrate that self-mistreatment constitutes over 50 percent of all concerns registered to officials in the United States and abroad. If self-mistreatment dominates the problem of what is lumped together as elder abuse, why is it the least studied? Connolly (2008) hypothesized that self-mistreatment is legally complex and not always easily distinguished from other types of elder abuse, neglect, and exploitation. This means, of course, that the proportion of self-mistreatment in the preceding citations is an underestimate.

Suicide is obviously the ultimate or most severe form of self-mistreatment. In addition, suicide among the elderly population is high when compared with other age cohorts (Marson & Powell, 2012; Sinyor et al., 2016). Unlike other age cohorts, elders have the highest suicide success rate and the lowest number of failed attempts (Miller, 1978). They are not likely to call attention to themselves. In addition, Chandler and Tsai (1993) and Sloan (2016) suggested that the rates of suicide will increase with modernization. Over 100 years ago, Durkheim predicted that rapid modernization would increase suicide. Condorelli (2013) provided data supporting Durkheim's position on modernization and anomic suicide.* Once we understand Durkheim's vision of suicide, we have the foundation for empathic understanding of the other forms of self-mistreatment. Thus, we will gain a greater level of understanding and insight into appropriate intervention. In terms of addressing suicide among elderly people, there are three types: passive, active, and medically assisted.

Passive suicide includes subconscious (and sometimes conscious) actions in which the person progresses toward terminating his or her own life without the outward appearance of doing so. Within Christian ideology, active suicide is envisioned as a sin, whereas passive suicide is not. Thus, even if a Christian person pursues a conscious path of passive suicide, he or she does not equate it as a suicidal act. The essential difference between active and passive suicide is nothing more than the speed of the action. Active suicide

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*Anomic suicide is addressed in chapter 3. Durkheim believed, and Condorelli (2013) had data to support, the notion that within a social structure, anomic suicides will eventually plateau. Both demonstrate that within our history, there are periods of rest between times of great social change.

is quick, while passive suicide is slower and does not result in a person being found in a blood-covered bathtub.

Most research addressing passive suicide can be found in the terminal drop literature. *Terminal drop* is defined as the process by which biological, psychological, and social dimensions are slowed and eventually death follows. Terminal drop was first noted in the work of Kleemeier (1962), but the term was not coined until Riegel and Riegel (1972) first proposed this concept. The original research envisioned terminal drop as phenomena found exclusively in old age. However, Vogel, Schilling, Wahl, Beekman, and Penninx (2013) discovered that regardless of a person's age, the process of terminal drop can be observed. In more recent research (Lynch, 2015), the concept of terminal drop has been further developed to refer to a rapid change in one's life trajectory. Currently, terminal drop is conceptually linked to passive suicide. Most relevant to our topic of suicide, Marson (2009) clearly illustrated that people do, in fact, accelerate and even initiate the terminal drop process. The initiation or acceleration of terminal drop is a key component to understanding suicide among elderly people.

Active suicide includes conscious and deliberate action or a series of actions in which an individual uses a strategy to accelerate the immediate termination of her or his own life. Active suicide has gained all the popular press attention because it is obvious and immediately disheartening. Heisel, Conwell, Pisani, and Duberstein (2011); Roff (2001); A. Shah (2012); and Waern, Rubenowitz, and Wilhelmson (2003) demonstrated that those age 75 and above have the highest active suicide rates of all age groups in most industrialized countries. Men, as in the case of Mr. Smith the engineer, are significantly more likely to commit active suicide than women (Conwell et al., 2002; Johnson, 1979).

Medical (or physician) aid in dying: At one time, the Dr. Jack Kevorkian–type of assisted suicide was envisioned as exploitative and illegal. As stated elsewhere, states are increasingly accepting his approach. Kevorkian did not have government support for his action but did gather quite a bit of sympathy from the public. Much of his public sympathy was gained from statements made by Thomas Youk (video-recorded on *60 Minutes*) and Youk's family. Youk was dying a slow and painful death and deeply desired to accelerate the process. However, when one scrutinizes Kevorkian's methodology, we see that he, too, was killing pain. He was accelerating death at a much greater velocity than overdosing on morphine.

