
Copyright © 2010 Published by Elsevier Ltd. All rights reserved.

This is the author’s version of the work. It is posted here with the permission of the publisher for your personal use. No further distribution is permitted. If your library has a subscription to this journal, you may also be able to access the published version via the library catalogue.

Accessed from Swinburne Research Bank: [http://hdl.handle.net/1959.3/189654](http://hdl.handle.net/1959.3/189654)
Running head: Depression and Suicide

Treatment of Depression and Suicide in Older Adults

Sunil S. Bhar, Swinburne University of Technology and University of Pennsylvania

Gregory K. Brown, University of Pennsylvania
Abstract

This article describes a cognitive behavior therapy (CBT) intervention for suicide prevention in older adults. Although many studies have found that CBT interventions are efficacious for reducing depressive symptoms in the elderly, researchers have yet to evaluate the efficacy of such interventions for preventing suicide or reducing suicide risk in older adults. In this article we describe a 12-session CBT protocol for reducing depression, suicide ideation, and other risk factors of late-life suicide. The following aspects of the treatment are described: assessing suicide risk, conceptualizing the problem through a cognitive behavioral framework, developing a safety plan, increasing hope and reasons for living, improving social resources, improving problem-solving skills and efficacy, improving adherence to medical regimen, and relapse prevention. In addition, we review other behavioral and cognitive strategies such as activity scheduling and cognitive restructuring that are commonly associated with CBT interventions for depression. We illustrate the application of these strategies through the use of case examples.
In the United States, older adults, especially older men, have a higher rate of suicide than any other age group of the population. Statistics from the Centers for Disease Control and Prevention (2008) show that in 2005, the rate of suicide for adults 65 years or older was 14.7 per 100,000, compared to the rate of 10.5 for younger individuals. Between 1999 and 2005, over 5,000 older adults have died by suicide per year, and men account for approximately 85% of these suicides. The rates for suicide are even greater in adults over the age of 85; approximately 16 per 100,000 adults in this age group die by suicide per year, and as Americans continue to age, the absolute number of late-life suicides is likely to increase (Haas & Hendin, 1983). There is an urgent need to identify effective interventions for reducing risk factors associated with suicide in older adults.

Depression is one of the most common risk factors for suicide in older adults (Conwell, 1995; Conwell, Dubertstein, & Caine, 2002; Conwell, Olsen, Caine, & Flannery, 1991). A prospective study on 12,000 retirement community residents found that one of the strongest predictors of elderly suicide was self-rated depression symptom severity (Ross, Bernstein, Trent, Hendeson, & Paganini-Hill, 1990). Psychological autopsy studies have found that depressive disorders are the most common diagnoses in elderly victims (Conwell et al., 2002). In a study of 31 older individuals who died by suicide, 74% met criteria for a lifetime history of mood disorder (Beautrais, 2002). In a study of 141 suicides, the most common psychiatric disorder in individuals over the age of 55 who died by suicide was major depressive disorder (Conwell, Duberstein, Herrmann, Forbes, & Caine, 1996).
Thus, the identification, prevention and treatment of depression is considered pivotal for preventing suicide in late life (Conwell et al., 2002; NIH Consensus Conference, 1992; Pearson & Brown, 2000). A range of psychological interventions are efficacious for treating depression in older adults—including reminiscence therapy, problem-solving therapy, cognitive-bibliotherapy, and CBT (Scogin, Welsh, Hanson & Coates, 2005). The efficacy of CBT for late-life depression is well established (Jarvik, Mintz, Steur, & Gerner, 1982; Laidlaw, 2001; Laidlaw et al., 2008; Laidlaw, Thompson, Dick-Siskin, & Gallagher-Thompson, 2003; Scott, Tacchi, Jones, & Scott, 1997; Thompson, Coon, Gallagher-Thompson, Sommer, & Koin, 2001; Thompson, Gallagher, & Breckenridge, 1987).

