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Tools, strategies and qualitative approach in relation to suicidal attempts and ideation in the elderly

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Abstract *The article analyses the quality and consistency of a comprehensive interview guide, adapted to study attempted suicide and its ideation among the elderly, and imparts the method followed in applying this tool. The objective is to show how the use of a semi-structured interview and the organization and data analysis set-up were tested and perfected by a network of researchers from twelve universities or research centers in Brazil, Uruguay and Colombia. The method involved application and evaluation of the tool and joint production of an instruction manual on data collection, systematization and analysis. The methodology was followed in 67 interviews with elderly people of 60 or older and in 34 interviews with health professionals in thirteen Brazilian municipalities and in Montevideo and Bogotá, allowing the consistency of the tool and the applicability of the method to be checked, during the process and at the end. The enhanced guide and the instructions for reproducing it are presented herein. The results indicate the suitability and credibility of this methodological approach, tested and certified in interdisciplinary and interinstitutional terms.*

Key words *Suicide attempts among the elderly, Suicidal ideation in old age, Semi-structured interview, Quality and precision of research tools*

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Introduction

This article presents a methodological study that uses a comprehensive interview[1] as a strategy for discovering what the elderly think about the situations that lead them to prefer death or to make choices that place their lives at risk. The proposition of a comprehensive interview is that such a conversation with a purpose can be measured against a semi-structured guide, but treated as orientation for more in-depth consideration of the matter. In this case, semi-structuring of the questions was important to include the main points covered by the related literature, and because it served a large group of researchers. The text discusses *attempted suicide by the elderly from a public health viewpoint*[2], with a view to understanding the impact of physical, neurobiological, psychological and social problems and their combined effects in this type of occurrence. The research was supported by the National Council of Scientific and Technological Development (*Conselho Nacional de Desenvolvimento Científico e Tecnológico - CNPq*).

The suitability of the tool was jointly assessed by a network of researchers from twelve university and research institutions in Brazil, Uruguay and Colombia, who conducted the survey. The version submitted here encompasses criticisms and suggestions from the aforementioned group, after conclusion of the field work. The focus of the dialogue was on the elderly themselves, and they also contributed to endorsing the tool and the method, insofar as they showed its suitability for guiding the account of the reasons that lead them to attempt or ideate suicide. It should be noted that knowing how to conduct an interview on the matter is crucial, in that this subject is taboo for families, the social and health services and in the community[3-5] not only in Brazil[6], but also in other countries.

Attempted suicide refers to the acts of an individual who intends to kill him/herself, but that does not result in death. *Suicidal ideation* materializes in various degrees of intensity of the idea of killing oneself[7,8].

Minayo and Cavalcante[9] assessed 75 articles on suicide attempts by elderly people worldwide, between 2002 and 2013. At the beginning of the first decade, the researchers' main focus was on depression, followed by analyses of its association with chronic illness and personality disorders. In the first decade, it could also be noted that the sources of the majority of articles on attempted suicide by the elderly were authors from North America, Europe and Asia. At the end of the first decade of the 21st century, many of these researchers started to look deeper into schemes for prevention, as can be seen in articles by researchers in Japan, China, France, England, Germany, the United States and Canada.

The start of the second decade of the 21st century shows great diversification between studies of attempted suicide according to country and continent. The first investigations commenced in South America, studies intensified in the Asiatic countries, but Africa is still absent from the scientific literature on the subject. The view on self-inflicted death attempts also expands and becomes more complex: by age band (older elderly people being acknowledged to be the most vulnerable); many authors start to consider the biography of those who attempt suicide; differences of gender, ethnicity, specific groups, such as war veterans and the homeless, and more in-depth analyses are conducted on the relation of attempts and ideations to family and micro social problems. Attempts and ideations also appear associated to social isolation, anxiety, low quality of life, cognitive disorganization and the hopelessness of old people with psychosis, as well as the existence of depression. The literature moves towards agreement that it is possible to predict and prevent attempted suicide by elderly people, with depressive symptoms, who try to kill themselves and have suicidal ideations, insofar as the factors that unleash such behavior are worked on. But, it is recognized that there is always the involvement of volition and of wishes of a person undergoing extreme suffering when he commits such acts.

It was noted that attempts are generally treated in juxtaposition with studies of suicide, in both epidemiological and qualitative investigations[9]. In such cases, interpretation is based on psychological autopsies, derived from family accounts and reports, and does not mention the person at risk. The aforementioned review[9] encountered a predominance of epidemiological investigations (94.7%), based on secondary data from health service files, population statistics, results of surveys, psychological tests and neuropathological analyses. In such cases, the investigations tend to take neither the context nor the subjects into account. On the other hand, studies based on qualitative research encountered in the literature present theoretical series, in applying the methodology and in the analyses. In the 90s, Lester & Thomas[10] already stressed the hegemonic trend of studies by standardized questionnaires based on secondary data, and made

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recommendations for the interactional relations and lifestyles involved in suicidal behavior to be examined *in loco*.

