

Counseling Older Adults at Risk of Suicide: Recognizing Barriers, Reviewing Strategies, and Exploring Opportunities for Intervention

Patricia Sawyer, Ph.D., Associate Professor, UAB Department of Medicine, Division of Gerontology, Geriatrics, and Palliative Care, UAB Center for Aging

Beverly Rosa Williams, Ph.D., Associate Professor, UAB Department of Medicine, Division of Gerontology, Geriatrics, and Palliative Care, UAB Center for Aging

Abstract

Age-related challenges to health and well-being among older adults give rise to a distinctive array of risk factors for suicide, calling for a unique approach to suicide interventions. Americans over the age of 65 are disproportionately overrepresented in the number of completed suicides. This paper examines the epidemiology of geriatric suicide, reviews age-specific risk factors for suicide, discusses interventional modalities for use with suicidal older adults, and describes the role of the counselor in geriatric suicide interventions. In particular, we focus on a gerocounseling perspective to guide strategies for intervening with older adults contemplating suicide. This model utilizes a multidisciplinary approach derived from the integration of physical, psychological, and sociological aspects of aging. Additionally we consider the potential for emerging therapeutic models promoting resilience, sense of coherence, and dignity to be incorporated into counseling services for older adults. Specific therapies discussed include Cognitive Reappraisal, Reminiscence Therapy, and Dignity Therapy. We conclude with a discussion of the potential application of the principles of palliative care in designing and implementing holistic approaches to counseling older adults presenting with suicidal ideation.

Background

Suicide is a phenomenon of public significance with implications on the personal, interpersonal, and institutional levels of society. Of considerable concern is the fact that the highest rates of suicide occur among older adults and the recognition that with the aging of the baby boom population this may be a problem of increasing magnitude (Van Orden & Conwell, 2011). While theorists and practitioners have contributed to our knowledge of the origins, manifestations, and management of suicidal behavior, there are unique challenges in intervention strategies when working with older adults. As scientists have explored the predisposing and precipitating factors associated with suicide, health care professionals have developed medical and psychosocial modalities for use in suicide prevention, intervention, and postvention.

Individual suicidal behavior can be viewed on a trajectory that includes suicidal ideation, attempts, and death (Van Orden & Conwell, 2011). Van Orden and Conwell highlighted the importance of intervening early in this trajectory. Thus, there is a blurring of classification between prevention and intervention when discussing actions to interrupt the progress from suicide ideation to attempts to take one's life. For example, activities generally labeled as "prevention," such as Suicide Prevention Hotlines can be seen as an intervention, requiring that individual thinking about suicide make an overt effort to seek someone with whom he/she can discuss thoughts and feelings.

Epidemiology of Geriatric Suicide

Describing the landscape of older adult suicide is the first step in identifying risk factors and understanding the unique characteristics of older adults who should be targeted for counseling interventions. Americans over the age of 65 comprise approximately 13% of the population, yet account for almost 19% of the suicides (Mental Health Association of Colorado, 2011). This is equivalent to "one elderly suicide every one hour thirty minutes" across the United States (Mental Health Association of Colorado). While this statistic is startling, it is even more striking that 83% of elderly suicides are among men, the majority of whom are white (Edelstein, Heisel, et al. 2009). Indeed, the rate of suicide for older black women is particularly low, 1.1 per 100,000 for women 55 years and older (Cohen, Colemon, Yafee, Casimer, 2008).

Older adults are less likely to attempt suicide, yet they are more likely to complete suicide (Edelstein, 2009). Over 75% of older men and 35% of older women used firearms to complete their suicide (Meehan, Saltzman, & Sattin, 1991). The scope of geriatric suicide is hard to ascertain due to societal pressure to attribute death by suicide to other causes. Because suicide data is abstracted from death certificates, this may not be a true reflection of the magnitude of the problem. Thus, the data presented here may underestimate suicide rates among older adults (Breiding & Wiersema, 2006). Moreover, research suggests that suicides are more likely to be attributed to injury of undetermined intent among people of color, perhaps contributing to higher reported rates of suicide among whites (Rockett et al., 2010).

Additionally, while it is often assumed that older adults attempting suicide are suffering from chronic disease at the end of life, only a small number (2-4%) have been diagnosed as being terminal (Mental Health Association of Colorado, 2011). Moreover, 70% of older adults who died by suicide had seen a health care provider within a month of their death (Edelstein), and 20% had seen a physician with 24 hours of completed suicide (Luoma, Martin, & Pearson, 2002; Conwell, Lyness, Duberstein et al., 2000).

Characterizing Older Adulthood

While this discussion uses chronological years as the basis for discussing older adulthood, it is only one perspective from which to view the aging process. Functional ability interacts with societal expectations and attitudes to influence personal perceptions of age (Chudacoff, 1989). The experience of "feeling old" has been associated with poor physical ability and health, and may be more prevalent among persons of lower socioeconomic status (Quadagno, 2011, p. 7). Gender differences in the perception of chronological and functional aging are important, as well, giving rise to sex-based variations in patterns of suicidal ideation across the life course. For example, although women may feel subjectively "older" than men in society, suicide among women declines after middle age (Mental Health Association of Colorado, 2011). In contrast, while cultural

perceptions of aging men are more favorable than those of older women, suicide rates are higher for older men than older women. In discussing the rates of suicide among older adults, it must be remembered that older women outnumber men and that this gap widens with increasing age.

Coming to Terms with Mortality in Older Adulthood

Older adulthood is characterized by a sense of the boundedness of the human life span. For the older adult, awareness of mortality interacts with the mental and physical challenges of aging to impact the existential relationship to the world. While younger adults may view time as a limitless resource, the older adult faces a limited future. When Erik Erikson was in the final stage of life, his wife noted that they had been premature in limiting development to eight stages, ending with “integrity and despair” (Erikson, 1997). She suggested adding a ninth stage, *gerotranscendence*, during which the older adult defines his/her position in the universe – an existential (or spiritual) time of life during which the older adult comes to terms with increasing vulnerability and disability while realizing that death is eminent (Tornstam, 2005). Kahana and Kahana (1996) also identified the period of declining health as a unique stage of the life-cycle and note three requirements to cope with this period of life: (a) a social support system; (b) the ability to find new roles to substitute for lost roles; and (c) having the resources to modify one’s environment, all of which reflect strengths developed earlier in the life-course. The therapeutic approach can be particularly relevant when helping the older adult to assess and to access the resources suitable to their individual situations. These can be important considerations for clinicians when designing interventions with a suicidal individual.

Although individual situations will vary, older adulthood can be characterized as an interaction of physical, mental, and social losses with potentially deleterious effects on wellbeing and quality of life. While counselors’ efforts to intervene in suicide prevention are perhaps targeted at helping older adults find meaning in life, it is also critical for counselors to understand the physical and mental challenges faced by older adult clients.

Aging-Related Challenges to Health and Well-Being

A useful framework for organizing the challenges faced by older adults was developed by George (1994) who conceptualized a model of the social antecedents of geriatric depression. Factors include: (a) demographic characteristics; 2) early-life events and achievements; 3) later life events and achievements including financial status; 4) social integration and support; as well as 5) vulnerability factors resulting from physical and mental illness. This model which addresses how the balance of provoking agents (chronic stresses as well as acute life events) and the presence or lack of coping strategies interact to result in depression has been adapted by researchers (Cohen, Coleman, Yafee, & Casimer, 2008).

Our utilization of this model highlights the importance of taking a life-course approach to suicide risk. The individual’s thought to consider and/or attempt suicide can be viewed in the context of earlier life experiences and exposures as well as current conditions, taking into account both personal life events and societal historical influences. On the individual level, personality, defined as “a social construct that defines who we are and how we react to our environment” (Quadagno, pg. 162), is a key factor carried into the later part of the life course and can be directly linked to the adaptive skills necessary to maintain resilience in the face of age-related decrements.

