Suicide Experiences Among Institutionalized Older Veterans in Taiwan

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Purpose Institutionalized veterans in Taiwan are a high-risk group for completing suicide due to their institutionalization and social minority status. The purpose of this study was to understand the suicide experiences, especially the triggers of suicide in this group. Design and Methods Data about suicide experiences were collected from 19 older (≥65 years) residents who had attempted suicide in four veterans’ homes in Taiwan from 2006 to 2007. Transcripts from 26 tape-recorded interviews were analyzed by thematic analysis. Results Five major themes related to suicide triggers were identified: illness and pain, death of close relatives or friends, conflicts with family members, disputes with friends or workers, and difficulty adapting to institutional life. Implications Illness and physical limitation issues were similar to suicidal findings on older people in Western culture. However, the suicidal behavior of these institutionalized, older Taiwanese veterans was influenced by expectations that did not match current social changes, money management issues, death of significant others, and changes in living environment. We suggest that money problems with paraprofessional institutional workers could be minimized among older institutionalized veterans by providing a convenient means for them to withdraw or manage money. Institutional staff should also be educated about communicating with older people and about death and dying; older residents should be educated about current social changes and money management. The study themes may be used to develop a new model for predicting suicide in this population and could be incorporated into current suicide prevention programs in clinical practice.

Key Words: Suicide, Institutionalization

Suicide rates are high for older persons (aged 65 years or older) worldwide. For example, suicide was the 11th leading cause of death for all ages in the United States in 2005 and accounted for 1.3% of all deaths (Centers for Disease Control and Prevention [CDC], 2005). However, of the approximately 32,000 deaths in 2005 resulting from suicide, more than 5,000 (14%) were among older people (CDC, 2007). Similar trends can be found in Asian countries (Chiu, Takahashi, & Suh, 2003). In Taiwan, suicide has been in the top 10 leading causes of death for more than 20 years, and the rate of completed suicides is increasing in older people every year (Department of Health, Executive Yuan, 2007a). Moreover, the suicide mortality rate of older people in Taiwan (39.3 per 100,000 people) was higher than the rates in the United States, Germany, United Kingdom, and Italy (6–24.3 per 100,000 people; Department of Health, Executive Yuan, 2007b). This background highlights the importance of studying suicidal issues among older Taiwanese people.

Unfortunately, suicide research in older people receives relatively little attention, possibly due to age bias and consideration of the greater economic productivity of younger people (O’Connell, Chin, Cunningham, & Lawlor, 2004). Among all suicides worldwide, up to 60% may occur in Asia or at least 60 million Asians could be affected by suicide or attempted suicide each year (Beautrais, 2006). However, suicide has received relatively
less attention in Asia than in Europe and North America (Hendin et al., 2008).

Thus far, no theory has been proposed to model suicide in older people. However, data from studies on older people revealed that the most important predictor of suicide is depression (Conwell, Duberstein, & Caine, 2002; Conwell & Thompson, 2008; Hendin et al., 2008; O’Connell et al., 2004). Other factors associated with suicide in older people are alcohol use disorder, neurological illness, malignancies, multiple illnesses (O’Connell et al.), suicide ideation, mental illness, personality vulnerability, losses and poor social supports, functional impairment, and low resilience (Heisel, 2006). A high-risk group among older people who complete suicide is previous suicide attempters (O’Connell et al.). Moreover, older people are less likely to volunteer having suicidal feelings (Gunnell & Frankel, 1994), but they commonly commit suicide using violent behavior and lethal means with high intent to die (Heisel). As a result, early detection and prevention in this population become important tasks worldwide.

