Social Relationships and Their Role in the Consideration to Hasten Death

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Purpose: This study explored the quality and functioning of terminally ill elders' social relationships and their impact on elders' consideration to hasten death. Design and Methods: In-depth, face-to-face interviews were conducted with 96 terminally ill elders. Logistic regression was used to determine whether aspects of social relationships significantly predicted the consideration to hasten death. The qualitative data was content analyzed to identify main themes and patterns. Results: Logistic regression revealed that conflictual social support was a significant predictor of the consideration to hasten death. Qualitative data provided insight into findings that responsibilities to loved ones or direct verbal attempts did not deter elders' consideration to hasten death. Implications: This research highlights the importance of quality social support in elders' consideration to hasten death and exhibits the need for practitioners to assess thoroughly the quality of elder–caregiver relations.

Key Words: Death, Social control, Social relationships

As legal battles and national debates are waged across the United States over physician-assisted suicide (PAS), researchers continue to seek a deeper understanding of the physical and psychosocial factors that may motivate individuals who have a terminal illness—an illness likely to result in death—or who are terminally ill—have less than 6 months to live—to consider hastening their death. (PAS refers to situations in which a physician provides a mentally competent, terminally ill patient with a prescription for a lethal dosage of pills to end his or her own life.) Information relevant to the PAS debate also serves to inform end-of-life palliative care, a holistic form of care that addresses the physical, emotional, spiritual, and social aspects of an individual's dying process. Not only have elders been found to endure physical (Bernabei et al., 1998; Cleeland et al., 1994; SUPPORT Investigators, 1997) and psychosocial (Chochinov et al., 2002; Pessin, Rosenfeld, & Breitbart, 2002) suffering in their dying process—sometimes to the point of preferring a hastened death—but they are also the most likely group to experience death in the United States (Arias, Anderson, Hsiang-Ching, Murphy, & Kochanek, 2003). These factors, combined with the vastly increasing growth rate of the population of persons 65 years of age and older (He, Sengupta, Velkoff, & DeBarros, 2005), make the issue of motivation to hasten death an extremely pertinent one for terminally ill elders and for the health care professionals who support and serve them.

Social relationships, a key aspect in the end-of-life process, have a strong association with health outcomes (Berkman, 1995; House, Umberson, & Landis, 1988; Reynolds & Kaplan, 1990; Umberson, 1992) and with the consideration to hasten death (Arnold, 2004; Breitbart, Rosenfeld, & Passik, 1996; Breitbart et al., 2000; Chochinov et al., 1995; Emanuel, Fairclough, & Emanuel, 2000; O'Mahony et al., 2005). Terminally ill individuals and individuals with a terminal illness who report considering a hastened death describe fewer social supports (Breitbart et al., 1996) and a lower quality of social support (Arnold; Breitbart et al., 1996; Chochinov et al.; Emanuel et al.) than do individuals not considering one. Findings regarding marital relationships have been less clear. Studies have shown the desire for a hastened death to be higher for married than nonmarried respondents (O’Mahony et al.; Oregon Department of Human Services, 1999, 2002, 2005), to be higher for nonmarried respondents (Oregon Department of Human Services, 2000, 2001, 2003), or to be no different for married or nonmarried respondents (Chochinov et al.; Oregon Department of Human Services, 1999, 2004, 2006). Although it is clear from these findings that social relationships play a role in the dying process,
a deeper understanding of the way in which they do so is needed in order for palliative care practitioners to utilize this information. Therefore, in this article I seek to explore quantitatively and qualitatively the role that the relational content of social relationships may play in the consideration to hasten death. Specifically, this study adds to current knowledge by examining the way in which the social regulation or control component within relationships impacts the consideration to hasten death, an area which has largely gone unexplored in prior work on social relationships and the hastening of death.

In exploring the links between social relationships and a terminally ill elder’s consideration to hasten death, one could conceptualize the hastening of death as either a negative or a positive health behavior. In the United States, family members or friends of the terminally ill elder may view the hastening of death as a negative health behavior to be discouraged because PAS is illegal except in Oregon, because committing suicide is socially unacceptable, or because the end result may mean the earlier death of the elder. In contrast, terminally ill elders may view the hastening of death as a positive health behavior that would enhance the quality of their death by ending their physical, emotional, or spiritual pain, or that would enhance the quality of their loved ones’ lives by reducing their caregiving burden. For example, 110 (38%) of the 292 Oregonians who died after ingesting a lethal dose of medication had told their physician that they felt they were a burden to family and friends (Oregon Department of Human Services, 2007), a finding supported in other studies on hastened death (Back, Wallace, Starks, & Pearlman, 1996; Meier et al., 1998; Emanuel et al., 2000). Thus, it is possible that the consideration to hasten death could be conceptualized by terminally ill elders as an action that may enhance the quality of their own dying process or the quality of their loved ones’ lives, or as a negative behavior to be avoided.