On the social and historical level, early life socio-economic and cultural constraints to the individual's pursuit of education may have resulted in a life time of lower paying jobs and a lack of financial resources for retirement. Likewise, in a period of economic recession, older adults might face the stress of being forced into retirement involuntarily because of workplace forces beyond their control. Similarly, the resources and investments an older adult had counted on to provide a secure retirement may be diminished by the societal economic situation. While the aging process is tempered by social and historical forces, the experience of becoming an older adult is shaped by challenges to health, function and wellbeing.

Physical and Mental Challenges of Older Adulthood

The geriatrician has the primary goal of helping "the patient regain lost function and maintain as much independence as possible. It is important to note that physical and mental illnesses affecting the elderly often interact and result in a loss of functional ability much more than any one problem in itself. The elderly are particularly vulnerable as they have less 'reserve capacity'" (Gambert, 2009, p. 1). Although many adults do not suffer disease-related functional disability, with age there is increased risk of functional decline measured by Instrumental Activities of Daily Living (such as doing housework, preparing meals, using the telephone, and handling finances) and Activities of Daily Living (such as getting out of bed, eating, toileting, dressing, and bathing) (Hooyman & Kiyak, 2011). Additionally older adults face the specter of Alzheimer's dementia, even if they have not been diagnosed (French, Floyd, Wilkins, & Osato, 2011)

Chronic Conditions and Geriatric Syndromes

Chronic conditions are prevalent among older adults, rarely occurring alone (multi-morbidity) and often requiring older persons to deal with ongoing and multiple challenges, including declining health and function (Yates, 2001). Available data suggests that 80% of those over the age of 65 years have a minimum of one chronic condition, while 20% have four or more conditions (Chodosh et al., 2005).

The term "geriatric syndromes," captures the distinctive features and complex nature of health processes commonly affecting aging individuals that are not uniquely due to any single underlying disease or cause. Thus, geriatric syndromes are "multi-factorial health conditions that occur when the accumulated effects of impairments in multiple systems render [an older] person vulnerable to situational challenges" (Inouye, Studenski, Tinetti, & Kuchel, 2007, p. 781.) Although these challenges are typically physical in nature, such as frailty, impaired mobility, incontinence, and cognitive decline, their course and ultimate outcomes are influenced by psychosocial factors including the individual's ability to adjust, adapt, and harness resilience in the face of changing circumstances (Hildon et al., 2010).

Social and Emotional Challenges of Older Adulthood

Anecdotally, we know that older adults often will tolerate socially-limiting conditions, excusing them as "What do you expect? I'm old." For example, older women may limit activities such as attending church because they need to stay close to a bathroom due to incontinence. An older adult with hearing problems may withdraw from interacting with others because of the communication difficulty. Medication regimens and side effects of medication may interact with physical disability to impose limitations on the life-style of the older adult.

Caregiving for a sick spouse presents physical and mental health challenges for the caregiver; when the spouse dies, widowhood may expose the older adult to loneliness and/or social isolation. Self preservation in the face of aging-related losses is an important task of advancing old age (Tobin, 1988), particularly in the presence of physical ailments. Physical disability may prompt role loss. For older persons, the coexistence of mental and physical illness, social and economic stressors, and age-related physiological changes and functional losses can have a destabilizing impact on the sense of self. Suicidal ideation among older adults may be a response to a diminishing sense the threat of continuity of self, reflecting a loss of personal meaning and purpose.

Feelings of hopelessness, inadequacy and perceived burden on others, particularly those for whom one feels a sense of responsibility, can engender or exacerbate thoughts of suicide as a means of bringing relief to loved ones (Britton et al, 2008; Cukrowicz, Cheavens, Van Orden, Ragain, & Cook, 2011; Jahn, Cukrowicz, Linton, & Prabhu, 2011). As an example of such thinking, we note that 55% of adults aged 55 and older in Alabama, reported that “being a burden to others” was an end-of-life concern (Baker & Allman, 2004).

One of the most challenging issues for aging adults is the pressure and desire to live independently in the face of age-related changes in health, function, and social roles. While medical care can target the maintenance of health for older adults, social services may be needed to assist older adults to maintain independent living. The counselor needs to help the older client explore services that may be available or consult with a social worker to provide this information. This would include options for transportation and nutrition (Senior Center programs and Meals on Wheels). It should be noted that the notion of intergenerational living is not equally devalued; some families will view such situations as reciprocal while others see the need as burdensome. As in retirement, the impact of the decision to live with others may reflect the voluntary versus. forced nature of the move and may result in the older adults feeling that they cannot contribute equitably to the social relationship (Wilmoth, 2000) The counselor can assist the older adult to understand this sense of imbalance in social reciprocity and find ways to restore a sense of control and dignity.

Risk Factors for Suicide

Societal and Structural Risk Factors

Why do older adults consider suicide? The classic discussion of suicide by the Sociologist, Émile Durkheim (1897, translated 1951) acknowledges that the act of suicide represents both a socio-historical fact, situated in the structure of society and a personal biographic feature, rooted in the subjective reality of the individual (Durkheim, 1897). Durkheim articulated four types of suicide: (a) egoistic, (b) altruistic, (c) anomic, and (d) fatalistic. In Durkheim’s typology, *egoistic suicide* was the act of an excessively individuated person with tenuous ties to the norms and values of the larger, cohesive social group. This may be the case of the isolated older adults whose social ties to family and others are weak or have been severed over time. *Altruistic suicide* was the polar opposite of egoistic suicide, occurring among individuals willing to sacrifice their life for the greater good of a larger social group to whose ideals and goals they were tightly bound. This may be the case for the older adult who worries about depleting family resources such as money, time, and physical care capabilities and becoming a burden.

In Durkheim’s conceptual scheme, *anomic suicide* occurred among individuals lacking personal and social direction who were living in societies characterized by social disruption and economic

instability. This may be the case of the older adult who lacks a sense of meaning and purpose in life. In contrast, *fatalistic suicide* arises in highly regulated, oppressive societies where the absence of personal autonomy engendered a sense of hopelessness, severely limiting the individual's options for acting on their own behalf. This may be the case of the older adult who feels powerless to effect positive change on their own behalf and cannot envision a future worth living. The interaction of aging-related social, emotional, and physical changes can engender a vulnerability to suicidality stemming from one or more aspects articulated in Durkheim typology.

Physician Assisted Suicide (PAS) and euthanasia are contemporary issues that have relevance for our consideration of suicide among older adults. Because of the contested nature of this topic, we sometimes overlook that fact that it involves a decision to end one's life that can be understood in the context of Durkheim's conceptualization of the causes of suicide: egoism, altruism, fatalism, and/or anomie. However, attempts to legalize PAS or euthanasia may lead to the de-stigmatization and decriminalization of the act, effectively making it qualitatively different from other suicide methods.

Physician assisted suicide is legal in only three U. S. states (American Medical News, 2010). Although it is reported that the American public is divided about whether or not physician assisted suicide should be legal (Quill and Greenlaw, 2008), 27% of older Alabamians reported that there might be a situation when they would consider requesting physician assisted suicide or euthanasia (Baker & Allman, 2004). There are three levels to consider: physician assisted suicide refers to the situation where the patient receives information or the means (medication) to perform the act themselves. Perhaps in response to the stigma associated with suicide, the trend is to call this physician assisted death (Quill and Greenlaw, 2008). Active euthanasia refers to assisting another to terminate his/her life while passive euthanasia refers to withholding treatment and/or life-sustaining activities (Quadagno, 2011). Another issue is self-neglect, the inability or refusal to adequately take care of one's health, hygiene, nutrition, or social needs (Abrams, Lachs, McAvay, Keohane, Bruce, 2002). Intentionality would place this in the literature on suicide.