Suicide prevention programs have recently been implemented among older Asians in Japan and Hong Kong. For example, a 7-year community-based program was implemented in Japan to prevent suicide among older people using depression screening with follow-up by general practitioners and a 10-year public education program (Oyama, Fujita, Goto, Shibuya, & Sakashita, 2006). Results revealed that these programs effectively prevented suicide among older women. Another community-based management program for late-life depression with mental health care supported by psychiatric treatment effectively prevented suicide among both older men and women in Japan (Oyama, Koida, Sakashita, & Kudo, 2004). Similarly, the government of Hong Kong implemented a comprehensive suicide prevention program to screen elders for depression and those at risk for suicide (Hong Kong Jockey Club Centre for Suicide Research and Prevention, 2005).

As in other developed countries, the proportion of people older than 65 years in Taiwan is increasing. This older population has grown from 7.9% of the total population in 1994 to 10.0% at the end of 2006 (Department of Health, Executive Yuan, 2007c). Among these elders, veterans account for one seventh (Veterans Affairs Commission, Executive Yuan, 2007) and have unique characteristics. Around the end of the Chinese Nationalist-Communist Civil War in 1949, many nationalist armed forces relocated from mainland China to Taiwan. After resigning from the armed forces, many of these men remained in Taiwan and the majority never married (Weng, 1999). Their languages, habits, and value systems were different from those of local people, making it difficult for them to form new social networks and to get jobs (Lv, 1998). These factors contributed to their becoming a vulnerable group in Taiwan.

To take care of these older veterans, the government has established veterans’ homes throughout Taiwan. Currently, Taiwan has 18 veterans’ homes, including 14 government-paid and 4 self-paid veterans’ homes (Veterans Affairs Commission, Executive Yuan, 2008). To live in a government-paid veterans’ home, veterans must be at least 61 years old, not have a paying job or be unable to work, and have an income at or below the poverty level. To live in a self-paid veterans’ home, veterans must be at least 61 years old (their spouse must be at least 50 years old), not have any physical and mental impairments, and able to pay living expenses of the home (Veterans Affairs Commission, Executive Yuan, 2008).

As mentioned above, older people in Taiwan have a high standardized suicide mortality rate (Department of Health, Executive Yuan, 2007b), but few suicide studies could be found on this population. Most of these studies have focused on the epidemiology of suicide. For example, men in Taiwan take their own lives at nearly two times the rate of women (Department of Health, Executive Yuan, 2007d; Li, Fu, & Chang, 2002; Liu, Wang, & Yang, 2006). For both genders, the most common methods of suicide were hanging, strangulation, and suffocation. Understanding these older people’s suicidal experience is important for designing suicide prevention programs. Depressive tendency is a strong predictor of suicide and is more prevalent among institutionalized older people than those living in the community (Beekman, Copeland, & Prince, 1999; Tsai, Yeh, & Tsai, 2005). Thus, institutionalized elders have been considered a high-risk group for completing suicide. This risk is even greater for institutionalized veterans in Taiwan due to their social vulnerability. Therefore, the purpose of this study was to understand suicide experiences, especially the triggers of suicide, among institutionalized older veterans in Taiwan.

**Methods**

**Design**

This study was part of a large research series to develop a suicide prevention program for residents....
of veterans’ homes. For this study, a qualitative design was used. Data were collected by individual interviews from 2006 to 2007.

**Sample and Setting**

Veterans’ homes were randomly selected by stratification according to location (northern, central, southern, and eastern areas) and payment method (government- and self-paid). Each area has two to four government-paid and one self-paid veterans’ home, except southern Taiwan, which has five government-paid veterans’ homes. Thus, we randomly selected government-paid veterans’ homes from each area as follows: north:central:southeast = 1:1:2:1. To obtain a representative sample of self-paid homes, we randomly selected two self-paid veterans’ homes. We first listed all veterans’ homes, assigned a number to each one, and selected numbers from a table of random numbers. The final sample included five government-paid and two self-paid veterans’ homes. Among these seven institutions, only three government-paid and one self-paid veterans’ home reported older residents who met the suicide criterion (see inclusion criteria subsequently). Therefore, these four veterans’ homes were chosen as settings for this study.