In this article, I seek to clarify how the relational content of social relationships affects a terminally ill elder’s consideration to hasten death; I control for religiosity, depression, pain, and education. These factors have played a prominent role in the PAS debate, have been shown to be characteristics of Oreganians who died from PAS, or have been found to be significant in studies on the hastening of death. For example, research has shown that individuals considering a hastened death are not likely to be religious (Breitbart et al., 1996; Emanuel, Fairclough, Daniels, & Claridge, 1996), and they are likely to report a high level of depression (Arnold, 2004; Breitbart et al., 1996; Chochinov et al., 1995; Emanuel et al., 1996; Emanuel et al., 2000). Research on pain has provided mixed results, with some studies showing that those individuals who consider a hastened death are likely to report a high level of pain (Arnold; Back et al., 1996; Chochinov et al.; Emanuel et al., 2000; Meier et al., 1998), and others showing that they are not (Breitbart et al., 1996; Emanuel et al., 1996; Lavery, Boyle, Dickens, Maclean, & Singer, 2001). Results regarding education are equally mixed. Several studies have found that education is not a significant predictor of hastening death (Breitbart et al., 1996; Breitbart et al., 2000; Chochinov et al., 1995); however, reports on Oregon’s Death with Dignity Act, an act that legalized PAS in Oregon in 1994, show that 63% of the 292 individuals who chose to die by PAS had some college education or more, compared with 34% of the 85,755 Oregon residents dying from the same diseases (Oregon Department of Human Services, 2007). Religiosity, depression, pain, and education are key factors to include in studies of social relationships and the consideration to hasten death.

Conceptual and Theoretical Issues of Social Relationships

Social relationships are pivotal to health and well-being across the life span (House et al., 1988) and throughout the dying process (Arnold, Artin, Griffith, Person, & Graham, 2006; Heyland et al., 2006; Schroepfer, 2006). An important dimension of social relationships is relational content, defined as the “functional nature or quality of social relationships” (House et al., p. 302) and consisting of three processes: social regulation or control, social support, and relational demands and conflicts. Social regulation or control is the control exercised in social relationships that can affect health behaviors positively or negatively. Social support is a positive aspect of relationships wherein individuals give each other the instrumental, informational, or emotional support they need to remain healthy. Relational demands and conflicts are “negative or conflictive aspects of relationships” that may negatively impact health (p. 302). Of these three processes, only the relationship between the social regulation or control exercised by the spouse or partner or adult children and the consideration to hasten death has yet to be studied. Researchers have, however, studied the area of social control in relation to several health-compromising behaviors.

Social Control Hypothesis.—Early social control theorists posited that an individual engages in social control either by internalizing societal norms of responsibility for established behaviors (Durkheim, 1951; Hirschi, 1969; Parsons, 1951) or by using sanctions for deviating from behavioral norms (Nye, 1958; Parsons). Rook (1994) and Umberson (1987) point out that members of an individual’s social network can also utilize these two methods to discourage health-compromising behaviors or encourage health-enhancing behaviors, a phenomenon called the social control hypothesis. For example,
Social Support and Relational Conflicts.—The other two processes of relational content—social support and relational demands and conflicts—also explain how social relationships discourage unhealthy practices and encourage healthy ones. Recent studies show that positive social support is associated with the practice of health-enhancing behaviors among middle-aged respondents (McNicholas, 2002) and with preventive health behaviors among elders (Potts, Hurwicz, Goldstein, & Berkanovic, 1992). However, House (2001) argues that although findings about positive social support are important, attention also must be given to the negative potential of social relationships and its impact on health behaviors.