In general, health care professionals equate the desire for suicide to be associated with mental illness and unclear thinking, often manifest as depression and cognitive impairment (Quill, et al., 2008; Abrams, et al., 2002). There is common agreement that death may be seen as the only way to escape suffering (Quill, et al.,) and that it is rare for persons with life-threatening disease not to consider suicide, at least in passing (EndLink Resource for End of Life Care Education, 2004). However, current medical practice has the means to relieve physical suffering and this should be available to all. The tenets of palliative care are based on the belief that all patients with life-threatening illness should have access to optimal symptom control and supportive care (Quill, et al.) which would greatly reduce the desire to hasten death. This model complements causes of suicide for individuals of all ages (Lester, 2001).

Psychosocial and Biographical Risk Factors

While suicidal ideation is "the clinical precursor" of suicide among older adults (Bruce et al., 2004, p. 1081), other psychosocial, biographic level, risk factors for geriatric suicide have been articulated (see Table 1). Such factors are useful not only for identifying high risk patients, but also for designing interventions appropriate for the older adult. Sadly, older adults completing suicide are more than twice as likely to have visited a primary care provider than a mental health specialist in the month preceding death (Vannoy, Tai-Seale, Duberstein, Eaton, & Cook, 2011). Therefore, it is

imperative to establish a systematic referral process from primary care to mental health services so that at-risk older adults are seen by counselors with training and experience in assessing risk and targeting interventions for geriatric suicidality.

Widowhood and bereavement. Research suggests that changes in marital status due to marriage, divorce, or spousal loss elevate the risk for suicidal behavior among older adults, especially during the 12 months immediately following the shift in status (Roškar, et al., 2011). Among older adults, spousal loss is a commonly occurring event, and is associated with increased risk of all-cause mortality, in general, and death by suicide, in particular. Compared to married persons, recently bereaved men have an excess mortality rate of 131%. In age-adjusted analysis, newly bereaved individuals are four times more likely to die from suicide than their married counterparts (Martikainen & Valkonen, 1996)

Although this bereavement effect has been widely studied, the mechanisms linking widowhood to excess mortality remain unclear. It has been suggested that exposure to the psychosocial stress of spousal loss has a deleterious effect on physiological processes, increasing the individual's risk for physical and psychiatric problems. Bereaved older adults are likely to avoid professional help because they fear a diagnosis of mental illness and the perception that they are unable to live independently. For these reasons, professional counseling services framed as supportive or self help programs tend to have greater acceptance among bereaved older adults (Bambauer & Prigerson, 2006).

Depression. Among aging individuals, an episode of depression is present in the majority of suicide cases. Geriatric depression is a major risk factor for suicide among older adults and is present in up to 75% of older adults who complete suicide. Clinical depression, in particular, is associated with an array of physical symptoms as well as problems with rational thought and concentration, feelings of guilt and worthlessness, desire for death, and recurring suicidal ideation (American Geriatric Society Foundation for Health in Aging, 2005). Because mental and physical health are inseparable in older adults (Katz, 1996), treatment for depression is an essential element of the medical care plan for suicidal persons. At the same time, seeking help for depression and other mental health concerns may be socially and personally unacceptable to some older persons, often engendering feelings of shame, and producing a stigmatized identity (Conner et al., 2010; Raue, Weinberger, Sirey, Meyers, & Bruce, 2011)

Substance Abuse. Substance abuse is on the rise among older adults and is associated with physical and mental health problems, particularly among older men. Abuse of alcohol and drugs is associated with elevated risk for impaired physical and psychological functioning and is a major risk factor for suicide among older adults (Kennedy, 2000). Misuse of alcohol, in particular, is harmful to the physical, psychological, and social wellbeing of older persons, negatively impacting self-esteem, coping skills, and relationships with others. Older adults are more likely to abuse prescription medicines than illicit drugs (Simoni-Wastila & Yang, 2006); and even medications taken as prescribed have side-effects of depression and/or dementia.

Although geriatric alcohol abuse can have its roots earlier in life, later life onset of problem drinking is associated with aging-related stresses, losses, and transitions such as retirement, bereavement, and the emergence of chronic health problems. Alcohol abuse can develop out of attempts to use alcohol to numb emotional, physical, or psychosocial pain of such losses. A subset of older adults who abuse alcohol are close to 3 times more likely than other older adults to suffer from other

psychiatric conditions including dementia, depressed mood, and suicide. Additionally, alcohol abuse is associated with deleterious interaction effects when mixed with over-the-counter or prescription medications and complicates the management of geriatric depression (American Geriatric Society Foundation for Health in Aging, 2005).

Table 1. Risk Profile for Late-Life Suicide

Clinical:

- Expressed intent
- Depression or other nondementing mental disorder
- Alcohol use, moderate to heavy
- Cancer, heart disease, lung disease
- Chronic pain
- Poor self-assessed health
- Smoking

Sociodemographic:

- White male
- Age 85 or older
- Firearms purchase/possession
- Divorced, widowed
- Recent life change event

Historical:

- Previous attempt
- Lethality of attempt (firearms, jumping from height)
- Family history of attempted or completed suicide
- Low probability of rescue
- Recent visit to primary care physician or mental health specialist
- Anniversary of loss

Source: Kennedy, 2000. Table reprinted with permission of publisher

Table 2. Practitioner-Based Interventions to Reduce the Risk of
Late Life Suicide

When few risk factors are present

- Annual screening for depression
- Advanced directives (Patient Self-Determination Act)
- Encourage abstinence or moderation in alcohol intake
- Encourage active social network

When several risk factors are present but suicidal ideas are denied

- All the above and . . .
- Optimize treatment of depression, anxiety, insomnia, pain, alcohol abuse

When risk factors and thoughts of suicide are present but without intent or
a plan

- All of the above and . . .
- Make family aware of elevated risk and ensure physician availability
- Family or third party to remove lethal means and alcohol
- Identify countervailing forces (concern for family, religion, life event goals)
- Fix an appointment (not as needed), ask that family attend

When lethal means are at hand, a plan is expressed, or intent is evident

- Refer for emergency psychiatric evaluation (involuntary if needed)
- Consider hospitalization, electroconvulsive therapy

When suicide has been attempted with lethal means, or countervailing forces are not available to prevent recurrent attempts

Emergency psychiatric evaluation (involuntary if need be)

Hospitalize if intent not convincingly recanted or attempt is a recurrence

Source: Kennedy, 2000. Table reprinted with permission of publisher

Table 3. Countervailing Forces That Might Lessen the Older Adult's Likelihood of Acting on a Suicidal Impulse

Supportive, involved family

Presence of spouse

Social network

Financial security

Physically independent

Alcohol abstinence

Dementia (inability to sequence steps toward death)

Positively anticipated life events in family members (e.g. graduation, bar or bat

Mitzvah, confirmation, marriage, childbirth)

Religious beliefs and values (optimistic rather than fatalistic)

Advanced directives, health care proxy

Practitioner's optimism and concern, regular appointments for ongoing care

Treatment of depression, anxiety, insomnia, pain

Source: Kennedy, 2000. Table reprinted with permission of publisher

Counseling the Older Adult

Counselors can make the greatest inroads against suicidal thoughts and behavior in the area of the older adult's life choices and decision-making processes (Dickerson & Watkins, 2009). The aging process is shaped not only by age-associated physical changes, but also by what is termed "secondary aging" — how the individual perceives and responds to growing older, in general, and the choices he or she makes to maintain well-being and quality of life, in particular. Social and cultural stereotypes about aging (ageism) persist, presenting unique challenges for the counselor working with older adults. Dickerson and Watkins (2009) delineated several issues that require additional attention by counselors serving the geriatric population. These include longer counseling sessions, more flexible scheduling, sensitivity to intergenerational barriers, and the potential for ageism on the part of both the counselor and the patient. In particular, older adults' attitudes about aging and mental health can impede client progress. At the same time, counselors' stereotypical perceptions of older adulthood can be a therapeutic barrier.