To be included in the study, residents had to meet four criteria: (a) living in a selected veterans’ home, (b) aged 65 years and older, (c) without severe cognitive deficit (Mini-Mental State Examination [MMSE] score ≥16 for those without formal education and MMSE ≥20 for primary school graduates or above; Folstein, Folstein, & McHugh, 1975; Liu, Tai, Lin, & Lai, 2000; Yip et al., 1992), and (d) exhibited suicidal behaviors in the previous 6 months based on veterans’ home records. Because these behaviors are documented by institutional nurses, they were asked to refer residents to this study. Of the 20 potential participants referred by nurses at the study sites, 19 older people agreed to participate and 1 was still hospitalized and refused to see any person.

**Data Collection**

Participants were interviewed by Yan-Chiou Lin or Yea-Pyng Lin. Data were collected in 26 audiotaped individual interviews in Mandarin Chinese, each lasting 45–120 min. Among the 19 participants, 7 were interviewed twice to complete the interview. Participants were told that the interviewer would like to understand their experiences of suicide, especially what happened around the time of the suicide attempt. Immediately after each interview, each interviewer used memos and reflective journals to record observations about participants’ behavior during the interviews and ideas about coding, respectively. Data were collected until analysis showed no new themes (data saturation).

**Ethical Considerations**

The veterans’ homes where participants were interviewed had no formal institutional review boards. Ethical considerations were addressed by obtaining permission to approach residents from administrators at the veterans’ homes, orally explaining to potential participants the purpose and nature of the study, the required time commitment, researchers’ contact information, confidentiality, and participants’ right not to participate or to withdraw from the study at any time. After potential participants fully understood this information, they were asked to sign a consent form. Those who agreed to participate were guaranteed confidentiality. A number was given to each participant to ensure that a resident’s decision to participate or not could not be identified. Furthermore, if participants expressed suicidal ideas or plans during the interview, they were referred to institutional nurses to further assess potential risk.

**Data Analysis**

All audiotapes were transcribed verbatim (in Mandarin) as soon as the interviews were finished. Transcripts were first compared with the audiotapes for accuracy, and relevant information, such as emotional content and nonverbal behavior, was noted from memos and reflective journals. Transcripts of all interviews were then analyzed to reveal themes in the interview data (Miles & Huberman, 1994). We first analyzed each transcript individually with regard to memos and reflective journals and identified key points. Next, we listed all key points, clustered them into groups to form initial categories and used these categories to recode the transcripts. Then, we listed all categories across all transcripts and clustered them into groups based on similarity and overlap. We further refined the grouping to initially identify the main themes. Coding and analysis were interactive processes using data from transcripts, memos, and
reflective journals. These processes continued until no new themes emerged. Finally, we labeled themes using participants’ own words and selected representative quotations. The second author translated the Mandarin themes into English. The equivalence of the two sets of themes was validated by comparison and discussion among the authors and an expert in qualitative research who was also bilingual in English and Chinese.

Trustworthiness of the data was established through prolonged engagement with transcripts, triangulation, participant observation, peer debriefing, and reflective journaling (Lincoln & Guba, 1985). Method triangulation involved comparing data from transcripts with data from other sources (memos, reflective journals, and debriefing notes). Peer debriefing involved discussing the analysis with experts in qualitative research. Confirmability was promoted by keeping memos and reflective journals on the decision trail during research, thus allowing further audit.

Findings

The 19 participating older people were on average 80.1 years old (SD = 3.3, range = 73–85 years). All were male and had been living in a veterans’ home for an average of 6.1 years (SD = 4.2, range = 1–16 years). Most participants had never married (84.2%), had graduated from a primary school or below (68.4%), and had attempted suicide more than once (57.9%).

Analysis of interview data indicated that these older people described their suicide triggers in terms of five themes: illness and pain (94.7%), death of close relatives or friends (36.8%), conflicts with family members (26.3%), disputes with friends or workers (26.3%), and difficulty adjusting to institutional life (21.1%). All participants expressed an experience that fit into at least one of the five suicide triggers. Among the participants, 42.1% expressed only one of the five suicide triggers, 26.3% expressed two of the five suicide triggers, 15.8% expressed three of the five suicide triggers, and 15.8% expressed four of the five suicide triggers.