In this approach, the importance is stressed of combining clinic, social and epidemiological evidence with arguments of the elderly people themselves about their existential trajectory and their reasons from giving up on life.

Method

A qualitative investigation was developed with a hermeneutic-dialectic approach[11], which takes into account opinions, beliefs, representations and the internal contradictions of these cultural articulations. The raw material of this type of research is comprised of the following philosophical and sociological categories: *practical experience*, learning from the actions and place that the person occupies in the world; *subjective experience*, the result of personal reflection on experience[12]; *common sense*, made up of opinions, values, beliefs and ways of thinking, feeling, relating and acting, extracted from practical and subjective experience and translated into language, attitudes and conduct[13]; and *social action*, which is the common and, at the same time, contradictory exercise of individuals, groups and institutions in constructing their lives, their stories and their institutions[14].

From a theoretical viewpoint, the study was based on the vision of Shneidman[15], who described the various degrees of disturbance as a result of which a person becomes an enemy to their own self; and on the psychosociological perspective put forward by Bertaux[16], who looks deeper into the relation between biography and life in society; on the classic vision of Durkheim[17], who defines suicide as an event in which the personal and psychological factors become present in specific social contexts; and on the recommendations of Lester & Thomas[10], who suggest the use of studies that establish a nexus between context, social aspects and subjectivity.

The hermeneutic-dialectic method of analysis, used here, leads researchers to seek to *understand,* to put themselves in the other's place, considering their history and singularity; *interpret* the words, seeking their meaning in the context, in conjunction with the advance in understanding of the subject; *debate,* i.e., contrast and criticize the narratives and the biographies in the light of the historical time and protagonism scenario of the subject who faces the subjective, social and cultural stresses[11]. This method was used both for the empirical approach and to analyze the material collected in the field, including in the shared observation.

Evaluation criteria used for adjustment of the tools – We followed the thinking of Golafshani[18], according to which, instead of looking for the validity and reliability of the terms used in quantitative studies, we focused on *the suitability, quality and credibility* of the tool and the method, in terms of both content and procedures, with a view to their replicability. The criteria of *credibility and quality* were followed in preparing the guides, based on an extensive review of the literature, the significant points of which were transformed into guide items. Meanwhile, the criterion of *suitability* was worked on in the process of building up the guide and treated in depth in the discussion of the pertinence and sensitivity of the questions for guiding the conversation with the elderly person; this was done in an online discussion group throughout the course of the field work; and at the end of the work, through a more systematic analysis of what had or had not worked, what was redundant or excessive and what would need to be added.

Operational tools – The main research tool was the interview guide, preparation of which respected the need to guide researchers in different places in their fieldwork and analysis of the material. The preparation was inspired by three sources: an international guide, *Guidelines for Suicidality*[19], produced by the *Suicide Risk Advisory Committee of the Risk Management Foundation of the Harvard Medical Institution;* the work of Sampaio[20], which presents an integrated view of the phenomenon of suicide; and the contributions of Shneidman[21-23]. In effect, Shneidman[22,23] did not systematize any interview guide, he only presented categories to steer the studies, as he always sought the plurality and expansion of vision about the phenomenon.

Procedures

A manual was built up that contains all the procedures foreseen and agreed upon by the research group for preparation of the study, the fieldwork and data analysis. The manual describes: (1) the tools tested and evaluated for conducting the *interviews* with elderly people and, if necessary, with professionals involved with caring for the health of the elderly person or with family carers; (2) the strategies for *case studies;* and (3) the

type of *organization, standardization, sharing and analysis* of the data produced by the field material, situating individual, social, local and regional specificities related to the elderly person, guided by the *hermeneutical-dialectic method*.

Qualitative evaluation of the manual containing the guides and the procedures. The task of preparing the manual took place in a capacity building workshop for all the researchers, who then participated in the use, critique and evaluation of the tools and the analysis procedures. The same seminal group replicated the training for their local field research teams[2,5,6]. At the end of the investigation, the senior researchers, responsible for the work in the various locations (in the five regions of Brazil and of two Latin American countries), re-read the manual and analyzed the tools and proposals for analysis.

Sixty interviews were conducted with elderly people and 28 with health professionals in 13 Brazilian municipalities (88 in all), four with elderly people in Montevideo and three in Bogota. Six health professionals were also heard in Bogota. A total of 101 people were interviewed.