Thus far, the discussion of elder suicide fits into Emile Durkheim's (1897) seminal work. Although published over 100 years ago, Durkheim's work continues to influence the conceptualization of social researchers today (for example, Abrutyn & Mueller, 2014; Cetin, 2016; Davenport & Davenport, 1987; B. Y. Lester, 2001; Recker & Moore, 2016; Zhao, 2014). However,

I am not suggesting that *Suicide: A Study in Sociology* lacks critics. For example, Skog (1991) argued that Durkheim failed to include alcohol consumption as a contributing social factor. Stack (1979) complained that Durkheim failed to appropriately address fatalism. Young (1972) contended that altruistic suicide is underdeveloped. Besnard (1982) identified problems of statistical interpretations, and Nolan and Triplett (2010) simply identified all of Durkheim's work on suicide as "fundamentally flawed." Pine (1974) stated that Durkheim lacks a "consistent position."

The essential problem with the application of Durkheim's *Suicide* to the elderly population is the theoretical issue of reductionism.[†] Many sociologists stress that social facts should remain exclusively in the arena of social facts. They should not be used or combined with lower-level concepts likely to be uncovered when addressing an individual's problem. Historically, reductionism has been found to be both seriously problematic and extremely fruitful in uncovering and understanding social reality. The essential problem of reductionism is the inability to distinguish whether it provides positive or negative outcomes. Lerner (2015) tried to establish guidelines to address the problem of reductionism. The best method of addressing reductionism is assessing how it works. And such an assessment must answer the following question: Does Durkheim's theory of suicide facilitate greater understanding and enhanced practice strategies in the arena of services to elderly populations? I find the answer is an unequivocal yes. After being a practicing and academic gerontologist for 40 years, I have found that Durkheim's research fits with gerontological cohorts more than with any other sector of the population. It is doubtful that the critics of *Suicide* were ever employed in a nursing home or have had a caseload of elderly clients.

WHAT IS DURKHEIM'S THEORY OF SUICIDE?

Over 100 years ago, Durkheim (1897) constructed an empirically based sociological theory that produced nonpsychological or nonphysical causes of suicide. The prominent feature of Durkheim's original work is the theory's practicality (Kaslow, 1975). Durkheim's motivation to study suicide emerged from his dear friend, Victor Hommay. Hommay committed suicide, and Durkheim dealt with this emotional tragedy the best he could. He decided to conduct sociological research on suicide (Lukes, 1985). Once a practitioner understands the theory, he or she can be guided to produce a meaningful
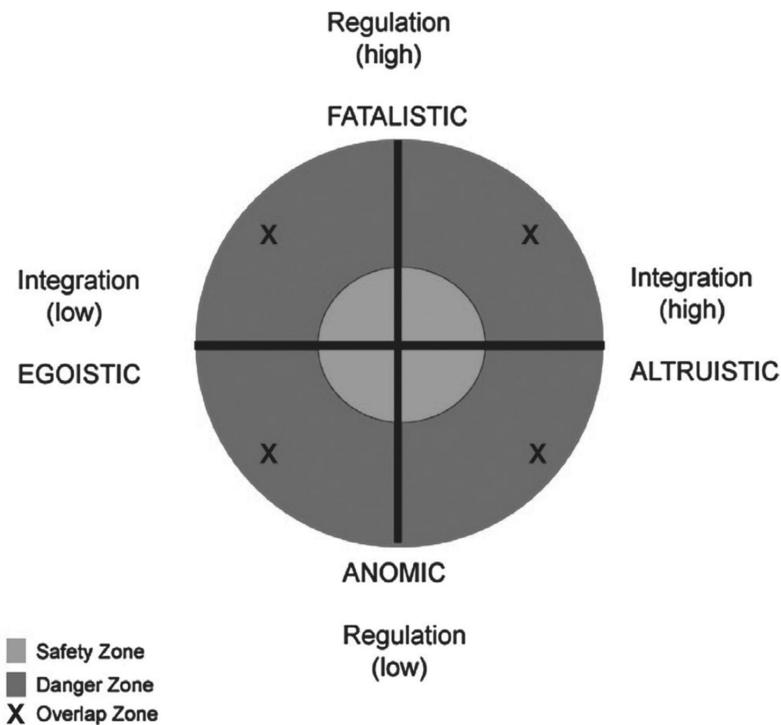

[†]Reductionism is the process of explaining phenomena by using a lower level of analysis—for example, using psychological terms to explain social facts or using biological terms to explain psychological facts.

interventional strategy. Durkheim produced four suicidal dimensions that provide predictors for suicide: anomic, fatalistic, egoistic, and altruistic. Figure 1.1 provides a good summary of the four dimensions.

Each of Durkheim's dimensions is relative. That is, they vary in different degrees. For example, everyone faces the problem of anomie but to different degrees. In the case of Mr. Smith, we can say that the greater the intensity in an anomic environment, the greater the probability of suicide. This is true of all the dimensions. In Figure 1.1, the safety zone symbolizes the experiences along the four dimensions that are "normal" or in control. The danger zone suggests movement into a stress-filled environment that, when pushed to its extreme, encourages a person to take his or her own life.