Illness and Pain

Participants described suffering from multiple illnesses and pain that interfered with their activities of daily life. As one participant (C) said,

I knew it was common to have multiple chronic illnesses and physical problems in old age. However, when it came, I really couldn’t bear it. I couldn’t see clearly. All my teeth were false, and I couldn’t eat hard foods. I was afraid to move because my legs were so weak and painful. I also couldn’t sleep well because I couldn’t find a comfortable position. I didn’t know why I should have such punishments. My life was so miserable; I couldn’t see any future for myself. Therefore, I did it [tried to drown himself].

Participants also described intolerable side effects of their medications. This view was exemplified by one participant’s (B) comment:

I need to take a lot of pills to control my diseases [hypertension, diabetes, and osteoarthritis]. A doctor changed my pills at that time. As a result, I got severe diarrhea. I almost couldn’t leave the toilet. My step was unstable and I fell down in the rest room. My left hip was then broken, and I was sent to a hospital. That was another nightmare. I don’t want to remember that experience. Anyway, I was allergic to certain pills and fell down several times. I couldn’t accept that I needed to take more and more pills and bear all their side effects. I felt my body was too old to go through such a process. So, I tried to hang myself.

Physical limitations were another major concern for participants. They worried that their physical condition would become worse and worse, leading to a loss of control and dignity. Participant K described his experience:

Because of my stroke, I needed to hire a person to look after me. You know, I used to be a military officer. I was very concerned about my appearance and dignity. But after the stroke, I needed help to go to the toilet. Even when I can’t control my urine or bowels, I have to face my helper. I felt that I was living without dignity. Moreover, I heard that I could have another stroke. My condition could become worse. I really don’t know how to protect myself from having another stroke. So, I decided to do it [tried to hang himself].

Death of Close Relatives or Friends

Participants also mentioned feelings of loss after the death of close relatives or friends. The grief process was very painful and endless, which induced their suicidal behaviors. As one participant (N) said,

My wife passed away. Suddenly, I lost the will to live. I missed her so much. I regretted that I didn’t treat her nicer after I resigned from the army. She was a very kind person and gave me great support.
to move on. Without her, I didn’t feel complete. I thought I should join her [in death]; otherwise, it was unfair to her.

Participants also expressed grief about the loss of close friends. Even though death may be a common phenomenon among older people, it occurs more frequently in institutions. If a resident did not die of natural causes but by suicide, that death could have a greater impact on his or her friends, as illustrated by one participant (F):

Mr. Wang and I met in this veterans’ home. The first time I saw him, I knew we could become good friends. He fell last winter and became socially withdrawn. He asked me to go with him every time he had an appointment at the VA hospital. One month, he asked me to go with him again, but I hadn’t slept well the night before and was not in a good mood. So, I talked to him loudly and said I wanted to take a nap. When I awoke, he was gone. They searched for 2 days. Finally, his body was found in the front pond. I couldn’t forgive myself. If I had gone with him, nothing would have happened. He would not have killed himself. How thoughtless I was! I kept thinking about his face and the events of that day. I couldn’t sleep. I told myself that I should pay for my mistake.

Disputes with Family Members

Even though a majority of participants had never married, many had family members in mainland China and adopted children in Taiwan. Some participants felt that they were abandoned by their family members when they could not provide money to support them. As one participant (L) said,

When the politics became less sensitive, I decided to go back to mainland China to visit my relatives. My parents had died, but one brother is still living. He got married and had several children and grandchildren. I brought a lot of gifts for them. I even helped them to build a new house. Before I left, I gave my brother a huge amount of money. I also sent money to them several times after I came back. Since I’ve been sick and couldn’t send them money, I started to lose contact with them. I even asked the staff [at the veterans’ home] to call them, but in vain. They must feel I have no money and decided to abandon me. That night, I drank a lot of wine and felt very angry and sad. So, I burned myself.