The *research network* included 53 people in Brazil, four in Uruguay and nine in Colombia. 10 Brazilian researchers and two foreigners were involved in local coordination of the work. The general coordination was carried out by two Brazilian researchers. The teams that participated in the investigation are multidisciplinary and included public health professionals, psychologists, nurses, social workers, doctors, anthropologists and sociologists, who work in research nuclei or work in institutions such as hospitals, Psychosocial Care Centers (*Centros de Atenção Psicossocial - CAPS*), Integral Care Centers for the Best Age (*Centros de Atenção Integral à Melhor Idade – CAIMI*), or are involved with the management of hospitals, health care units and epidemiological surveillance centers, as well as Masters and Ph.D. students.

Access to the cases – All the teams had great difficulty in finding and accessing cases of suicidal attempts and ideation among the elderly. It was therefore necessary to contact a three to six times greater number of people in order to obtain the proposed sample of at least five people per location. The theme of suicidal behavior constitutes a taboo and stigmatizes the person and their family, and there is therefore a subtle tendency in the domestic sphere and in the services to conceal rather than throw light on the episode. Many elderly people had difficulty and were ashamed to speak about the matter. Among the reasons detected in the field, the marked under-notification of the attempts, and even more so of the ideations drew our attention, because the health professionals and services themselves tend to afford little significance to the cases and maintain disorganized and incomplete records. The most successful part of this experience was activation of the networks of professional contacts working in hospitals, health care centers for the elderly (*CAPS* and *CAIMI*), in Family Health Strategy (*Estratégia de Saúde da Família - ESF*), Long-Term Institutions (*Instituições de Longa Permanência - ILPI*) and in Health Surveillance Centers. Specific people in these services helped us to sift through the record cards in which suicidal behavior was mentioned, above all, in recent cases. We stress the collaboration of community health agents who were aware of the events and were fundamental facilitators in accessing the cases.

Organization of the data in case studies – The interviews, their systemization and preliminary analysis were conducted by pairs of researchers and the fieldwork generated data which was sorted, standardized and then organized in the form of case studies, and finally, submitted to various analysis procedures. The reports from each location took into account multiple dimensions of the life story of the elderly person that culminated in the suicidal behavior.

Systemization of the local analyses and of the interviews as a whole – A second workshop was held after the fieldwork with a view to an individual and collective critique of the findings in the field and of the guide used to steer the researchers. Correction of the tools and the procedures was processual and confirmed by the interaction of the group of researchers who conducted a contextualized review of the tools, the proposals for changes in the guides and the ways in which they were applied. A situation report was drawn up on the process of selecting cases and the strategies used in data organization and analysis. Finally, the coordinators presented the steps of an analysis of the whole which included all the field material and the preliminary analyses performed locally, based on the frequency of relevant data and hierarchy of variables[6].

Results

Four tools were used for the interview: (1) *Identification form* of the elderly person who attempted suicide or is overwhelmed by thoughts of death; (2) *Interview guide* containing 56 simple and

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composite questions about social characteristics; biography and way of life of the elderly person; description of the attempts and ideations, of the mental state of the elderly person and the risk circumstances; The person's view of their thoughts of suicidal behavior and of the repercussions on their family; and access to some kind of support in the face of the critical event; (3) *Additional interview with a family member,* with six questions – if it proved necessary to contact them, as the focus of the research is the conversation with the elderly person – to understand unclear points in the interview with the subject; (4) *Interview guide with professionals operating in care for and attention to the elderly person,* with eight questions – also if the researcher considers it necessary – seeking to understand how they and the institutions in which they work deal with the risk of self-inflicted death.

Identification form – This form contains a detailed record of the characteristics of the elderly person and their family. In this respect, it is necessary to emphasize the need to maintain confidentiality about the names of the people mentioned, and also to have the interviewees sign the Consent Form, stating their willingness to provide information. The identification form (Chart 1) complements the interview guide (Chart 2) and certain data, such as information about attempts and ideations, needs to be filled in at the end.

Chart 1. Identification Form.

Name:		
Date of Birth:	Age:	Sex:
Marital Status:	Nationality:	Ethnicity:
Race:	Educational Level:	Occupation:
Income of the elderly person:	Family income:	Religion:
Living with (family, alone, in Long-Term Institutions – ILPI, or other):		
Address:		
Current occupation:		
Family group		
Spouse (current):	Age:	
Educational Level:	Occupation:	
Children (age):		
Educational Level:	Occupation:	
Other unions, marriages and children:		
Complete at the end		
Attempted Suicide*		
Number and lethality:		
Method(s) used:		
Gravity:		
Place:	Date:	
Time:		
Ideations*		
Frequency and Intensity		
Method(s) considered:		
Suicide plan:	Gravity:	
Relevant comments:		
Did any family member respond to the interview?		Relationship:
[ ] Yes [ ] No		Age:

* The information should cover all the attempts and ideations.

Chart 2. Interview Guide for studying attempts and ideations.