In this article, I seek to gain a deeper understanding, both quantitatively and qualitatively, of the role that the relational content of social relationships may play in the consideration to hasten death, bearing in mind that a terminally ill elder could view the hastening of death as either a negative or positive health behavior. First, using Umberson’s proxy measures for indirect social control (marital and parental status), I examine whether the internalized responsibility presumably inherent in the spousal or parental role results in a consideration to hasten or not hasten death. Second, I investigate whether terminally ill elders who experience fewer attempts by caregivers at direct social control over their health behaviors are more likely to consider a hastened death than are elders who experience more attempts (direct social control). Once these two questions have been explored quantitatively, I then use qualitative methods to clarify or expand on the quantitative results. Third, I explore quantitatively whether terminally ill elders who receive poor or conflictual social support are more likely to consider a hastened death than are elders who receive positive social support.

Methods

Participants

I obtained a purposive sample of 96 respondents at hospices, hospital-based inpatient palliative care programs, and hospital-based outpatient clinics caring for the terminally ill throughout Michigan. I recruited participants from various regions of Michigan so as to obtain a population that varied in race and socioeconomic status. Respondents had to meet three selection criteria: (a) be 50 years of age or older; (b) be deemed mentally competent by their physician, nurse, or social worker; and (c) have a physician’s prognosis of 6 months or less to live. The original age criterion for the study was 60 years of age or older, but 6 months into the study, I lowered the age to 50 and older in order to obtain a sufficient number of male respondents. Health care professionals asked eligible elders to participate in the study, and 96 agreed.

Procedure

I conducted face-to-face interviews with all 96 terminally ill elders, and each interview was completed in a single session. The survey instrument utilized a mixed-method approach, and I audiotaped the interviews so that the qualitative portions could be captured verbatim. The quantitative portions of the interview were captured on tape as well as written in the survey booklet. Interviews ranged in length from 20 to 150 minutes, with a mean of 54 minutes.

Measures

Dependent Variable.—The dependent variable, current consideration to hasten death, is a dichotomous variable: 0 for respondents who were not currently considering hastening their death, and 1 for respondents who were currently considering hastening their death. I first asked each respondent if he or she had ever “given serious thought to hastening the end of your life in any way.” If respondents acknowledged having done so, they were asked whether they were still considering doing so.
Seventy-eight respondents (81%) reported not considering hastening their death at the time of the interview, and 18 (19%) reported considering doing so.

Previously Studied Variables.—Because the sample size was small (N = 96) and thus created a potential power issue, I sought to have a parsimonious model. I ran bivariate analyses (data not shown) to determine if age and gender were significant predictors of the consideration to hasten death; these variables were not significantly related to the dependent variable. I also included the variables in both logistic regression models, and I found that the estimates for the other variables did not change. Therefore, I chose not to include age and gender in the regression analyses.

I collected information about four key factors that had been investigated in previous studies on the consideration to hasten death: education, religiosity, depression, and pain intensity. I coded education as a continuous variable based on the number of years of schooling that respondents had completed. I measured religiosity by means of a single item shown to be correlated with a variety of behaviors and feelings among elders (Chatters, Taylor, & Lincoln, 1999). Respondents were asked to rate the importance of religious or spiritual beliefs in their day-to-day life on a 4-point scale ranging from 1 (not at all important) to 4 (very important). I found this variable to be negatively skewed and I recoded it into a dummy variable for data analyses: 0 = very important (74%) and 1 = not at all; not very; and somewhat important (26%).

To measure current depressive symptomatology, I chose an abbreviated version of the Center for Epidemiologic Studies–Depression scale, the 11-item Iowa Form (Kohout, Berkman, Evans, & Cornoni-Huntley, 1993), because it has a briefer administration time and is less confusing for elders. I deleted 4 somatic items from the 11-item scale (loss of appetite, everything being an effort, sleep disturbance, and not being able to “get going”) to prevent obtaining falsely elevated depression scores for the terminally ill respondents; research shows that such items are not only signs of clinical depression but also symptoms of illness (Kathol et al., 1990). The resulting 7-item scale had an acceptable level of internal consistency (.74). I transformed it from the Iowa Form’s reduced potential scale range (0–14) to the Center for Epidemiologic Studies–Depression scale’s full-length potential scale range (0–60) to allow for use of the original cutoff point of 16. After the scores underwent transformation, I coded them into a dummy variable: 0 = low likelihood of clinical depression (0–15) and 1 = a likelihood of clinical depression (16–43). I measured pain intensity with the 6-item Philadelphia Geriatric Center Pain Intensity Scale (Parmelee, 1994). Respondents were asked all 6 items, but I dropped the question about pain interfering with “day-to-day activities” from the analyses because it was not applicable to respondents who were bedridden and unable to perform any daily activities. Cronbach’s alpha of .86 for the 5-item composite score of pain intensity was very close to the alpha of .88 for the 6-item version.