Another participant (S) had a similar experience:

I wanted to die in my hometown [in China] and planned to move back before I turned 70. After I became poor and sick, I couldn’t reach them [relatives in China] by phone or by mail. I didn’t receive any message for 6 months. In the beginning, I was worried about their safety. Later, my roommate shared his bad experience with me. He reminded me it [the lack of contact] was related to money. I finally understand the reality, felt very disappointed, and decided to kill myself.

In addition, some participants were very hurt because they thought their children no longer respected them, as expressed by one participant (M).

I didn’t get married because I was illiterate and couldn’t find a good job after I left the army. Since Chinese sons traditionally never violate filial piety, I adopted a son when he was a baby. I worked very hard to save money to raise him and supported him in studying for his master’s degree. He is an engineer in a big company. He was extremely busy and visited me infrequently. Last year, he got married and had a son. I missed my grandson. So, I called and asked him to bring my grandson to visit me one day. He refused. His attitude was very rude, as if I was a worthless person. I am his father. I only asked to see my dear grandson. How could he treat me like garbage? I became so sad; I lost any reason for living.

Disputes with Friends or Workers

Participants described having arguments with their friends or workers before making suicidal attempts. These disputes mainly focused on money. As one participant (H) said,

I worked very hard to save money. I didn’t have any relatives in the world. I needed to save money to support myself. Mr. X said he planned to invest in a new business and could help me to make more money. I had known him more than 30 years and considered him a sincere friend. So, I went to the bank and withdrew all of my savings. How could I know his wife would take all his money and run away? I couldn’t blame my friend because he was also a victim. I could only blame myself for making such a stupid decision. I didn’t know how to live without any savings and couldn’t forgive myself. So, I took poison.

Participants also had some money problems with paraprofessional workers in the veteran homes. Their angry feelings are represented by the experience of participant D:

I used to withdraw NT10,000 at the beginning of each month to pay for my transportation to hospitals and for extra food. Since I couldn’t walk well, going to a bank became difficult for me. He [a paraprofessional worker] said he also needed to go
Difficult Adapting to Institutional Life

Changing one's living place is a big life event for all people, but it is an especially difficult adaptation for institutionalized older people. After moving into a strange place, they have to follow a highly structured daily schedule in the veterans' home. As one participant (D) said,

I felt that I had become useless. My daily life was full of eating and sleeping. I didn't make any new friends here. No one talked to me except the worker. He was busy too. Sometimes, I didn't say one word the entire day. Life was so boring. Why should I live to waste food? It could be used to save other people's lives. No one told me in advance that I was going to move to another room. One day, the worker came in and asked me to pack and move right away. Why me?

Similarly, Q said, “Personally, I felt that my mind was sick after moving here. I couldn't fit into the environment. It became harder and harder to get up and keep going.”

However, some participants felt that they were not treated respectfully in the veterans' home. Their life was controlled by workers, as described by one participant (G):

No one told me in advance that I was going to move to another room. One day, the worker came in and asked me to pack and move right away. Why me? My old room was fine even though one of my roommates snored every night. I felt that they [workers] did not respect me. I worked for the government when I was young. When I became old, my government took care of me. That was fair. But these workers didn't live through any wars, so they didn't understand our efforts to protect this country. They treated me only as an old and dying person. I refused to move, but still couldn't resist them. Why should I live in such a place without respect and freedom? However, I had no money to move to a nursing home. The longer I thought about my condition, the more I wished I could die right away.