Among today's older adults there may be a cohort effect such that the stigma associated with seeking mental health services will be a barrier to providing interventions. Thus, seniors not likely to seek "counseling" may be open to interventions under another name. For example, group therapy may be more attractive reframed as a peer support group. Likewise, older adults may be more open to telephone intervention programs if they are reframed from crisis interventions to talking opportunities. For example, a telephone help/check line was shown to be successful in reducing suicides (Van Orden & Conwell 2011). The Senior Talk Line sponsored by the Jefferson County Crisis Center is another example.

Gerocounseling

Gerocounseling is a subspecialty targeting the needs of older adults. It is premised on the belief that aging is associated with a distinctive array of developmental tasks and life processes that distinguishes older adulthood from other phases and stages of the life course. The Gerocounseling Model (Burlingame, 1995) utilizes a biopsychosocial approach, drawing upon theories of aging from the biological, psychological, and sociological sciences and differentiating among processes of optimal aging, normal aging, and pathological aging (Dickerson & Watkins, 2009). In Gerocounseling educational programs, trainees are urged to (a) "explore their feelings about aging and themselves;" (b) "challenge personal myths and stereotypes regarding the older adult;" and (c) develop "awareness of their personal responses to older adults who are their clients" (Cavallaro & Ramsey, 1984, pp 75-76). The Gerocounseling Model is generating renewed interest, and has promise for the care of suicidal older adults (Foster & Kreider, 2009).

There is an increasing need for professional counselors to provide services to community-dwelling older adults. Gerontological counseling services range from one-time consultations and referrals to community resources, social services, and medical providers to ongoing therapeutic interventions related to issues of physical and emotional function, family stress, and existential crises involving role loss, meaninglessness and hopelessness. Additionally, counseling services for older adults may require putting into place coordinated client support systems on the family, community, and the organizational levels to support long-term situational management needs (Cavallaro & Ramsey, 1984).

Developing Geriatric Suicide Interventions

A 2011 systematic review on suicide prevention and intervention programs for older adults recommended the development and implementation of multi-component clinical strategies to promote positive aging and resilience among at-risk geriatric patients (Lapierre et al., 2011). In response, an international consensus panel on suicide among older adults articulated key considerations for evidence-based suicide interventions targeting the geriatric population. These guidelines for interventions are organized into universal, selective, indicated, and general classifications, which in combination, provide the most effective and comprehensive approach to reduce the prevalence and impact of suicidal behavior (Erlangsen et al, 2011).

Universal interventions. Universal interventions target older adults in general. They include programs for self-administered depression screenings, limited access to means of suicide, attention to concerns about aging and age-related dependency on others, and educational interventions to (a) promote healthy aging, resiliency, and empowerment; (b) increase awareness of suicide risk factors and suicide protective mechanisms; and (c) systematize and publicize procedures for reporting suicidal behavior (Erlangsen et al., 2011).

Selective interventions. Selective interventions target multiple stakeholders, including medical, social, and psychological service providers, high risk elders, and the community at large. For medical practitioners and trainees, the panel recommends: (a) providing systematic screening tools in medical care (primary, specialty, and long term) and social and psychological service settings and (b) sensitizing medical, social, and psychological service trainees to the relevance of geriatric losses associated with declines mobility and sensory acuity. For caring for high risk elders, the panel's recommendations include the following; (a) offering systematic outreach services to assess and support recently retired or bereaved, socially-isolated older men suffering from functional decline, chronic pain, and subject to marital and family stressors; (b) improving quality of life and reducing suicidal ideation by optimizing treatments for pain and non-pain symptoms; and (c) enhancing psychiatric treatment modalities (i.e. drug compliance) by designating case managers and introducing psychotherapeutic, psychosocial, and other non pharmacologic adjuvant therapy such as problem solving training. For sensitizing the community at large, the panel recommends drawing attention to the problem of geriatric alcohol abuse (Erlangsen et al., 2011).

Indicated interventions. Indicated interventions target risk reduction among older adult survivors of suicide attempts, as well as those presenting with acute suicidal ideation. For the highest-risk patient and their family, the panel's recommends that social and psychological service providers: (a) communicate with elderly suicidal patients, their family and caregivers before initiating treatment, stressing the importance of monitoring suicide risk status; (b) help at-risk older adults to envision a future self that is congruent with reality; and (c) engage the older adult in follow-up activities (home visits, phone calls, post cards) to reassure them of ongoing interest in their wellbeing and to communicate appreciation for the meaning and value of their life. Additionally, the panel urges implementing lay "gate-keeping" training programs for identifying at risk individuals and referring them for treatment for depression.

For professional providers and trainees in a wide variety of helping specialties, the panel advocates (a) offering training and continuing education to detect, intervene, and manage depression and suicide risk in older adults; (b) designing and implementing interdisciplinary depression care management modalities; (c) promulgating practice guidelines for detecting and management later-

life suicide; and (d) facilitating referrals to social and community services with resources and expertise to assess and manage a wide variety of physical and psychosocial problems and to activate programs for improving living conditions, reducing stress, and providing psychological support. Finally, ongoing assessment of the impact of the intervention, surveillance of patient status, and provision of educational and social support is critical during the post-intervention period to the prevention of future suicide attempts (Erlangsen et al, 2011).

Considerations on the Older Adult's Interventional Readiness

Applying the Transtheoretical (TTM) model of change, typically used to describe adopting healthy behaviors, can target points of intervention to prevent suicide among older adults. The stages of precontemplation, contemplation, preparation, and action are particularly applicable as target points for interventions although the specific time periods may not be applicable (Redding, 2000). *Precontemplation* (defined as no intention of action within the next 6 months) nonetheless may represent a time when the act of suicide becomes a conscious option. Both passive thoughts about death and active ideation of wanting to die (Cohen, et al., 2008) could be placed in this phase of the model. Understanding the risk factors for older adults who commit suicide would allow targeting vulnerable individuals before they themselves have thoughts of employing lethal actions.

As older adults move from being aware of suicide as an "option" to individualizing and *contemplating* what that would mean for themselves, significant others may remain unaware of the suicidal ideation. In the TTM model this is time defined as contemplated action within a six month period. Careful attention to verbal cues for persons identified at risk could trigger intervention strategies and prevent the progression to the stage of *Preparation*, defined by TTM as action within 30 days, and action. Older adults typically do not verbalize movement as they progress between contemplation to preparation to action, and because most suicide attempts in older adults are likely to be completed, interventions must necessarily occur early in the process.

Specific Recommendations for Counselors

In many cases the counselor of a suicidal older adult may need to recommend a geriatric assessment to identify undiagnosed or undertreated conditions for which medical care is available. Once medical and social support aspects of clients' lives have been explored, and the counselor has the opportunity to address reasons their clients are in despair, the counselor may want to consider recent therapeutic approaches that have emerged as a way to increase meaning and the desire to live. These modalities, promoting resilience and dignity, were developed to for older adults (and others) suffering from life-threatening disease and have relevance for adults with suicidal ideation.