Part one – personal and socio-economic profile
I) Initial Contact 1. Explain about the research, ensure informed consent to the interview, create an atmosphere of empathy and ensure confidentiality in respect of personal and family identity. 2. Reading and clarification of the Consent Form for the interview; 2. Filling out the identification data; 4. Target audience: individuals over 60. **II) Social Profiling** 1. Talk about the former or current occupation and its importance to the individual. 2. Talk about their current activities. Their opinion about them. 3. Income and sources of family income. Does the individual use their wages to help their family and children. Or does the individual have no income and are they supported by the family. 4. Does the individual own the house in which they live. 5. If the house is theirs, does the person continue to occupy the same space in it as previously. Or have they been put in a different room to make space for the children. Do they like the place they occupy in the house. 6. If they are in a relative's house, how do they feel: welcome? isolated? a participant? purposeless? **III) Way of life** 1. How the individual occupies their time: do they take care of the house; take care of the grandchildren; visit friends; take part in associative activities. 2. How has the individual been feeling recently in relation to retirement, aging, health. 3. How does the individual react to difficult situations What upsets them most. 4. Does the person frequently feel sad, isolated, useless and without purpose in the family or where they live. 5. Does the individual feels depressed; do they take medication for depression; are they receiving psychological care. 6. Does the person suffer from an illness that worries them; do they have any disability; do they feel much pain; do they have a nervous complaint. 7. Does the person have relationship problems with their family; or with their friends. 8. Is there someone in the family who gives the individual more care and affection. Identity of this family member. Why do they consider them important at this time of life. 9. Who provides support when the individual needs it. 10. Does the individual have a professional carer. 11. Has the individual already dealt with loss situations that have greatly affected them: children, spouse, brothers and sisters, friends, job, assets. 12. Has the individual suffered violence during their life, at work or after growing old. Take into account verbal, psychological, physical, sexual and property-related violence. 13. Does the person practice a religion. Do they participate in any religious group. Does this help them to cope better with life's difficulties.

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Interview Guide – It should first be stressed that the following guide, divided into two parts, was not conceived as a questionnaire, but as a list of important matters to be looked into in depth in the conversation with the interviewees. The first contains the personal and socio-economic profile and detailed information about the living conditions of the elderly person, in their biographic context. The second considers the circumstances of the attempts and the ideations, the precipitating factors and the impact on the elderly person's health and on the family. Organizing the tool in stages of increasing complexity permitted a gradual approach to the critical event, in a biographic contextualization that anchors the subject in their history. The orientation was for the approach to the elderly person to take place in the form of a fluid and informal conversation, in an atmosphere of empathy and of care for their fragility. However, *flexible use of the guide* was recommended, leaving it open to the inclusion of topics and subjects introduced by the in-

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Chart 2. continuation

Part two – Atmosphere and impact of the attempt and ideation

IV) Assessment of the Atmosphere of the Attempted Suicide

1. How does the individual describe their attempted suicide. Had they thought much about it beforehand.
2. How does the individual describe the reasons they had for trying to kill themselves.
3. Had the individual planned the attempt. Did they advise anyone of their intention.
4. Where (place) and when the attempted suicide occurred (date, day of the week and time).
5. Does the person remember the time that elapsed between the attempt and the care they received from someone. Who found them and under what circumstances.
6. Was the individual taken to a first aid post. Who accompanied them.
7. How does the person evaluate (whether or not they approved of) the care received in hospital or other health services.
8. Had the individual already attempted suicide on other occasions Ask them to describe what happened.
9. Had family members or neighbors of the individual already committed suicide or tried to kill themselves. If affirmative, did this make an impression on them.

V) Evaluation of the suicidal ideation

1. Did the individual have ideas, thoughts about or the desire to take their own life.
2. Are the ideas frequent. Does the individual think a lot about this.
3. Has the individual already thought about how they would kill themselves.
4. What reasons does the individual give for thinking about suicide.
5. Has the individual already talked to someone about their death ideations.
6. Does the individual think they need help to drive away such thoughts.
7. Is the person monitored by any health service

Note concerning how to assess the time of the attempted suicide[24]

(1) Acute suicidal crisis (period of high lethality) - short-lived interval, over some hours or days, with a rapid release of emotion and self-destructive attack;
(2) Ambivalence present to a greater or lesser degree. To some extent, individuals who attempt suicide do and do not wish to die;
(3) The existence of a relational aspect, i.e. of a significant element that transforms the self-destructive gesture into a way of behaviour and communication
(4) Specialized evaluation from a medical viewpoint – knowing whether or not it was serious

Check the following indicators: the severity of the attempted suicide, the lethality of the chosen method and its visibility and proximity to sources of help.

Elevated severity criteria: violent methods; attempt by the individual when alone; previous threats of suicide; premeditation. Elderly males are more vulnerable.