Discussion

This study is the first to report the suicide experiences of older people in Taiwan. The older institutionalized veterans in this study described their suicide triggers in terms of five themes: illness and pain, death of close relatives or friends, conflicts with family members, disputes with friends or workers, and difficulty adapting to institutional life. Illness and pain influenced all these older people's daily activities: eating, sleeping, walking, and going to the toilet. They felt that their life was full of suffering. Worry about loss of control in an institutional environment also strengthened their intention to kill themselves. Some of our participants' suicidal experiences were similar to those from Western studies, such as illness (O’Connell et al., 2004), functional impairment, losses, and poor social support (Heisel, 2006). It is noteworthy that the majority of our sample had attempted to kill themselves more than once. This finding demonstrates the importance of paying close attention to older people who have previously attempted suicide.

On the other hand, our findings reveal that our sample of older veterans in Taiwan had some different suicidal experiences than older people from Western culture. These older people's expectations, based on their traditional Chinese upbringing, sometimes did not match changes in Taiwan's society. This cultural shift contributed to their negative feelings about their life. In Chinese society, family relationships form basic and strong bonds. Dying in one's hometown is a traditional belief in a natural and peaceful ending to life (Department of Education, 2008). Through social modernization and the influence of Western culture, individual needs and concerns have become more emphasized in Taiwan. The ties between people and their family of origin have thus become weaker (Tsai, Chung, Wong, & Huang, 2005). Even though these veterans moved to Taiwan over 45 years ago, they still wanted close connections with their family of origin and to die in their hometowns. War separated them from their family and created different living situations. The distance between these life situations may have been shortened by money in the first contact. However, the value systems of the two places may be quite different now, making it difficult to maintain relationships. Abandonment by family members had a great impact on these older people. They could not live with this feeling.

Family conflict was also associated with suicide in older people from Western culture (Waern,
Rubenowitz, & Wilhelmsson, 2003), but the problem may be more severe in Chinese society. In traditional Chinese culture, older people are accorded great respect and given the best care in the family. With the modernization and industrialization of Taiwan, the extended family has gradually been replaced by the nuclear family. Care and respect for older people have deteriorated in recent decades. Living in an institution already had a negative impact on these older people. This impact may be aggravated by loss of respect.

Due to lost productivity, money became a significant issue among these older people. Even though the Taiwan government provides welfare funds every month, it may not be enough to support veterans' living expenses. They worried that the policy of supporting veterans would end and tried to save more money. Arguments with friends or workers were mainly related to money. Helping these older people to manage their money is an important issue for administrators of veterans' homes to consider.

Older people tend to more frequently encounter the deaths of friends and partners than younger people. This problem is even worse for institutionalized older people who face the death of other residents more frequently than older people living in the community (Hou, 2004). Indeed, institutionalized older residents in Taiwan tend to reduce their social contact to avoid affective involvement with other residents, thus protecting themselves from having to face too much death (Tsai, 2002). Thus far, few studies have focused on developing educational programs about death and dying for older people and institutional workers. Such programs would enable institutional workers to spend time with older residents who survive the death of friends and family and provide support to help them through this process.

Moving is a stressful life event for all people, but older people may have less resilience than younger people to cope with a new living situation (Chen, 2002). Moreover, institutions use regulations and schedules to maintain an orderly lifestyle for their residents. New residents need to be accustomed to a new environment and a different daily routine at the same time (Tsai & Tsai, 2008). In addition, feelings of separation from family members and neighbors may induce negative feelings. Therefore, assisting residents to adapt to the new living environment is a key point to prevent suicide in institutions.

Our findings suggest that suicide prevention among older people in veterans' homes should emphasize three aspects: convenient banking and money management, staff education about dealing with older people as well as death and dying, and resident education about changes in Chinese/Taiwanese culture. First, institutional managers should consider facilitating older people's money management by installing at least one automated teller machine in veterans' homes. Another convenience would be to consider opening a bank branch in veterans' homes. Second, institutional staff should be better managed to maintain quality care of residents. Workers should receive training courses about communication with older people and education about death and dying. In the communication course, respect for older people should be addressed. Death education should include characteristics of people at high risk for suicide, detecting suicidal ideas, and discussing death with older people. Third, older people should be introduced to current social changes and beliefs in their regular monthly group meeting. These meetings could also include information about money management.