Indirect Social Control.—The proxy variables for the indirect social control self-regulation process were marital status and parental status. I coded both as dummy variables (0 = married and 1 = single, separated, divorced, or widowed; 0 = at least one child and 1 = no children).

Direct Social Control.—I measured direct social control by means of a single item based on one used by Umberson (1992) in her study of the relationship between direct social control and health outcomes. Umberson asked, “How often does anyone tell, remind, or encourage you to protect your health?” Respondents in my study were asked, “How often does anyone tell, remind, or encourage you to continue with your medical treatment or medical care?” Response categories ranged from 1 (never) to 5 (very often); however, I grouped categories 1 (never) and 2 (rarely) because of a convergence problem that occurred when I tested for linearity.

Social Support.—Researchers have found that social support has its most beneficial effect when the type of social support provided matches the needs created by a stressor, in this case the dying process (Bass, Noelker, & Rechlin, 1996; Krause, 1990). I used a series of close- and open-ended questions to capture the type and quality of social support provided by caregivers to respondents in relation to their dying process. An initial close-ended question asked respondents whether they could talk about fears and concerns they may have regarding their illness and its outcome (emotional support) with caregiving family or friends closely involved in the respondents’ dying process. The 86 (90%) respondents who said yes and the 10 (10%) who said no were asked to talk about why they felt this way. I used a series of probes to encourage respondents to talk about the other types of support they were receiving from these involved individuals and whether they perceived the support to be positive or conflictual. For example, they were asked, “Do you feel supported in other ways by [person’s name]? How does [person’s name] support you? How do you feel about this support?” I content analyzed the results and I found respondents to report on the receipt of emotional or instrumental social support from their primary caregivers. When asked about the quality of this support, they described it either as very positive or as poor or conflictual; no respondent reported receiving both positive and negative support from one or multiple caregivers. Because of these
dichotomous results, I coded social support as a dummy variable (0 = positive social support and 1 = poor or conflictual social support).

**Quantitative Analytic Approach**

I used hierarchical logistic regression to test my three hypotheses. I calculated unstandardized regression coefficients ($b$), standardized regression coefficients ($\beta$), and odds ratios (ORs) for two models. Model 1 is based on the four factors previously found to be related to the consideration to hasten death: more years of education, low religiosity, likelihood of clinical depression, and higher pain intensity. Model 2 adds the four variables that measure relational content: marital status and parental status (indirect social control), fewer direct social control attempts (direct social control), and poor or conflictual social support.

**Qualitative Analytic Approach**

I asked respondents if they had thought seriously about hastening their death since finding out they had a terminal illness. I then asked them to talk about their reasons for considering or not considering a hastened death. Using a content analysis approach, I read the interview transcripts multiple times, grouped participants’ responses by emerging themes (Patton, 1990, p. 381), and then generated preliminary codes to represent these themes. As a reliability check, I hired a hospice social worker to code the responses independently on the basis of the themes I had identified. The social worker and I initially reached 89% agreement; we then discussed our findings and came to consensus on the remaining 11%. In this article, I discuss the themes relevant to relational content: sense of responsibility toward loved ones (indirect social control), effect of verbal encouragement (direct social control), and positive and poor or conflictual support.

**Results**

**Sample Description**

Respondents’ demographic characteristics were varied. Respondents ranged in age from 51 to 98 years, with a mean age of 73.5 years; 54% were female and 46% were male. The majority of respondents were White ($n = 81$; 84.4%), and 15.6% ($n = 15$) were Black. Respondents’ religious preferences were diverse: Catholic (19.8%), Methodist (14.6%), Baptist (15.6%), other Protestant religions (35.4%), Jewish (2.1%), and no religious preference (12.5%). Many respondents had some form of cancer (49.0%), and the next most common diagnoses were end-stage renal disease (26%) and heart disease (15.6%). The remaining 9.4% of the respondents were dying of respiratory and neurological diseases.