Each concept is paired with another. At first, this pairing may seem too complex to understand. However, it is critical for practitioners and students to envision the pairing of the concepts. These concepts are relative and balanced. In practical terms, it is surprisingly common for a suicidal person to

Figure 1.1   A Summary of Durkheim's Theory

exist at one end of a pair set and slide to the other extreme. This "sliding phenomenon" was first acknowledged by the Central Intelligence Agency (CIA) in examining how terrorists eventually volunteer to commit suicide (Benmelech, Berrebi, & Klor, 2012). When I first learned about the CIA's description of suicidal patterns among terrorists, I realized that the exact same pattern exists among elders. There have been cases (one is reported in this book) where an elder moves from one extreme to another—then commits suicide.

Anomic is paired with fatalistic, whereas egoistic is paired with altruistic. The concepts are paired because they represent opposite ends of a shared continuum. Can an elderly person be placed at two ends of two different dimensions simultaneously? The answer is yes. It is common among elders to experience being dragged into an environment that shares two profound difficulties. One cannot experience concepts that are housed on opposite ends of a single continuum simultaneously. However, like the CIA's discovery of terrorists who agree to commit suicide for the "cause," elders may likewise slide from one end of a continuum to the other. Conceptualizing these concepts in pairs is critical for the development of healthy environments in which suicide is unlikely.

Anomic–Fatalistic

Durkheim (1897) created the basis for a continuum between two discrete concepts: "anomic" and "fatalistic." In *anomic suicide*, Durkheim described a social structure that was dominated by social rules for which the person could not gain familiarity or could not keep up with the rapidly changing social rules. The unprecedented rapid changes in technology (particularly communications) can baffle an elderly person to the point of profound frustration. When such frustration becomes unrelenting with no foreseeable slowing, the pathway for suicide becomes cleared.

Fatalistic suicide, of course, is the exact opposite of anomic suicide. Within a fatalistic social structure, the person is confronted with a social environment in which there is little to no change in role expectations. Monotony is the centerpiece of such a social environment. The lack of change and no hope of social stimulation becomes the catalyst for a desire to end one's life. Of Durkheim's four concepts, fatalistic suicide is the one for which he offers little elaboration. This is somewhat ironic because within the arena of gerontology, fatalistic suicide dominates. In fact, he limits his discussion of fatalistic suicide to a footnote (Durkheim, 1897, p. 276).

In essence, Durkheim is noting that life satisfaction is a balance (noted by the safety zone in Figure 1.1). Too much rapid change induces emotional distress. Likewise, the total absence of a changing social environment also

induces emotional distress. Although the emotional state of a person confronted with overwhelming social change is very different from the emotional state of a person confronted with total social stagnation, both can be emotionally devastating. Durkheim stressed that people must have a balance between the two. Taken to their extreme, both can propel an elder into passive or active suicide (noted by the danger zone in Figure 1.1).

Egoistic–Altruistic

Durkheim (1897) also created the basis for a continuum between another two discrete concepts: "egoistic" and "altruistic." By *egoistic suicide*, Durkheim envisioned a social structure in which the person survives in an isolated environment. Essentially, the person neither feels part of a family or group nor has any sense of belongingness. The fertile soil for this type of environment is the nursing home, where the resident has little to no visitation and where the facility is short staffed. Ultimately, the person's lack of connectedness and absence of role expectations evolve into an emotional state of hopelessness, which in turn induces the person to contemplate a suicide option.

By *altruistic suicide*, Durkheim intended to describe a social structure characterized by social suppression. The social world becomes a clinging vine that strangles the person into an uncompromising set of social roles and standards. Personal identity is stripped away as the group dominates the person. Although altruistic suicide is more common among specific subcultures in our country and very common within Asian cultures, we rarely find it within mainstream American society. The most common example within an elderly cohort is the person who accelerates his or her death to enable heirs to inherit as much of his or her estate as possible before the cost of health care bites into it.

As within the dichotomy of anomic–fatalistic, Durkheim noted that life satisfaction is a balance between egoistic and altruistic (noted by the safety zone in Figure 1.1). Too much social isolation induces emotional distress, whereas immersion into a clinging vine social environment also induces emotional distress. Humans must have times of quiet solitude, but we also require social interaction. Too much solitude or overwhelming social demands can propel an elder into passive or active suicide (noted by the danger zone in Figure 1.1). Like anomic and fatalistic social environments, egoistic and altruistic social environments are exact opposites.