A Focus on Resilience

Resilience can be defined as "the experience of being disrupted by change, opportunities, adversity, stressors or challenges, and after some disorder, accessing gifts and character to grow stronger through the disruption (Bradshaw et al., 2007, p. 643)." Resilience theory is comprised of a growing body of knowledge that describes the *qualities* of resilient individuals, delineates the *processes* through which resilient qualities are acquired, and models the *pathways* by which resilience responses emerge (Richardson, 2002). Resilience is both a biopsychosocial phenomenon comprised of: (a) *recovery or the capacity to* regain equilibrium physiologically and psychosocially following acute stressors; and (b) *sustainability* or the capacity to endure and carry on in the face of chronic

stressors (Zautra, 2009, p. 1935). Resilience is thought to be a common response to stress, representing a distinct trajectory in the process of recovery and sustainability with multiple pathways based on individual characteristics and circumstances (Bonanno, 2004). The role of the counselor fits nicely into helping the suicidal older adults discover (or rediscover) strengths and coping strategies.

There is growing interest in utilizing resilience interventions as clinical tools in primary care settings for a variety of chronic conditions, including depression (Bradshaw, Richardson, & Kulkarni, 2007; Dowrick et al., 2008). Adaptive responses to aging are pervasive in the daily lives of older adults and not restricted to acute life events (Ong, Bergeman, & Boker, 2009). Historically, research on resilience among older adults has been tied closely to the concept of optimal aging (Baltes & Baltes, 1990; Rowe & Kahn, 1987; Schulz & Heckhausen, 1996). Using data from the MacArthur Foundation Network on Successful Aging, Seeman and colleagues studied functional levels of community dwelling older adults and found that psychosocial resources provided a protective benefit against the deleterious impact of advancing years (Seeman, et al., 1995). In a similar vein, Ryff and colleagues recognized the need for research focused on resilience among older adults, to examine the unique strengths and capacities that enable them to respond positively to chronic stress or adversity (Ryff, Singer, Love, & Essex, 1998). Fry and Debats (2010) believe that identification of the source of personal life-strengths is linked to the capacity for resilient aging. Thus, although individuals may vary in whether or not their major life-strength resides within themselves or comes from an outside force, the acknowledgement itself promotes resilience.

Sense of Coherence

The theoretical framework of resilience utilizes an autogenic rather than pathogenic approach to health and illness, focusing on individual strengths and assets, rather than deficits (Antonovsky, 1979). It is theorized that resilience stems from the interplay of biological, psychological, social and environmental resources. One of the most important psychosocial resources at work in resilience is the sense of coherence. Antonovsky defined sense of coherence as "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (a) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; (b) the resources are available to one to meet the demands posed by these stimuli; and 3) these demands are challenges, worthy of investment and engagement (Antonovsky, 1987, p. 11).

Cognitive Reappraisal

Research suggests that good or excellent self-rated health is a surrogate for resilience (Hardy, Concato, & Gill, 2004; Pierini & Stuijbergen, 2010). Other markers of resilience have been described in the research literature as well. Primary among them is the process of cognitive transformation, characterized by a reappraisal of the impact of the adverse experience from a negative and life diminishing perspective to one that is positive and life enhancing (Tebes, Irish, Puglisi Vasquez, & Perkins, 2004). Cognitive re-interpretation is closely associated with the process of adversarial growth or stress related growth, the experience of positive change emerging from trauma and loss. Cognitive appraisal variables such as acceptance, optimism, and positive affect have been shown to be correlated with adversarial growth and are described in the literature as markers of resilience (Linely & Joseph, 2004; Ai & Park, 2005). Additional markers of resilience examined in the literature include positive affect, in general, which has been associated with

physiological resilience (Fredrickson & Joiner, 2002; Tugade & Fredrickson, 2004; Tugade, Fredrickson, & Barrett, 2004) and optimism, in particular, which has been linked to perseverance and coping (Peterson, 2000; Segerstrom, Taylor, Kemeny, & Fahey, 1998).

Reminiscence Therapy

There is increasing interest in the use of reminiscence as therapy for older adults struggling with issues of hopelessness, meaninglessness, or loss of social roles. Structured reminiscence has been shown to be a useful psychosocial intervention, targeting patient mood, well-being, and behavior. As a psychosocial tool, structured reminiscence can promote mastery, reduce depression, and increase meaning in life (Bohlmeijer et al, 2009; Bohlmeijer, Westerhof & Emmerik-de Jong, 2008; Peng, Huang, Chen & Lu, 2009; Stinson, 2009; Stinson, Young, Kirk & Waller, 2010).

Dignity Therapy

Dignity Therapy is an empirically-derived psychotherapeutic reminiscence intervention, originally designed to moderate psychological distress among terminally-ill cancer patients. The goal of Dignity Therapy is to generate positive emotions, improve the sense of mastery and esteem, and promote psychosocial wellbeing. Dignity Therapy uses the process of guided life review to promote a sense of personal continuity, enhance feelings of mastery, and restore meaning to life (Chochinov, 2002; Chochinov, 2004; Chochinov, 2006; Chochinov, Hack, Hassard, Kristjanson, McClement & Harlos, 2004; Chochinov, Hack, McClement, Kristjanson & Harlos, 2002; Hack, Chochinov, Hassard, Kristjanson, McClement & Harlos, 2004; Thompson & Chochinov, 2008).

Dignity Therapy is derived from Erikson's theory of psychosocial development and focuses on the Integrity versus Despair stage of the life course where life review and acceptance are important psychological tasks (Erikson, 1950 & 1959). Dignity therapy is thought to be both generative and restorative for patients facing the end of life. In particular, the life review process utilized in dignity therapy fosters the creation of a legacy document, helping to dispel feelings of meaninglessness and despair over a lost past, a stressful present, and an uncertain future. As part of dignity therapy, patients tell the story of their life, recalling important events, reminiscing about significant relationships, expressing values and beliefs, and articulating how they would want to be remembered by posterity. Dignity therapy sessions are conducted by trained interviewers, audio-recorded, transcribed, and edited into a generativity document, celebrating the patient's life and preserving his or her memories.

Dignity therapy has been shown to ease psychological suffering among terminally ill patients, with benefits including an enhanced sense of self-esteem and self worth, as well as a heightened sense of purpose and connectedness (Chochinov, et al., 2002; McClement et. al, 2007). In a randomized control trial comparing dignity therapy with client-centered care or standard palliative care, terminally ill patients in the dignity therapy arm saw greater reduction in sadness and depression than those receiving palliative care as well as greater improvement in spiritual wellbeing than those in client-centered care (Chochinov et al., 2011). Additionally, researchers have also explored the efficacy of family-based life review activities with older adults approaching end of life. A study conducted by Allen et al (2008), found that patients in the intervention group reported a reduction in depressive symptomology.

Research in the area of dignity therapy shows promise for a variety of clinical applications (McClement et al., 2004). In the clinical setting, dignity therapy offers a way for the therapist to focus on the patient's life stories, valued memories, and unique composite of character and personality traits (Chibnall, Tumosa & Desai, 2009). A recent study by Montross, Winters & Irwin (2011) examined the use of Dignity Therapy in a clinical setting where patients were referred by members of an acute care interdisciplinary team such as social workers, nurses, and physicians. The completion of an individualized dignity therapy document required an average of 6.3 hours over 4 sessions. Training manuals and workshops on the use of dignity therapy are available (Chochinov, 2010).

Dignity therapy is a "new horizon" and "emerging paradigm" for the care of persons approaching the end of life (Kissane, Treece, Breitbart, McKeen & Chochinov, 2009, p. 342; Chochinov, 2006, p. 84), offering a window into the subjective experience of facing death (Hack et al., 2010). As such, Dignity Therapy offers a therapeutic modality for targeting psychosocial distress among older adults facing death for any reason, including suicidal ideation. Although the efficacy of dignity therapy as a clinical intervention for suicidality has yet to be tested, evidence to date points to a potential role in the care of suicidal older adults (Chochinov et al., 2011)

Palliative Care

Palliative care may provide a model for suicidal interventions among older adults. According to the World Health Organization (2004):

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

Palliative care modalities encompass holistic, multidisciplinary approaches and can inform suicide intervention therapies and policy. Recent literature advocates the role of counselors in the palliative care setting, highlighting the specific skills of counselors to address "complex emotional, cultural, and spiritual" issues and enhance communication between patient's, families, and health care providers (Babcock & Robinson, 2011).