Table 1 shows the bivariate relationship between each predictor and the dependent variable, which is consideration to hasten death. Social support had the clearest relationship with the dependent variable. Poor or conflictual social support was experienced by 33.3% of the respondents who considered a hastened death but only 2.6% of those not considering one. Education, depression, and religiosity were also associated with the dependent variable. The mean number of years of schooling for respondents considering a hastened death was 13.6, compared with 11.7 years for those not considering one. I found a high likelihood of depression in 66.7% of the respondents who considered a hastened death and in

<table>
<thead>
<tr>
<th>Variable</th>
<th>Full Sample</th>
<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Variables previously studied</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years of education ($x$)</td>
<td>12.1</td>
<td>11.7</td>
<td>13.6**</td>
</tr>
<tr>
<td>Low religiosity (%)</td>
<td>26.0</td>
<td>21.8</td>
<td>44.4*</td>
</tr>
<tr>
<td>High likelihood of depression (%)</td>
<td>37.5</td>
<td>30.8</td>
<td>66.7**</td>
</tr>
<tr>
<td>High pain intensity ($x$)</td>
<td>12.5</td>
<td>12.4</td>
<td>12.9</td>
</tr>
<tr>
<td>Relational content variables</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Indirect social control</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Marital status (% not married)</td>
<td>47.9</td>
<td>48.7</td>
<td>44.4</td>
</tr>
<tr>
<td>Parental status (% childless)</td>
<td>14.6</td>
<td>14.1</td>
<td>16.7</td>
</tr>
<tr>
<td>Low direct social control ($x$)</td>
<td>2.2</td>
<td>2.3</td>
<td>1.8*</td>
</tr>
<tr>
<td>Conflictual social support (%)</td>
<td>8.3</td>
<td>2.6</td>
<td>33.3***</td>
</tr>
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</table>

Notes: The number of respondents is as follows: full sample, $N = 96$; no consideration to hasten death, $n = 78$ (81%); consideration to hasten death, $n = 18$ (19%). The levels of significance for categorical variables are based on Fisher’s Exact Test; levels of significance for continuous variables are based on $t$ tests.

$p < .10; *p < .05; **p < .01; ***p < .001.$

Table 1. Bivariate Relationships Between Predictors and Consideration to Hasten Death
30.8% of those not considering one. Low religiosity was reported by 44.4% of the respondents who were considering a hastened death but only 21.8% of those not considering one. Finally, respondents not considering a hastened death had fewer experiences of direct social control than did those considering a hastened death, but this association was only marginally statistically significant ($p = .09$). I found no relationship between the dependent variable and pain intensity or the two proxy variables for low indirect social control (marital status and parental status).

### Regression Results

In Table 2, consideration to hasten death is regressed on all independent variables for two models. Model 1 is based on the four variables investigated by previous research: education, religiosity, likelihood of clinical depression, and pain intensity. I found neither religiosity nor pain intensity to be a significant predictor of the consideration to hasten death. Although the lack of significance found in regard to pain intensity is consistent with prior studies (Breitbart et al., 1996; Emanuel et al., 1996; Lavery et al., 2001), the finding for religiosity is not (Breitbart et al.; Emanuel et al.).

The likelihood of clinical depression was a statistically significant predictor of the consideration to hasten death, a finding that is consistent with prior studies. Individuals with a high likelihood of clinical depression were four times ($OR = 4.38$; $p < .01$) more likely to consider a hastened death than were those with a lower likelihood of clinical depression.

Respondents with more years of education were more likely to consider hastening their death than were respondents with fewer years of education. The OR ($1.38$; $p < .01$) indicates that each year of education increased the odds of considering a hastened death by 38%. The relative magnitude of the standardized regression coefficient for education ($\beta = .45$) was larger than that for the other significant predictor variable, likelihood of clinical depression ($\beta = .40$). Thus, in Model 1, the variable most strongly associated with consideration of a hastened death is education.

Model 2 is based on the four previously studied variables plus the relational content variables: low indirect social control (no spouse–partner or no children), low direct social control, and poor or conflictual social support. A chi-square test of the difference between the two models ($\chi^2$) revealed that Model 2 is a significantly ($p = .001$) better fit than Model 1; prediction of the dependent variable was improved by the addition of the relational content variables.

The regression results provide insight into the role that the three processes of relational content (indirect and direct social control, and social support) play in a terminally ill elder’s consideration to hasten death. In regard to indirect social control, I found no statistically significant relation between the dependent variable and pain intensity or the two proxy variables for low indirect social control (marital status and parental status).