The question becomes, "How can a theory that is over 100 years old be relevant today?" Frankly stated, if Durkheim attempted to publish his research today, it would be rejected by every legitimate publisher. Durkheim worked at a time when statistics was in its infancy. Although p values were formally

introduced in an 1823 publication by Pierre-Simon Laplace (Stigler, 1986),[‡] it was not until the work of Karl Pearson (1900) and Ronald Fisher (1915) that p values became accessible to those outside the field of advanced mathematics. The work of Pearson and Fisher was not available until decades after Durkheim's publication. Thus, Durkheim's data analysis was rudimentary at best. To test Durkheim's theory of suicide, Condorelli (2013) applied Bayesian change-point analysis to Italian suicide rates from 1864 to 2005. She was able to confirm by using advanced statistical techniques that Durkheim's work on suicide remains relevant and statistically significant today.

PSYCHOLOGICAL SUICIDE VERSUS SOCIOLOGICAL SUICIDE

In the first chapter of his book titled *Suicide: A Study of Sociology*, Durkheim takes a seemingly defensive posture. He recognizes that psychologists treat people with suicidal ideations but contends that theories in psychology do not provide a comprehensive analysis of the causal features. Authors such as Engelbrecht (1970) point out that Durkheim "aroused opposition among those in psychology, psychiatry & psychoanalysis, who were convinced that suicide was always the product of some psycho-pathological condition" (p. 36). Richard-Devantoy, Turecki, and Turecki (2016) are currently searching for biomarkers of suicidal risk in elderly adults. Their work, of course, reduces psychosocial explanations to biology. In terms of providing intervention, the pattern within the current literature is to ignore the social environment and focus on the psychological and psychiatric factors (Malfent, Wondrak, Kapusta, & Sonneck, 2010; Ron, 2004; Suominen et al., 2003). I am not suggesting that psychological and psychiatric variables be ignored but that social variables (particularly Durkheim's insight) be included as a strategy to eliminate the contemplation of suicide.

Durkheim and those who followed him (for example, Kleiner & Dalgard, 1975) contended that sociology could assist in the intervention process by providing greater insight. More recently, Briody and Briller (2017) demonstrated that when social and cultural issues are systematically addressed in nursing homes, residents greatly benefit. If Durkheim was writing today, he most likely would not include chapter 1 of this book. Theory textbooks (for example,

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[‡]The concept of p values in social science is critical. In social science statistics, p values provide the best evidence that the data being analyzed are not a result of random chance. For example, is the difference between suicide rates between Catholics and Protestants a result of random chance, or is the difference real? Statistical p values help sort out these types of questions.

Figure 1.2   Fatalistic Causal Linkage

Fatalistic environment ➡ Mental distress ➡ Suicide

Coser, 2003; Ritzer, 2013) that summarize Durkheim's work articulate the position that there are strict lines of demarcation between the psychology of suicide and the sociology of suicide. Some authors stress that sociologists do not conduct therapy as this is a job for a psychologist or a psychiatrist.

When authors of college textbooks address Durkheim's vision of suicide, they reduce this complex framework into four or five paragraphs. When students are first introduced to Durkheim's (1897) *Suicide*, causal features are excluded. For example, in addressing fatalistic suicide, a social environment in which there is no change or social stimulation is likely to cause diagnosable mental distress, when taken to its extreme, leads to suicide as illustrated in Figure 1.2.

In addressing an anomic suicide, a social environment in which there is a dizzying amount of social change, a diagnosable state of anxiety is likely to emerge as illustrated in Figure 1.3.

In addressing an egoistic suicide, a social environment in which there is profound social isolation, a diagnosable state of depression is likely to emerge as illustrated in Figure 1.4.

In addressing an altruistic suicide, a social environment exists in which the group takes precedence over the individual. In its extreme form, the group is everything, while the individual is nothing. An individual embraces a self of nothingness and from that emerges a diagnosable state of self-destruction, as illustrated in Figure 1.5.

In essence, when Durkheim's vision of suicide is reduced to its simplest conceptualization, one can identify how psychiatric diagnoses can emerge from the social environment. Therefore, it becomes incumbent on the practitioner to address the social environment, which is the first cause of the emotional distress. Change the social environment and the practitioner can reduce the emotional distress. In practical terms, it does not take a professional with a PhD in clinical psychology or a doctor specializing in psychiatry to successfully intervene. For example, the medical model embraces the concept of prescribing antidepressants (Suominen et al., 2003). Instead of pumping frail bodies with chemicals, perhaps assessing the social environment and altering it might be a better alternative by being more cost-effective and avoiding complex drug

Figure 1.3   Anomic Causal Linkage

Anomic environment ➡ Mental distress ➡ Suicide

Figure 1.4   Egoistic Causal Linkage

Egoistic environment ➡ Mental distress ➡ Suicide

interactions (Salzman, 2001). Interventions can be successfully administered by family, by friends, and, in most complex situations, by social workers.