Evaluation of the suicidal intent: (a) non-existent: lacking ideation or plans; (b) slight: ideation with no specific plan: (c) moderate: ideation with a plan to kill oneself; (d) severe: frequent and intense ideation, with a lethal plan and available means; (e) extreme: clear intention to commit suicide and frequent seeking of an opportunity; presence of many risk factors[24].

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terlocutors, adjustment of the questions to their language and prioritizing spontaneous progression of the conversation. However, it was suggested that all the researchers should look into the guide's eight central topics in depth, whether because they include the set of assumptions based on the bibliography studied about the matter in question, or to permit comparability of all the documents resulting from the fieldwork. Particular attention was also paid to the amount of time spent on the interviews, to avoid emotional exhaustion on the part of the interviewees. The researchers were advised to value and preserve in their entirety the words of the elderly person. On account of all the points stressed here, we recommend that no-one should replicate this guide without prior training[24] (Chart 2).

Guide for interview with the family – The complementary interview format provides guidelines for a conversation with a family member – main-

Chart 2. continuation

Part two – Atmosphere and impact of the attempt and ideation
VI) Mental state that preceded the attempted suicide (if able to reply) 1. How the individual felt mentally prior to the attempted suicide. 2. Did the individual nourish feelings of guilt, sadness or despair. 3. Did the person feel depressed, uneasy or agitated. 4. Did the person feel confused or did their thinking appear to be different. 5. Did the individual hear voices or think they had visions. 6. Did the individual receive attention to their situation from any community, health or religious organization. If affirmative, for how long and what recommendations were made to them. 7. If the individual has been seen by a psychiatrist or psychologist. If affirmative, for how long and what recommendations were made to them. 8. Does the individual use any medication If affirmative, which and how much (note down). 9. Has the individual already been attended to by the CAPS in their municipality. Did they approve of the care or not.
VII) Impact on Health and on the Family 1. If the individual feels that the attempted suicide affected their health: physical, organic, psychological, functional or social. 2. How the individual feels about the family's reaction to the attempt to end their life. If there is someone who specifically cared for them, how the individual assesses their reaction to the act. 3. Does the individual believe there was some kind of conflict between the members of the family because of their attempt to kill them self. Also, was there any change in the way family members treated them after the act. 4. Has the individual received any support or care from the family, since the attempt. 5. Does the individual feel that their family needs help in dealing with the problems that led them to suicide. If affirmative, prompt talk on what this help should be.
Check the following indicators of the elderly individual's interaction with the family: Types of communication: open with criticism, implied, veiled and with secrets, insufficient, or containing double messages; The barriers between individuals: mixed, rigidly marked or flexible. Family system types: cohesive, united, separated, conflictual or cohesive-conflictual: Establishing of rules and limits: the explicit or otherwise nature of rules, inflexibility or flexibility in the face of change and the ability of individuals and the family group to adapt to new life challenges.
VIII) Getting over the Attempts or Ideations 1. Does the individual think they have overcome the thoughts of taking their own life. 2. If they have overcome them, to what does the individual attribute this positive change in their life. 3. If they have not overcome them, how do they feel they could be helped. 4. Does the individual feel that the family helps them in the process of overcoming. 5. Did the individual receive professional help in dealing with the problem, after the attempt. 6. At the current time, what does the individual consider most important in their life. Do they endeavor to achieve what they wish for. 7. Would the individual, at this time, like to change anything about their way of life. 8. How does the individual see the future and act to achieve this.

ly with the carer - about the critical events that led the elderly person to attempt suicide: social, economic, family, relational, personal, physical or mental health or neglect (Chart 3).

Guide for interview with professionals - This tool guides the researchers' conversations with professionals about their knowledge of the existence of attempts and ideations among the elderly and the reasons for these; about how the health, care or public safety institutions deal with the problem; and about what they think could be done to prevent extreme suffering linked to the risk of suicide (Chart 4).

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Chart 3. Complimentary interview with a family member.

Name:_____ Age:_____
Family relationship: _____

1. Did the family member notice that the elderly person showed or shows ideas of ending their life.
2. Did the family member notice that the elderly person is or was experiencing this problem.
3. How the family member describes the daily life of the elderly person from a personal, relationship, family, social, economic and mental and physical health viewpoint.
4. Does the family member believe that the person has reasons for killing, thinking about, or attempting to kill themselves.
5. Does the interviewee think the family knows how to deal with the elderly person's ideas and intention to die.
6. Does the interviewee think the elderly person or their own family need help in order to cope better with these events.

Chart 4. Guide for Interview with professionals.