At present, the literature does not describe a well-defined role for palliative care interventions for suicide among older adults, except in specific cases. These include responses to individuals with terminal or progressive and life-limiting conditions who express the desire to end life or request physician-assisted suicide or euthanasia. In such cases, palliative medicine implements interventions to relieve physical pain, emotional/psychological suffering, and psychosocial, spiritual, and existential distress. Growing evidence shows that relief of suffering decreases the desire for death, and that meaning-making interventions such as Dignity Therapy reduce depression among the terminally ill.

Conclusion

Increasingly, counselors will encounter older adults who are contemplating suicide. Because the work of the counselor is client based they are in the position to understand that today's older adult is part of a cohort of individuals with unique attitudes and expectations based on the social and historical period in which they came of age. Intervention targeting suicidal behavior in older adults requires a multi-faceted interdisciplinary approach that adopts emerging therapeutic modalities such as those used in palliative care. Counselors have a unique role in suicide interventions based on their training, expertise, and experience. Partnerships with institutional and community health care professionals can strengthen and support the work of the counselor in this endeavor.

References

- Abrams, R. C., Lachs, M., McAvay, G., Keohane, D., & Bruce, M. J. (2002). Predictors of self-neglect in community-dwelling elders. *American Journal of Psychiatry*, *159*, 1724-1730.
- Ai, A. & Park, C. L. (2005). Possibilities of the positive following violence and trauma: informing the coming decade of research. *Journal of Interpersonal Violence*, *20*(2), 242-250.
- Allen, R. S., Hilgeman, M. M., Ege, M. A., Shuster, J. L., & Burgio, L. D. (2008). Legacy activities as interventions approaching the end of life. *Journal of Palliative Medicine*, *11*(7), 1029-1038.
- American Geriatric Society Foundation for Health in Aging. (April 22, 2005). Aging in the Know: Depression, http://www.healthinaging.org/agingintheknow/chapters_ch_trial.asp?ch=32 Accessed August 3, 2011.
- American Geriatric Society Foundation for Health in Aging. (Jun 6, 2005). Aging in the Know: Substance Abuse, http://www.healthinaging.org/agingintheknow/chapters_ch_trial.asp?ch=36 Accessed August 3, 2011.
- American Medical News. (January 2010). Physician-assisted suicide legal in Montana, court rules. <http://www.ama-assn.org/amednews/2010/01/18/prsb0118.htm>. Accessed August 3, 2011.
- Antonovsky, A. (1979). *Health, Stress, and Coping*. San Francisco, Jossey-Bass Publishers.
- Antonovsky, A. (1987). *Unraveling the Mystery of Health - How People Manage Stress and Stay Well*. San Francisco, Jossey-Bass Publishers.
- Babcock, C. W., & Robinson, L. E. (2011). A novel approach to hospital palliative care: an expanded role for counselors. *Journal of Palliative Medicine*, *14*(4), 491-500.
- Baker, P. S., & Allman, R. M. (2004). Charting the Course. <http://www.aging.uab.edu/SubChannel/Research/charting-course.aspx>. Accessed August 18, 2011.

- Baltes, P. B., & Baltes, M. M. (Eds.). (1990). *Successful Aging: Perspectives from the Behavioral Sciences*. New York, Cambridge University Press.
- Bambauer, K. Z., & Prigerson, H. G. (2008). The stigma receptivity scale and its association with mental health service use among bereaved older adults. *Journal of Nervous and Mental Disease*, 194(2), 139-141.
- Bohlmeijer, E., Kramer, J., Smit, R., Onrust S., & van Marwijk, H. (2009). The effects of integrative reminiscence on depressive symptomatology and mastery of older adults. *Community Mental Health Journal*, 45(6), 476-484.
- Bohlmeijer, E., Westerhof, G. J., & Emmerik-de Jong, M. (2008). The effects of integrative reminiscence on meaning in life: results of a quasi-experimental study. *Aging and Mental Health*, 12(5), 639-646.
- Bonanno, G. A. (2004). Loss, trauma, and human resilience: have we underestimated the human capacity to thrive after extremely adverse events? *American Psychology*, 59(1), 20-28.
- Bradshaw, B. G., Richardson, G. E., & Kulkarni, K. M. (2007). Thriving with diabetes: an introduction to the resilience approach for diabetes educators. *Diabetes Education*, 3(4), 643-649.
- Breiding, M. J., & Wiersema, B. (2006). Variability of undetermined manner of death classification in the US. *Injury Prevention*, 12 (2), ii49-ii54.
- Britton, P. C., Duberstein, P. R., Conner, K. R., Heisel, M. J., Hirsch, J. K., & Conwell, Y. (2008). Reasons for living, hopelessness, and suicide ideation among depressed adults 50 years or older. *American Journal of Geriatric Psychiatry*, 16(9), 736-741.
- Bruce, M. L., Ten Have, T. R., Reynolds III, C. F., Katz, I. I., Schulbery, H. C., Mulsant, B. H., et al. (2004). Reducing suicidal ideation and depressive symptoms in depressed older primary care patients. *Journal of the American Medical Association*, 291(9), 1081-1091.
- Burlingame, V. S. (1995). *Gerocounseling: Counseling Elders and their Families*. New York, Springer.
- Cavallaro, M., & Ramsey M. L. (1984). A model field practicum in gerontological counseling. *Gerontology and Geriatrics Education*, 4(3), 71-80.
- Chibnall, J.T., Tumosa, N., & Desai, A. K. (2009). The ABCDs of end-of-life care for people with dementia. *Aging Successfully*, 19(1), 1, 4-7.
- Chodosh, J., Morton. S., Mojica, W., Maglione, M., Suttorp, M. J., Hilton, L., et al. (2005). Meta analysis: chronic disease self-management programs for older adults. *Annals of Internal Medicine*, 143, 427-438.
- Chudacoff, H. P. (1989). *How Old Are You?: Age Consciousness in American Culture*. Princeton, N. J., Princeton University Press.
- Chochinov, H. M. (2004). Dignity and the eye of the beholder. *Journal of Clinical Oncology*, 22, 1336-1340.