### Table 2. Logistic Regression Models of the Consideration to Hasten Death ($N = 96$)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1 $b$</th>
<th>$\beta$</th>
<th>OR</th>
<th>Model 2 $b$</th>
<th>$\beta$</th>
<th>OR</th>
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<td>Variables previously studied</td>
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<td></td>
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<tr>
<td>Years of education</td>
<td>0.32</td>
<td>0.45</td>
<td>1.38**</td>
<td>0.39</td>
<td>0.55</td>
<td>1.48**</td>
</tr>
<tr>
<td>Religiosity (low$^a$)</td>
<td>0.94</td>
<td>0.23</td>
<td>2.56</td>
<td>0.81</td>
<td>0.20</td>
<td>2.25</td>
</tr>
<tr>
<td>Depression (high$^b$)</td>
<td>1.48</td>
<td>0.40</td>
<td>4.38*</td>
<td>1.18</td>
<td>0.32</td>
<td>3.26†</td>
</tr>
<tr>
<td>Pain intensity (high = more)</td>
<td>0.04</td>
<td>0.10</td>
<td>1.04</td>
<td>0.02</td>
<td>0.06</td>
<td>1.02</td>
</tr>
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<td>Relational content variables</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Marital status (not married$^a$)</td>
<td>0.53</td>
<td>0.15</td>
<td>1.70</td>
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</tr>
<tr>
<td>Parental status (no children$^a$)</td>
<td>–0.92</td>
<td>0.18</td>
<td>0.40</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Direct social control (high = less)</td>
<td>–0.59</td>
<td>0.41</td>
<td>0.56</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Social support (poor–conflictual$^a$)</td>
<td>3.24</td>
<td>0.50</td>
<td>25.46*</td>
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</table>

Model fit ($–2 \log$ likelihood) $74.393^{**}$  $61.489^{***}$

**Notes:** OR = odds ratio.

$^a$This is the coding for Level 1 of the dummy variables.

$^b$This is the coding for Level 1 of the dummy variables.

$^p < .10$; *$p < .05$; **$p < .01$; ***$p < .001$. 

Vol. 48, No. 5, 2008 617
control in regard to the consideration to hasten death, I did find social support to be a significant predictor. Respondents who received poor or conflictual support were significantly (p = 0.02; OR = 25.46) more likely to consider a hastened death than were respondents receiving positive social support. The possibility exists, however, that respondents who were depressed may have reported more negative evaluations of their social support, or that poor or conflictual social support may have resulted in depression. In order to check for a possible confounding relationship between depression and social support, I dropped depression from Model 2 (data not shown). Poor or conflictual social support remained a significant predictor of the consideration to hasten death, regardless of whether depression was or was not controlled.

Table 2 illustrates that the regressions for the previously studied variables changed between Model 1 and Model 2. In Model 2, education’s significant relationship slightly increased, which may suggest that the relational content variables play a small suppressor role with regard to education. The likelihood of clinical depression went from being a strong and significant factor (b = 1.48; p = 0.05) to being only a marginally significant factor (b = 1.18; p = 0.08). This decrease in significance implies a mediating role of relational content with regard to the association between clinical depression and the consideration of hastening death. Religiosity and pain intensity remained nonsignificant. The standardized coefficient for poor social support (β = 0.50) was less than that for education (β = 0.55). Thus, education remained the only statistically significant factor through both models.

Qualitative Results

Social Control Hypothesis.—As I noted in the introduction, it is possible that some terminally ill elders could view the hastening of death as either a negative or positive behavior, which may help explain the lack of significance reported in the quantitative results. Sense of responsibility toward loved ones (indirect social control) and verbal encouragement to continue medical care (direct social control) were two related themes that emerged from the qualitative analyses of respondents’ reasons for considering or not considering a hastened death. These themes and their underlying stories provide insight into the lack of a significant relationship between the social control hypothesis and the consideration to hasten or not hasten death.

Sense of responsibility toward loved ones (indirect social control) led some respondents to view considering a hastened death as a health behavior that would negatively impact their loved ones. These respondents who viewed not considering a hastened death as acting responsibly were concerned about how their loved ones would fare financially and emotionally after such a death. For example, one respondent expressed concerns about her much younger husband’s financial welfare:

[T]hat’s what bothered me most about the whole thing, more than me dying, was leaving my family behind with all the bills and what were they going to do, and how is he [husband] going to get along without my pension.

Respondents who were no longer physically able to hasten their death talked about their desire to do so but did not want to place their loved ones in the emotionally difficult position of assisting them. Other respondents spoke about wanting to protect loved ones from the taint of suicide. For example, one 55-year-old married man was worried about the effect his suicide would have on his wife because their son had committed suicide after killing his own wife and children. The respondent spoke of the anguish his wife suffered when the couple discovered the bodies, and he resolved that he “would never do that to my wife. I wouldn’t do that.”