Name: _____ Age:_____ Educational level:_____
Profession: _____Position:_____ Length of service:_____
Experience with the elderly:_____ Time since graduation:_____

1. Based on their experience, to what does the professional attribute the fact of elderly individuals attempting suicide.
2. How does the professional identify the occurrence of suicidal ideations and attempts among the elderly people they attend.
3. How does the professional behave towards an elderly individual who has attempted suicide or has intense and persistent ideations. Do they appeal to any institution.
4. What difficulties does a professional face in detecting, assessing and redirecting cases of individuals at risk of suicide.
5. Does the professional belief that the social care, security or public health service systems (AT, CAPS, ESF, CREAS, CRAS, DP) are prepared for attending to elderly individuals at risk of suicide. If negative, describe the main problems.
6. What does the professional thinks could be done to prevent the extreme suffering that leads elderly people to want to take their own life. Whether and how the services could do more.
7. Does the professional know of any manual to guide professionals in caring for people at risk of suicide. If so, do they use it.
8. Is the professional familiar with the WHO SUPRE-MIS manual, which advises professionals on caring for people at risk of suicide.

Organization of the cases

An overall analysis of the field data has been described in other studies[6,7]. The purpose here is to speak about how the cases were and could be organized and prepared for analysis. We present a strategy for combining and standardizing the data from the identification form and the interviews. Chart 5 shows the *Data organization guide* with three organizational methods: (1) information that identifies the case and describes the attempt and the ideation, detailing the circumstances associated to the event, including the sociodemographic data of the interviewee; (2) Data that contextualizes the attempts and the ideations in the individual background: personal and social characterization of the elderly person, biographic information, mental state, motivation and relevant facts, precipitating or stressing factors and effects of the suicidal behavior on the family; (3) The professionals' view of the signs, the gravity and the reasons for the attempt and ideation, difficulties in detecting, assessing, redirecting and preventing risk cases in the care network. (Chart 5).

Socio-anthropological data organization guide – The purpose of this tool this to organize data with a socio-anthropological contextualization. It includes information about the urban or rural characteristics of the various regions studied, situating the ethnicity of the participants, the social and economic conditions and whether or not the community has an active social life, with specific leisure, sociability and social and health facilities for the elderly person (Chart 6).

Chart 5. Case study organization guide.

I) Identification data for the case of attempt or ideation
• Criteria for choosing the case • Interviewee's details • The individual's information about the suicide attempt and ideations. • Methods used and circumstances of the attempt (elderly person's account and medical report)
II) Studies of the individual cases
• Personal, social and family description (social profiling). • Biography of the person who attempted suicide (self-portrait and lifestyle). • Mental state that preceded the attempt (psychiatric and psychosocial risk). • Evaluation of the setting of the attempts and ideations (circumstances before and after the act). • Impact of the event on the family (view of the act, reactions and impressions). • Summary or final comments (relevant points should be highlighted).
III) View of the professionals
• Identification of signs and causes attributed to attempts and ideations among the elderly. • Assessment of the severity of the situation and ways of dealing with it. • Difficulties in detecting, assessing and redirecting cases of risk of suicide. • Limits and possibilities of the care system in the health area. • Prevention of extreme suffering and suicidal behavior among the elderly. • Suggestions for improving the strategies for prevention of suicide and care for the elderly.

Use of the hermeneutical dialectic method in the study of attempted suicide and ideation

The comprehensive process of the suicidal attempts or ideations in elderly people started with an in-depth preliminary analysis of each case. In the study mentioned[1,2], the researchers reorganized the material: (1) a comprehensive description of each episode in accordance with historical and contextual data, risk and protective factors, relevant facts, motivations or suicidal intent; (2) evolution and dynamics of the case (flow of events, aggravating factors such as illness, comorbidity and critical affective, social or economic circumstances and consequences on the personal life); (3) description of the attempts and the ideations and the impact on the family according to the means used, state in which the elderly person was found, effects on or of physical and mental health; (4) reflections on reasons for the attempts and ideations obtained from the discursive and behavioral pointers and conjectures about the case. The objective of this stage was to stress the most relevant factors from the viewpoint of the elderly person and to correlate them in a circumstantial way, while at the same time noting the contradictions between their words and their behavior.

Following on the preliminary analysis of the individual cases, a logistic was set up for making all the material available in a common databank

Chart 6. Socio-anthropological data organization guide.

1. Main features of the municipality: urban or rural. 2. Social formation of the municipality and origin of the population. 3. How is the municipality currently organized economically, socially and culturally. 4. What are the people's lives like in terms of health, education and security services 5. Are there social facilities for the population: clubs, religious groups, community, leisure, cultural and tourism activities. 6. Characteristics of the elderly population of the region, above all what services are available to them: (Healthcare, Social Centers, Life Enhancement Centers, CAPS, etc.). 7. Summary of the situation, living conditions and care for the elderly in the location.

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accessible by all the researchers responsible for the final elaboration, with a view to building up a *qualitative and at the same time singular, local and compared analysis*.