- Chochinov, H. M. (2002). Dignity-conserving care – a new model for palliative care: helping the patient feel valued. *Journal of the American Medical Association*, 287, 2253–2260.
- Chochinov, H. M. (2010). *Dignity Therapy Workshop Training Manual*. Winnipeg, Manitoba: Dignity Therapy International Workshop.
- Chochinov, H. M., Hack, T., McClement, S., Kristjanson, L., & Harlos, M. (2002). Dignity in the ill: an empirical model. *Social Science and Medicine*, 54, 433–443.
- Chochinov, H. M. (2006). Dying, dignity, and new horizons in palliative end-of-life care. *CA: A Cancer Journal for Clinicians*, 56, 84–105.
- Chochinov, H. M., Hack, T., Hassard, T., Kristjanson, L. J., McClement, S., & Harlos, M. (2002). Dignity in the terminally ill: A cross-sectional, cohort study. *Lancet*, 360, 2026–2030.
- Chochinov, H. M., Hack, T., Hassard, T., Kristjanson, L. J., McClement, S., & Harlos, M. (2005). Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life. *Journal of Clinical Oncology*, 23(24), 5520–5525.
- Chochinov, H. M., Kristjanson, L. J., Breitbart, W., McClement, S., Hack, T. F., Hassard, T., et al. (2011). Effect of dignity therapy on distress and end-of-life experience in terminally ill patients: a randomized controlled trial. *Lancet Oncology*, 12(8), 753–762.
- Cohen, C. I., Coleman, Y., Yafee, R., & Casimer, C. J. (2008). Racial differences in suicidality in an older urban population. *The Gerontologist*, 48(7), 71–78.
- Conner, K. O., Copeland, V. C., Grote, N. K., Rosen, D., Albert, S., McMurray, M. L., et al. (2010). Barriers to treatment and culturally endorsed coping strategies among depressed African-American older adults. *Aging & Mental Health*, 14(8), 971–983.
- Conwell, Y., Lyness, J. M., Duberstein, P., Cox, C., Seidlitz, L., DiGiorgio, A., et al. (2000). Completed suicide among older patients in primary care practices: a controlled study. *Journal of the American Geriatrics Society*, 48, 23–29.
- Cukrowicz, K. C., Cheavens, J. S., Van Orden, K. A., Ragain, R. M., & Cook, R. L. (2011). Perceived burdensomeness and suicide ideation in older adults. *Psychology and Aging*, 26(2), 331–318.
- Dickerson, B. E., & Watkins, D. R. (2009). Gerocounseling.
http://highvaluesolutions.com/index.php?option=com_content&task=section&id=43.
Accessed July, 25, 2011.
- Dowrick, C., Kokanovic, R., Hegarty, K., Griffiths, F., & Gunn, J. (2008). Resilience and depression: perspectives from primary care. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 12(4), 439–452.
- Durkheim, E. (1997, 1951). *Suicide: A Study in Sociology*. New York, The Free Press.

- Edelstein, B. A., Heisel, M. J., McKee, D. R., Martin, R.R., Koven, L. P., Duberstein, P. R., et al. (2009). Development and psychometric evaluation of the Reasons for Living – Older Adults Scale: a suicide risk assessment inventory. *The Gerontologist, 49*(6), 736–745.
- EndLink Resource for End of Life Care Education. (2004). Module 5: Physician-Assisted Suicide Debate. http://endoflife.northwestern.edu/physician_assisted_suicide_debate/why.cfm.
- Erikson, E. (1950). *Childhood and Society*. New York, Norton.
- Erikson, E. (1959). *Identity and the Life Cycle*. New York, International Universities Press.
- Erikson, E. (1997). *The Life Cycle Completed: Extended Version with New Chapters on the Ninth Stage of Development* by Joan Erikson. New York, W. W. Norton and Co.
- Erlangsen, A., Nordentoft, M., Conwell, Y., Waern, M., De Leo, D., Linder, R., et al. (2011). Key considerations for preventing suicides in older adults: consensus opinions of an expert panel. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 32*(2), 106–109.
- Foster, T. W., & Kreider, V. (2009). Reinventing gerocounseling in counselor education as a specialization. *Educational Gerontology, 35*(2), 177–187.
- Fredrickson, B. L., & Joiner, T. (2002). Positive emotions trigger upward spirals toward emotional well-being. *Psychological Science, 13*(2), 172–175.
- French, S. L., Floyd, M., Wilkins, S., & Osato, S. (2011). The Fear of Alzheimer's Disease Scale: a new measure designed to assess anticipatory dementia in older adults. *International Journal of Geriatric Psychiatry, 27*(5), 521–528.
- Fry, P.S., & Debats, D. L. (2010). Sources of human life-strengths, resilience, and health, pp 15–59 in *New Frontiers in Resilient Aging: Life-Strengths and Well-Being in Late Life*, edited by P.S. Fry, and C. L. M. Keyes, Cambridge, UK, Cambridge University Press,
- Gambert, S. R. (2009). Chapter 26: Comprehensive geriatric assessment: a multidimensional process designed to assess an elderly person's functional ability, physical health, cognitive and mental health, and socio-environmental situation. American Society of Nephrology, Geriatric Nephrology Curriculum. http://www.asn-online.org/education_and_meetings/distancelearning/curricula/geriatrics/Chapter26.pdf. Accessed June 14, 2012.
- George, L. (1994). Social and economic factors in late life. Pp 131–153 in L. S. Schneider, C. F. Reynolds, B. D. Leibowitz, & A. J. Friedhoff (Eds.) *Diagnosis and Treatment of Depression in Late Life*. Washington D.C., American Psychiatric Press.
- Hack, T. F., Chochinov H. M., Hassard, T, Kristjanson, L., McClement, S., & Harlos, M. (2004). Defining dignity in terminally ill cancer patients: a factor analytic approach. *Psychooncology, 13*, 700–708.
- Hack, T. F., McClement, S. E., Chochinov, H. M., Cann, B. J., Hassard, T.H., Kristjanson, L.J. et al. (2010). Learning from dying patients during their final days: life reflections gleaned from dignity therapy. *Palliative Medicine, 24*, 715–723.

- Hardy, S., Concato, J., & Gill, T. M. (2004). Resilience of community-dwelling older persons. *Journal of the American Geriatrics Society*, 52(2), 257-262.
- Hildon, Z., Montgomery, S. M., Blane, D., Wiggins, R. D., & Gopalakrishnan, N. (2010). Examining resilience of quality of life in the face of health-related and psychosocial adversity at older ages: what is "right" about the way we age? *The Gerontologist*, 50(1), 36-47.
- Hooyman, N.R., & Kiyak, H.A. (2011). *Social Gerontology: A Multidisciplinary Perspective*. Boston, Allyn & Bacon.
- Inouye, S. K., Studenski, S., Tinetti, M. E., & Kuchel, G. A. (2007). Geriatric syndromes; clinical, research, and policy implications of a core geriatric concept. *Journal of the American Geriatric Society*, 55, 780-791.
- Jahn, D. R., Cukrowicz, K. C., Linton, K., & Prabhu, F. (2011). The mediating effect of perceived burdensomeness on the relation between depressive symptoms and suicide ideation in a community sample of older adults. *Aging & Mental Health*, 15(2), 214-220.
- Kahana, E., & Kahana, B. (1996). Conceptual and empirical advances in understanding aging well through proactive adaptation, pp 18-40 in *Adulthood and Aging*, edited by V. Bengtson, New York, Springer.
- Katz, I. R. (1996). On the inseparability of mental and physical health in aged persons. *American Journal of Geriatric Psychiatry*, 4, 1-6.
- Kennedy, G. J. (2000). *Geriatric Mental Health Care: A Treatment Guide for Professionals*. New York, The Guilford Press.
- Lapierre, S., Erlangsen, A., Waern, M., De Leo, D., Oyama, H., Scocco, P., et al. (2011). International research group for suicide among the elderly: A systematic review of elderly suicide prevention programs. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 32(2), 88-98.
- Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: a review. *Journal of Traumatic Stress*, 17(1), 11-21.
- Luoma, J. G., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. *American Journal of Psychiatry*, 159, 909-916.
- Kissane, D.W., Treece, C., Breitbart, W., McKeen, N. A., & Chochinov, H. M. (2009). Dignity, meaning, and demoralization: emerging paradigms in end-of-life care. Pp 324-340 in Chochinov, H. M. & Breitbart, W. (eds): *Handbook of Psychiatry in Palliative Medicine*. New York, Oxford University Press, Inc.
- Lester, B.Y. (2001). Learnings from Durkheim and beyond: the economy and suicide. *Suicide and Life-Threatening Behavior* 31(1), 15-31.
- Martikainen P., & Valkonen T. (1996). Mortality after the death of a spouse: rates and causes of death in a large Finnish cohort. *American Journal of Public Health*, 86(8), 1087-1093.