Sense of responsibility toward loved ones (indirect social control) led some respondents to view considering a hastened death as a means of protecting their loved ones (a positive behavior). A respondent with a muscular degenerative disease spoke about how devastating it was for his family to watch him slowly become completely paralyzed. He felt that his family could more easily deal with his death than with the effects of his illness. Another respondent wanted to end his life because his wife was burdened with earning a living, cleaning house, and taking care of him:

I’m sitting in the chair, on a chair, in the kitchen at the table and H. is going top speed. Shall we clarify that speed, yes, with one word: berserk. I can’t help, but I know I normally did. And here it is on her, and I can’t move from A to B.

This respondent felt that his care was too stressful for his wife and viewed hastening his death as a responsible act (a positive behavior) because it would relieve her of the burden of caregiving. On the basis of these responses, the internalized responsibility presumably inherent in a spousal or parental role (indirect social control) resulted in respondents considering or not considering a hastened death.

The second theme, verbal encouragement to continue medical treatment or care (direct social control), emerged from respondents who were considering a hastened death and whose family members were encouraging them to continue living and receive medical care. It is interesting to note that, in these cases, the hastening of death was viewed by respondents as a positive behavior that
would either relieve their own suffering or that of their loved ones.

Two respondents reported experiencing terrible suffering that they felt their loved ones were ignoring in order to keep them alive and with them. The first respondent was angered by her children’s admonitions that she continue with dialysis. She said that her children were grown, had full and active lives of their own, and only visited infrequently and that it was selfish of them to want her to continue living what she felt was a horrible, useless existence.

Every time I talk about not taking it [dialysis] they [her children] get very upset because they know what would happen. They won’t listen. I thought, well, big deal, they’re way down there and they see me maybe once a month and they don’t come see me!

The second respondent talked about how his spouse encouraged him every day to continue his medical care and would not listen when he spoke of hastening his death. He understood her desire to keep him alive and with her, but his understanding was outweighed by the psychosocial unpleasantness of his current existence. He felt that his spouse was ignoring his feelings and his misery. Both this respondent and the dialysis patient were still considering suicide at the time of their interviews, and they felt that hastening death would relieve them of their own suffering.

Other respondents reported concern over the caregiving burden they felt their dying was placing on their loved ones, and so the verbal encouragement exerted by family members had no effect. These elders heard the loved ones’ pleas to eat and to take their medications, but they also heard exhaustion in those voices and believed that their death would be a relief to their families. On the basis of these qualitative responses, direct social control may not have been effective because elders viewed the hastening of death as a positive behavior that would alleviate their loved ones of the stress and burden of caregiving.

Discussion

The mixed-methods approach that I used in this study offers a deeper understanding of the role that the relational content of social relationships plays in an elder’s consideration to hasten death. This study provided no quantitative support for the social control hypothesis. Terminally ill elders considering a hastened death were not influenced by the internalized responsibility presumably inherent in the spousal or parental role (indirect social control), nor by loved ones’ verbal attempts (direct social control).

The qualitative data, however, provided some additional insight in to the lack of significance found for the social control hypothesis. First, it revealed that the relationship between social control and a terminally ill elder’s consideration to hasten death is complicated by the fact that some respondents appeared to view the hastening of death as a negative behavior whereas others viewed it as a positive behavior. Some respondents believed that hastening their death would be the best thing for their loved ones (positive behavior) because it would relieve their suffering, whereas others felt it would cause their loved ones greater suffering (negative behavior). Thus, the view that hastening death is a negative health behavior and one not reflective of an internalized sense of responsibility toward loved ones may not accurately reflect the beliefs of terminally ill elders.

Second, the qualitative data revealed that respondents who were suffering unbearably or who perceived that their loved ones were suffering reported being unaffected or even put off by loved ones’ verbal encouragement (direct social control). Some respondents considering a hastened death were encouraged by loved ones to continue living, but the respondents’ own suffering was so great or they perceived the loved one’s caregiving burden as so unwieldy that they viewed the hastening of death as a positive behavior.