The two research workshops described previously were essential in ensuring cooperative work, within common parameters. While the first produced an initial improvement in the tools, defined the fields and agreed on the care and procedures for data collection, the second promoted shared reading of the cases collected. The first meeting brought together the researchers who participated in the local and general coordination, while the second was expanded and also included a representative percentage of the local teams (23 researchers) over two days of intense work, defining improvements in the final organization of the data and establishing a consensus about the relevant categories that should be analyzed at greater length.

Ten analysis categories were selected from the material: (1) factors associated to the attempts and ideations in elderly people; (2) diagnosis and administration of medication; (3) weight of the chronic illnesses and dependence; (4) socio-familial relations associated to the suicidal behavior; (5) subjective and social life experience associated with attempts and ideations; (6) risk of suicide and religiosity; (7) attempts and ideations as a way of "calling attention"; (8) differing subjective life experience of men and women; (9) processes of overcoming; (10) services and care network for elderly people at risk of suicide.

The data was worked on in the countries of origin, Brazil, Uruguay and Columbia, sharing the methodology and production of articles. In Brazil, the database placed at the disposal of the whole team was organized into six compartments: identification forms for the elderly; interviews with elderly people; interviews with professionals; socio-anthropological data; analytical categories and preliminary analysis of the cases. Standardization of the analytical categories was organized into nuclei of meaning made up of associated ideas and significant conversations.

On reviewing the tools at the end of the research, some researchers suggested that at least two members of each local team should be included in the preparation workshops. Also that a third seminar should be organized on termination of the investigation, to share the knowledge acquired.

Finally, it should be stressed that the team that carried out the research is familiar with the use of the qualitative method in studies of suicidal behavior among the elderly, as they have been working together for five years. It is worth mentioning, for those who apply the tools, that investigators of this matter need to be people of personal and professional maturity, in view of the contact with a group of extreme physical, emotional, medical, social and environmental vulnerability.

Discussion

Once the tools have been presented in their final format, points that have guided their enhancement and use will be discussed, in view of the necessary care in respect of their logic and internal coherence, with a view to making suggestions for their use by other researchers.

The following were important points in ensuring the quality of the work: (1) the training workshop held at the beginning with the group of senior researchers and those organized for the local teams, all based on the manual, which standardized the procedures by mutual consent; (2) access by all the investigators to the literature on which the research assumptions and hypotheses were based; (3) the workshop held after completion of the fieldwork and the preliminary analysis process, in which the subject matter and evidence from each interview was shared; and (4) collective deliberation which established, in consensus, the relevant matters identified by the fieldwork.

The team expanded inside and outside Brazil and this permitted dissemination of the methodology in a further two Latin American countries. *In loco* training was provided by the general coordinators for the Bogota group as well as a group orientation session for the Montevideo group. The starting point for the local Brazilian teams was the sharing and discussion of the Research Manual. Some proceeded systematically, reproducing the workshop held with the senior researchers; others employed the tools by dramatization and simulation in the form of role-playing, to familiarize the team with the interview situation. In this respect, the focus was on the place of the interviewee and the interviewer, the development of feelings of empathy and acceptance and the posture of avoiding judgment in the light of the interlocutor's account.

The majority of the research teams had to submit the project to their local Research Ethics Committees, even though the research had been approved by the Committee of the Oswaldo Cruz Foundation, where the survey coordination was

located. The delay in redirecting and authorization by these Committees impeded or made the study unfeasible in certain areas. After the whole process was approved, Brazilian teams tried to access hospitals and service and care networks for the elderly. In many cases, they were unsuccessful, on the grounds that there was no record of attempts in their units, which once again is evidence of the taboo surrounding treatment of the matter. The strategies that were most helpful in reaching the cases were the networks of professional relationships and the informal conversations in universities and communities: in the services, the Long-Term Institutions, the Psychosocial Care and Family Health Strategy Centers. However, even teams that experienced less difficulty were surprised by the barriers to access to the cases. A number of contacts and the physical presence of the researcher were necessary in order to establish a chain of confidence, with both the professionals and family members. In many cases, family members did not authorize the interview with the elderly person. It was also not easy to locate telephone numbers and addresses and some interviews held in the home only took place after much coming and going on the part of the investigators. The Uruguayan team conducted the study with institutionalized patients, and the Columbian team worked in psychiatric clinics. In both cases, it was personal contacts with professionals that facilitated going into the field.

A preliminary informal contact proved the best strategy for gaining the confidence of family members and the elderly, in preparing for the interview. A good way of communicating the objective of the research to the older person was to tell them that the intention was to converse with them about *their life story and their illnesses and suffering.* The researchers were advised to treat the interview as a time at which the elderly person could express their anxieties and feel they were being heard, and also to respect their moments of tears and silence. Conversation about such a delicate matter is known to mobilize a range of deep feelings. In cases of high risk and recurrent attempts, the interview does not provide relief. The researchers were therefore advised to seek aid, redirecting the people to the health services, particularly those providing psychological and psychiatric care. Interviewers are also recommended to make a phone call or even pay a visit, a few days after the meeting with the elderly person, to obtain feedback about the conversation they had and the ways in which the matter has been carried forward.