The mechanisms of suicide in older people have not yet been modeled or proposed. However, relationships between suicide and mental disorders, especially depression, have consistently been reported (Conwell & Thompson, 2008; Conwell et al., 2002; Hendin et al., 2008; O'Connell et al., 2004). Other factors related to suicide in older people include physical illness (e.g., neurological illness, malignancies), personality vulnerability, losses and poor social supports, functional impairment, and low resilience (Heisel, 2006) as well as previous suicide attempters (O'Connell et al.). Our findings shed light on suicide attempters’ experiences of suicide, especially what happened around the time of the suicide attempt. Unlike other qualitative studies that may focus on few demographic or ill risk factors, our study provides a broad scope for understanding these institutionalized older people’s life experiences and the triggers for their suicidal behaviors.

Our findings suggest that the risk for institutionalized older people to complete suicide may be influenced by physical (illness and pain) or emotional (death of close relatives or friends) losses; changes in relationships with family members, friends, and institutional staff; and their adaptation to institutional life. Therefore, these suicide triggers could be incorporated in future studies to elaborate a new model for predicting suicide in this group. After model testing, a new prevention program for suicide might be developed. This new
model might be suitable not only for residents of Taiwanese veterans’ homes but also for other institutionalized older Chinese people due to their cultural similarity. Regardless of culture, all institutionalized older people may share similar environmental factors, such as separation from family and friends. Therefore, the present study may also serve as a reference to establish a theory for suicide among institutionalized older people in Western countries.

Current suicide prevention programs for community-dwelling older people have focused on depression screening and follow-up (Mann et al., 2005; Oyama et al., 2004, 2006). Our findings suggest other strategies that may be incorporated into clinical practice. A formal training course in suicide prevention is recommended for institutional staff. They should be made aware of these suicide triggers and learn to regularly assess suicide risk among residents. When a resident encounters life events that might be suicide triggers, such as physical or emotional losses and changes in relationships with family members, friends, and institutional staff, suicide risk assessment and prevention are necessary. Moreover, our participants who expressed difficulty adjusting to institutional life had lived in a veterans’ home 1-16 years. This time range implies that no matter how long an older person has been living in an institution, adapting to living there is an ongoing and difficult struggle. Thus, it is important to regularly assess residents’ feelings and concerns about institutional living along with other suicide triggers. Because most institutions have contact with clinics or hospitals for their residents’ medical care, health care providers in those clinics or hospitals should also receive training in suicide prevention, similar to that for institutional staff. With such training, health care providers could then be sensitive to suicide triggers and provide further professional assessment and treatment at an early stage. Finally, the suicide prevention training should be regularly offered and evaluated to ensure that all new institutional staff and affiliated health care providers have appropriate training and that old institutional staff and health care providers have up-to-date suicide knowledge.

This study had three limitations. First, the sample was all male. Women’s experiences of suicide might differ from those of men. Older women in general have been found to be more likely than men to attempt suicide, but men more often complete suicide (Pearson & Brown, 2000). Further studies are needed to explore the gender issue in suicide experiences of older people. Another limitation is that residents of veterans’ homes may be different than other institutionalized elders. As mentioned earlier, veterans’ languages, habits, and value systems were different from those of the local people in Taiwan. These differences might also lead to different explanations about their life (suicidal) experiences than for other institutionalized elders. Residents in other kinds of institutions, such as elder care or nursing homes, should be recruited in future research on the suicidal experiences of institutionalized older people. Third, the study sample was small to allow an in-depth analysis of participants’ experiences as is characteristic of qualitative studies. However, this limitation was minimized by saturation of the data.

**Conclusions**

This study adds to our understanding of institutionalized older people’s subjective experiences of suicide, especially events that might have triggered their suicide attempt. The findings demonstrate a need for and provide direction to develop suicide prevention programs for this group. In addition, the themes identified in this study can be incorporated into developing a comprehensive model of suicide among older people.

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**References**