However, researchers have yet to examine if CBT that is specifically focused on suicide prevention is efficacious for reducing suicide in older adults. While interventions for depression are expected to reduce risk for suicide, some research suggests that these interventions do not go far enough to sufficiently reduce key indicators of suicide risk, such as suicide ideation and hopelessness (reviewed in Pearson & Brown, 2000). For example, one study (Bruce et al., 2004) found that following successful treatment of depression using interpersonal psychotherapy, a significant proportion of older adults continued to report suicidal ideation. Similarly, another study found that despite reduction in depressive severity for older adults, those with a history of suicide attempts continued to have high levels of hopelessness (Szanto, Reynolds, Conwell, Begley, & Houck, 1998). These results suggest that suicide risk can persist despite the remission of depression, and despite the provision of treatment focused on ameliorating depression.
Thus, suicide prevention protocols for older adults may need to target other risk factors of suicide as well, such as hopelessness, suicide ideation, social isolation, problem solving deficits and physical illness burden (Alexopoulos, Bruce, Hull, Sirey, & Kakuma, 1999; Conwell et al., 2002; Finch, Ramsay, & Katona, 1992). In their suicide prevention protocol for older adults, Coon, DeVries, and Gallagher-Thompson (2004) suggested that cognitive-behavioral interventions for suicidal older adults focus on such factors. Although the efficacy of their protocol is yet to be empirically investigated, a recent study by Brown and colleagues found that a 10 sessions of cognitive therapy that focused on reducing multiple risk factors for suicide reduced the rate of suicide reattempts by 50% in a younger population (Brown et al., 2005). Thus, such an approach may also be efficacious for preventing suicide in older adults.

Given this finding, we are currently conducting a randomized clinical trial to examine the efficacy of cognitive therapy for suicidal older adults. Like other CBT protocols for late-life depression, we used cognitive and behavioral strategies to help the individual develop more adaptive ways of thinking about their situation and more functional ways of responding during periods of depression or emotional distress. However, our protocol was distinguished from those used for depression or with younger individuals in two ways: First, it was focused on reducing suicide ideation and other risk factors in late life, rather than on solely reducing depression. According to the cognitive model of suicide (Wenzel, Brown, & Beck, 2009), suicide crises are most closely precipitated by states of high hopelessness. Such states are purported to emerge from dysfunctional attitudes about the futility of reaching solutions to problems, or from an intolerance to cope with problems. In short, according to the model, suicide is a
culmination of one’s perceived failure at solving problems or coping. Such perceptions and the resulting sense of hopelessness were the initial targets of our protocol, followed by the other more distal risk factors such as social isolation and physical illness.

Second, the protocol was delivered in a way that took into account potential age-related limitations of older adults. Various methods have been described in the literature for modifying “standard” cognitive therapy to accommodate limitations in attention, memory and mobility, sensory deficits and the increased reliance by older patients on others for support and transportation (Areán, Hegel, & Reynolds, 2001; Arean & Feliciano, 2008; Laidlaw et al., 2003; Scogin, 2000; Zeiss & Steffen, 1996). Consistent with these methods, we arranged to have frequent breaks during the sessions, write key points and agenda items on the white board, and use brief versions of self-report questionnaires in order to accommodate limitations in attention span. For older patients with mild impairments in working and short-term memory, we provided the patient with memory aids, such as audio-recorded or written summary of the session. In addition, we (a) provided frequent capsule summaries and redirection during the session to remind the patient of the issue that has been discussed and conclusions reached and (b) reviewed the past session at the start of each new therapy session. Each session ended with a written review and clarification of key points. Patients with mobility and transportation difficulties needed help from their clinicians to organize transportation to session. We accommodated these difficulties by arranging for some sessions to be conducted by phone, and to arrange for sessions to coincide with other appointments that the patient need to attend nearby. Older adults who had problems with eyesight or hearing required additional accommodation. We used large fonts on questionnaires and read items aloud
for those with visual impairments, and used simple declarative language for those with hearing difficulties. Similar to other protocols for older adults (Areán et al., 2001), treatment was augmented with case management services. A case manager was assigned to each patient to assist in coordinating the treatment with the patient’s medical appointments and establish linkages to social, financial, and community services.

**The Suicide Prevention Protocol for Older Adults**

The protocol was delivered as an outpatient service and conducted on site at our research center. Patients were eligible for treatment if they were 60 years old or older and reported suicidal desire (i.e., admitted to having weak, moderate, or strong desire in response to the question: “During the past month, what has been your desire to kill yourself?”). Referrals were received from Philadelphia Veteran Affairs Medical Center, primary care physicians and psychiatrists. Patients were excluded from the trial if they presented with cognitive impairment (e.g., scored less than 23 on the Mini-Mental status examination), psychosis or required priority treatment for other psychiatric or medical conditions (e.g., severe alcohol dependence). The protocol was provided to men only, given that older men have been identified as the demographic with one of the highest risk for suicide (Centers for Disease Control and Prevention, 2008). The average age of our sample \( n = 33 \) was 66.7 \( (SD = 6.5, \text{ range } 60–87) \), with 64% of the sample Caucasian and 36% African American.