At the beginning of this chapter, I noted that the AARP chapter president expressed concern about individuals' right to self-determination. Using Durkheim's model as a platform for understanding, the change agent is altering a social environment, not the person. The change in the environment increases the quality of a person's life. It does not manipulate the elderly person to continue to live in an arena that is envisioned by the client as being intolerable. The AARP chapter president sees psychologists and psychiatrists as unwanted interventionists.

ORGANIZATION OF CHAPTERS

Beginning with chapter 2, I address Durkheim's four concepts separately. Keep in mind that in the reality of social work practice, the concepts are paired as addressed earlier in this chapter. Within chapters 2 through 5, I address the concepts singly rather than in their true theoretical state to dissect each in a manner that promotes an intimate understanding of its application to real-life situations. Fatalism is analyzed in chapter 2 and followed in chapter 3 by its opposite, anomic suicide. Chapter 4 addresses egoistic suicide, which is conceptually linked to its opposite, altruistic suicide, examined in chapter 5.

The phrase "evidence-based practice" has become a recent theme among professors, students, and practitioners, and it is the heart and soul of Durkheim's vision of sociological theory. In chapter 6, I examine qualitative and quantitative methodologies that ground Durkheim's work in the realities of effective social intervention. Most of the chapters dissect Durkheim's concepts individually to focus and learn with limited distraction. Chapter 7 pulls together all the issues addressed earlier in the chapters in a holistic manner. Simply stated, in chapters 2 through 6, I deconstruct Durkheim's theoretical concepts, and then in chapter 7, I rebuild the concepts to their original organic state.

Chapter 2 through 5 require additional explanation. At the beginning of each chapter, I introduce Durkheim's concepts historically with an

Figure 1.5   Altruistic Causal Linkage

Altruistic environment ➡ Mental distress ➡ Suicide

explanation of the evolutionary process of how the concept emerged in his thoughts. When writing his book on suicide, his older concepts came into clearer focus. These concepts did not emerge within Durkheim's observations simultaneously. For example, anomie emerged in Durkheim's thought patterns decades before the other concepts. Durkheim used the concept of anomie prior to the publication of *Suicide*.

Over the last 40 years of teaching, I have discovered that Figure 1.1 is a critical catalyst for facilitating an in-depth understanding of Durkheim's theory. In the classroom and presentations to practitioners, I constantly reference Figure 1.1. The figure (or sometimes just parts of it) appears in each chapter to stress the inherent balance that Durkheim insisted on and the reality of social work practice demands. Each time the figure reappears, it changes slightly to emphasize the concept being presented. At first reading, the reoccurrence of the figure may seem redundant. It is not. After reading the book, practitioners in particular will find themselves returning to a chapter because of a client or environment situation they have encountered. Reproducing the figure in each chapter will reduce the frustration of finding it elsewhere to recall the relationship among the pairs.

After the presentation or representation of the figure, each chapter describes the social environment most conducive for the concept to thrive. These social environmental descriptions are empirically based. I use social science research studies on unhealthy environments as a platform to demonstrate how each concept is housed and how the concept becomes a catalyst for suicide. A case illustration is presented in a manner that incorporates the research findings. The case illustration is critically important for linking research findings to environmental circumstances confronted by many elderly people. The intent is to assist practitioners in applying the findings to specific situations they currently encounter.

The generalization of the case illustration begins with an overview of the unique social environment in which the elder is situated. The case illustration stresses a developmental theme. A continued abrasive environment has a profound impact on a person's perspective—regardless of his or her resilience. Practice implications are included. If one is seeking clinical strategies for suicide prevention, such strategies will not be found within this book. The practice implications in this book stress environment issues. These practice implications include actions that should have taken place decades before the suicide. In a few cases, data demonstrate interventions that may reduce current suicidal ideation. However, these interventions are not included in the toolbox of the typical clinician. For example, taking a self-defense course helps elderly women who have been traumatized by a sexual assault in their youth. The practice implications are introduced with bullets. Each chapter ends with final remarks that synthesize the entire chapter and prepares the reader for the final chapter.