- McClement, S., Chochinov, H. M., Hack, T., Hassard, T., Kristjanson, L. J., & Harlos, M. (2007). Dignity therapy: family member perspectives. *Journal of Palliative Medicine, 10*(5), 1076-1082.
- McClement, S.E., Chochinov, H. M., Hack, T., Kristjanson, L. J., & Harlos, M. S. (2004). Dignity conserving care: application of research findings to practice. *International Journal of Palliative Nursing, 10*, 173-170.
- Meehan, P. J., Saltzman, L. E., & Sattin, R. (1991). Suicides among older United States residents: epidemiologic characteristics and trends. *American Journal of Public Health, 81*, 1198-1200.
- Mental Health America of Colorado, 2011. Older Adult Suicide Fact Sheet. http://www.mhacolorado.org/file_depot/0-10000000/30000-40000/31946/folder/76270/Suicide,%20Older%20Adult%20Facts.pdf Accessed August 1, 2011.
- Montross, L., Winters, K. D., & Irwin, S. A. (2011). Dignity therapy implementation in a community-based hospice setting. *Journal of Palliative Medicine, 14*(6), 729-734.
- Ong, A. D., Bergeman, C. S., & Boker, S. M. (2009). Resilience comes of age: defining features in later adulthood. *Journal of Personality, 77*(6), 1777-1804.
- Peng, X. D., Huang, C. O., Chen, L. J., & Lu, Z. C. (2009). Cognitive behavioural therapy and reminiscence techniques for the treatment of depression in the elderly: a systematic review. *The Journal of International Medical Research, 37*(4), 975-982.
- Peterson, C. The future of optimism. *American Psychologist, 55*(1), 44-55.
- Pierini, D., & Stuijbergen, A. K. (2010). Psychological resilience and depressive symptoms in older adults diagnosed with post-polio syndrome. *Rehabilitation Nursing, 35*(4), 167-175.
- Quadagno, J. (2011). *Aging and the Life Course. An Introduction to Social Gerontology*. McGraw Hill, New York
- Quill, T. E., & Greenlaw, J. (2008) Physician-assisted death. Pp 137-141 in *From Birth to Death and Bench to Clinic: The Hastings Center Bioethics Briefing Book for Journalists, Policymakers, and Campaigns*, ed. Mary Crowley. Garrison, New York, The Hastings Center, 2008.
- Raue, P. J., Weinberger, M. I., Sirey, J. A., Meyers, B. S., & Bruce, M. L. (2011). Preferences for depression treatment among elderly home health care patients. *Psychiatric Services, 62*(5), 532-537.
- Redding, C. A., Rossi, J. S., Rossi, S. R., Velicer, W. F., & Prochaska, J. O. (2000). Health behavior models. *The International Electronic Journal of Health Education, 3* (Special Issue), 180-193. <http://www.iejhe.siu.edu>. Accessed 6/14/2012.
- Rockett, I. R., Want, S., Stack, S. De Leo, E, Frost, J. L., Ducatman, A. M, et al. (2010). Race/ethnicity and potential suicide misclassification: window on a minority suicide paradox. *BioMed Central Psychiatry, 10*:35. <http://www.biomedcentral.com/1471-244X/10/35>. Accessed 6/14/2012.

- Richardson, G. E. (2002). The metatheory of resilience and resiliency. *Journal of Clinical Psychology, 58*(3), 307-321.
- Roškar, S., Podlesek, A., Kuzmanić, M., Demšar, L. O., Zaletel, M., & Marušič, A. (2011). Suicide risk and its relationship to change in marital status. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 32*(1), 24-30.
- Rowe, J. W., & Kahn, R. L. (1987). Human aging: usual and successful. *Science, 237*, 143-149.
- Ryff, C. D., Singer, B., Love, G. D., & Essex, M. J. (1998). Resilience in adulthood and later life. Pp 69-96 in: Lomranz, J. ed. *Handbook of Aging and Mental Health: An Integrative Approach*. New York, Plenum Press.
- Schulz, R., & Heckhausen, J. (1996). A life span model of successful aging. *American Psychologist, 51*, 702-714.
- Seeman, T. E., Berkman, L. F., Charpentier, P. A., Blazer, D. G., Albert, M. S., & Tinetti, M. E. (1995). Behavioral and psychosocial predictors of physical performance: MacArthur studies of successful aging. *The Journals of Gerontology: Series A Biological Sciences and Medical Sciences, 50*(4):M177-183.
- Seegerstrom, S. C., Taylor, S. E., Kemeny, M. E., & Fahey, J. L. (1998). Optimism is associated with mood, coping, and immune change in response to stress. *Journal of Personality and Social Psychology, 4*(6), 1646-1655.
- Simoni-Wastila, L., & Yang, H. K., (2006). Psychoactive drug abuse in older adults. *The American Journal of Geriatric Pharmacotherapy, 4*(4), 380-394.
- Stinson, C. K., Young, E. A., Kirk, E., & Waller, R. (2010). Use of a structured reminiscence protocol to decrease depression in older women. *Journal of Psychiatric Mental Health Nursing, 17*(8), 665-673.
- Stinson, C. K. (2009). Structured group reminiscence: an intervention for older adults. *Journal of Continuing Education in Nursing, 40*(11), 521-528.
- Tebes, J. K., Irish, J. T., Puglisi-Vasquez, M. J., & Perkins, D. V. (2004). Cognitive transformation as a marker of resilience. *Substance Use and Misuse, 39*(5), 769-788.
- Thompson G., & Chochinov, H. M. (2008). Dignity-based approaches in care of terminally ill patients. *Current Opinion in Supportive and Palliative Care, 2*(1), 49-53.
- Thornstam, L. (2005). *Gerotranscendence: a developmental theory of positive aging*. New York, Springer Publishing Co.
- Tobin, S. (1988). Preservation of self in old age. *Social Casework, 69*(9), 550-555.
- Tugade, M. M., & Fredrickson, B. L. (2004). Resilient individuals use positive emotions to bounce back from negative emotional experiences. *Journal of Personal and Social Psychology, 86*(2), 320-333.

- Tugade, M. M, Fredrickson, B. L., & Barrett, L. F. (2004). Psychological resilience and positive emotional granularity: examining the benefits of positive emotions on coping and health. *Journal of Personality, 72*(6), 1161-1190.
- Unutzer, J., Tang, L., Oishi, S., Katon, W., Williams, J.W., Jr., Hunkeler, E., et al. (2006). Reducing suicidal ideation in depressed older primary care patients. *Journal of the American Geriatrics Society, 54*, 1550-1556.
- Vannoy, S. D., Tai-Seale, M., Duberstein, P., Eaton, L. J., & Cook, M. A. (2011). Now what should I do? Primary care physicians' responses to older adults expressing thoughts of suicide. *Journal of General Internal Medicine, 26*(9), 1005-1011.
- Yates, J. W. (2001). Co-morbidity considerations in geriatric oncology research, *A Cancer Journal for Clinicians, 51*(6), 329-336.
- Yancey, A. K., Ortega, A. N., & Kumanyika, S. K. (2006). Effective recruitment and retention of minority research participants. *Annual Review of Public Health, 27*, 1-28.
- Van Orden, K., & Conwell, Y. (2011). Suicides in late life. *Current Psychiatry Reports, 13*, 234-241.
- Warnecke, R. B., Oh, A., Breen, N., Gehlert, S., Paskett, E., Tucker, K. L. et al. (2008). Approaching health disparities from a population perspective: the National Institutes of Health Centers for Population Health and Health Disparities. *American Journal of Public Health, 98*(9), 1608-1615.
- Wilmoth, J. M. (2000). Unbalanced social exchanges and living arrangement transitions among older adults. *The Gerontologist, 40*(1), 64-74.
- World Health Organization, (2004). WHO definition of palliative care. Available at: <http://www.who.int/cancer/palliative/definition/en/>. Accessed August 17, 2011.
- Zautra, A. J. (2009). Resilience: one part recovery, two parts sustainability. *Journal of Personality, 77*(6):1935-1943.