The multivariate results revealed a significant relationship between social support and the consideration to hasten or not hasten death. Terminally ill respondents who received poor or conflictual social support were more likely to consider a hastened death than were respondents who received positive social support. Responses to the probes employed to encourage respondents to talk about the quality of support they were receiving, and from whom they were receiving, indicated that the source of the poor or conflictual social support was an immediate family member or partner with whom the respondent had daily contact. Thus, the consideration to hasten or not hasten death in terminally ill elders appears to be impacted not simply by the number of network members providing support but also by the quality and, potentially, the provider of that support.

Of the control variables, only the lack of significance found for pain intensity was consistent with prior studies; the findings for education, religiosity, and depression were not. The only variable that remained statistically significant in both models was education: Respondents with more years of schooling were more likely to consider a hastened death. One potential explanation for this finding is that individuals with a higher education may have more information on physician-assisted death and, in some cases, possess the skills necessary to plan a hastened death. For example, one respondent, a mechanical engineer, spoke of using his knowledge of engineering to devise a plan.

After I included the relational content variables in the analysis, the likelihood of clinical depression was not a significant predictor. This finding was surprising because the groups opposed to physician-assisted
death have emphasized depression as a factor. The quantitative measure of religiosity in this study asked respondents about the importance of religious beliefs in their daily lives but not about their religious beliefs regarding dying or hastening death. On the basis of the quantitative and qualitative data, religious beliefs about daily life and those regarding dying or hastening death may have varying influence on a terminally ill elder’s consideration to hasten or not hasten death.

Thus, overall it would appear that the relational content of social relationships may play an important role in regard to whether terminally ill elders consider hastening their death. Receiving poor or conflictual social support from their loved ones, regardless of depression, pain intensity, or importance of religious beliefs, may contribute to the consideration to hasten death for elders, particularly those with a high level of education. In addition, if an elder’s own suffering or the suffering his or her care is placing on loved ones is great, the elder may be likely to consider a hastened death. These findings have implications for future research and for practitioners.

Future Research

Future quantitative research about the influence of social relationships in terminally ill elders’ consideration to hasten death requires larger sample sizes and a longitudinal research design. This study’s small sample size prevented the use of other potential proxies for indirect social control, such as health care professionals or extended family, and also restricted the measurement of direct social control because verbal attempts made by spouses, children, or others were combined. A larger sample would allow multiple measures to serve as proxies for indirect and direct social control. It would also allow researchers to control for the relationship between the elder and the individual exerting direct social control, for the gender of the individual exerting direct social control, and for the number of network members making such attempts.

The importance of the perceived quality of social support in relation to considering a hastened death begs for additional research to clarify its powerful role. As I previously noted, no respondent in this study received both positive and conflictual social support from loved ones. An important next step for future research would be to ask respondents about each person who provides them with support, about the type of support each person provides, and about respondents’ satisfaction with each person’s support. In addition, with more information about how respondents define conflictual support, researchers can construct new survey questions. Is lack of support less harmful than the receipt of conflictual support at the end of life? Does the source of conflictual support matter? Is support viewed as positive when the type of support received (i.e., emotional, informational, or instrumental) matches the type of support needed? These issues would most effectively be explored by means of a combined quantitative and qualitative approach.

Qualitative exploration would help researchers better understand the relevance of the social control hypothesis in terminally ill elders’ consideration of a hastened death. Does an elder’s feeling of responsibility extend to other caregivers residing in the household, such as siblings or friends? Does the sense of responsibility felt by an elder extend to loved ones living outside the home? How do the verbal social control attempts made by these various individuals impact the elder’s consideration to hasten death?

Implications

The results of this study hold several important implications for practitioners providing psychosocial or spiritual care at the end of life. Terminally ill elders who are considering a hastened death may have psychosocial or spiritual concerns that are impacting the quality of their dying process. Practitioners talking with elders who are considering a hastened death may find it more effective to first discuss motivations for the consideration than to focus on dissuasion. For example, an elder’s motivation for considering a hastened death may be based on a sense of responsibility to loved ones (indirect social control), that is, wanting to relieve them of their burden of providing care. The practitioner can talk through these concerns with the elder and them have him or her share them with the caregivers in order to determine whether the concerns are valid and, if so, how best to address them. If the elder is negatively affected by loved ones’ verbal attempts to control health behaviors (direct social control), the practitioner could again encourage the elder to explain this unintended effect to his or her spouse or partner or children, and offer to facilitate an ensuing discussion. Finally, practitioners’ thorough assessment of the quality of elder–caregiver relationships rather than the quantity of available caregivers may help ensure that elders receive the support they need in order to have an optimal dying process.

References