One of the problems of operationalisation of the interview occurred in cases in which the family member tried to stay with the elderly person and act as their spokesperson, rendering the conversation with the elderly person more difficult. Great efforts were made to hear them on their own, as the objective was to hear their reasons for the attempts and ideations. In cases where they pronounced themselves before or after the interview, the interviewers were advised to pay attention to crossed interference, facial expressions of discontent and comments that generally signal conflict in the domestic environment. However, in some cases, after interaction with the elderly person, conversation with a family member proved very enlightening, in providing a better understanding of their story. This procedure was only following as an exception.

The following were among the main difficulties experienced in applying the tools: the taboos and what is left unsaid in connection with the occurrence of the attempt and the ideations and which take the form of a stigma, discrimination and shame; recollections associated with the guilt, anger or rancor aroused by chronic family conflicts; discontent with the lack of support to elderly people by the public and care organizations; censure of the behavior of the person part on the part of their close relatives.

Based on the experience in the field, a number of changes were made to the research tools. The identification form was added to the race/ethnicity category. Information about profession, income and educational level of family members and the elderly, previously included in Chart 2, was carried over to this form. The form requests specification of who the elderly person lives with. Furthermore, details of ideation (frequency, intensity, methods considered, suicide plan and gravity) were also included in Charts 1 and 2. A fifth item about ideation and an eighth, about overcoming, were added to the interview guide, each having seven questions. The order of the questions was altered to improve the flow of the interchanges.

There were no suggestions for changes to the list of subjects in the guide, but it was emphasized that the questions, transformed into subject for conversation, should be treated simply and adjusted to the language of the elderly person, their capacity to understand and educational level. It is important to stress that in the fields, as was to be expected, certain researchers made more flexible use of the guide, while others followed it closely, tending to restrict something that was designed

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merely as a guide to a conversation with a purpose.

There was a consensus that the guide for interviews with health professionals was clear and objective. However, in the guide for hearing family members, personal or professional details were included in Charts 3 and 4. The latter was reorganized into six topics.

Finally, we stress once again that every question raised here derives from a solid theoretical base, grounded on accumulated worldwide knowledge. However, this theoretical weight has been continuously tested by its empirical suitability for listening to and understanding the speech and situation of elderly people. Accordingly, in this work, the hermeneutics of the cases have been checked, dialectically, against the general situation of the whole and of universal knowledge, thus creating what Marx aptly named "thought concrete"[25].

Final considerations

This study has a number of limitations. The first arises from the actual object of the study: the difficulties in gaining access to people were immense and many that the researchers would have liked to interview proved not to be available. The second derives from the fact that this is a first investigation of the matter in Brazil, which gives it a practically exploratory nature. The third concerns the diversity of places studied and the relatively few elderly people heard in each of them. However, the investigation needs to be continued and taken further.

The intention in showing the paths followed in the work is to enable it to be replicated and analyzed, which is essential in that there is no available Brazilian literature on the subject. Initial in-depth interview guides, techniques and strategies were therefore improved, particularly at the end of the fieldwork and preliminary analysis, by which time the research group was able to reflect on how their studies had progressed and take a critical and clearer look at procedures.

Attention should be drawn to the various forms of training, didactic material, the collection of articles shared with all team members and the on-going exchanges between the researchers. Face-to-face meetings, the availability of the databases and the operation of a communication network were ways of sharing ideas and interests, a common thread that aligned both the process and the results of the investigation. At the end, a written debate recorded the critical and reflexive thinking of the group, enabling a step-by-step review of the research.

The tools and strategies presented here proved to be reliable and appropriate, whenever proper care was taken in applying them. However, it is always worth remembering that methods and techniques are means always used by researchers in their work. What makes the difference is the researcher's understanding and empathy with people. This is what the study showed, when it succeeded, with a careful methodological approach, in revealing the taboo subject of suicidal attempts and ideation, breaking the silence and making room for hearing about situations in which guilt, secrets, shame and fear are interlaced. In such cases, the interviewers were able to contribute towards relieving the suffering of the elderly person, whether by showing them new ways of dealing with self-harm and self-neglect or by directing them to specialized care.

Finally, it is important to stress that the perseverance of all the researchers, which succeeded in revealing a type of extreme suffering of which many elderly people are victims cannot hide the invisibility of the suicidal ideations and attempted suicide that cry out for the care and understanding of family members, but also of the social services and health system.

Collaborators

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