The purpose of this article is to provide practitioners with information about the following key aspects of this intervention protocol: (a) conducting an assessment of suicide risk, (b) developing a cognitive case conceptualization, (c) developing a safety plan, (d) increasing hope and reasons for living, (e) improving social resources, (f)
improving problem-solving skills and efficacy, (g) improving adherence to medical regimen, and (h) relapse prevention. In addition, we also review other common cognitive and behavioral strategies for reducing depression, such as activity scheduling, cognitive restructuring, and homework exercises.

The application of these strategies is illustrated through a case study of a 77-year-old man who presented to our research center with depression and suicidal desire. The patient, “Jim,” was a widower and had been living alone for nearly 10 years, since his wife died. He did not have children. He had retired from his job the year after his spouse died. Soon after this, he felt adrift. Having considered himself energetic and virulent in the past, he now was becoming more conscious of his failing health and the limitations in mobility. He experienced difficulty walking and worried that he would soon no longer be able to sustain an independent lifestyle. His desire for suicide was strongest in the mornings, when he perceived that day ahead of him as a “looming stretch of unplanned time.” He thought about overdosing on his medication. He had not attempted suicide yet because he did not know who would care for his cat. Thus, he felt trapped—not wanting to live with his chronic sense of purposelessness, loss and isolation, yet also not wanting to rescind on his perceived duty to his pet.

Assessment of Suicide Risk

The assessment of the risk for suicide is challenging given the complex array of risk and protective factors that can be taken into account for the individual patient. The assessment of such risk in older adults can be even more complex because older adults may be more reluctant to reveal suicide ideation to the clinician (Conwell et al., 1998), or may not perceive indirect self-destructive methods (such as failing to adhere to a
treatment regimens) as suicidal attempts (Nelson & Farberow, 1976). The development of a collaborative therapeutic relationship is essential to allow patients to disclose thoughts about death and suicide. It is also important to ask about less obvious or more passive plans to kill oneself. For example, when the clinician asked Jim if he had thoughts about killing himself in the past week, he denied such thoughts, saying that he had not thought about, nor could foresee, “stabbing” himself with a knife. However, later in the therapy session, he revealed that he had often thought about overdosing on his medication, which he recognized would result in death.

When assessing for suicide ideation in older adults, clinicians may begin the conversation with less specific questions about suicide ideation and more general questions about death or meaningfulness in life, such as, “Have things got so bad that you have thought about death?” and “Have you had thoughts that life is not worth living?” Then, clinicians may ask more specific questions: “Have you been thinking about hurting yourself in some way that could result in your death?” If the answer is yes to any of these questions, patients may be asked whether they have any desire or intent to kill themselves and if they have thoughts about a specific method or plan to do so. The way in which these questions are sequenced and phrased can be pivotal to eliciting accurate disclosure of suicide ideation.

Another useful way of eliciting suicidal ideation from older adults is through the use of self-report measures or structured assessments. For example, Item 9 of the Beck Depression Inventory (BDI-II: Beck, Steer, & Brown, 1996) assesses for suicide ideation. For a more detailed assessment of suicide ideation, the Scale for Suicide Ideation may also be administered (SSI; Beck, Kovacs, & Weissman, 1979). The SSI is a 21-item,
interviewer-administered rating scale that measures the current intensity of patients’ specific attitudes, behaviors, and plans to commit suicide on the day of the interview. Each item consists of three options graded according to suicidal intensity on a 3-point scale ranging from 0 to 2. The ratings for the first 19 items are summed to yield a total score, ranging from 0 to 38. The SSI consists of five screening items: 3 items assess the wish to live or the wish to die and the 2 remaining items assess the desire to attempt suicide. If the respondent reports any active or passive desire to commit suicide, then 14 additional items are administered. Individual items assess suicidal risk factors such as the duration and frequency of ideation, sense of control over making an attempt, number of deterrents, and amount of actual preparation for a contemplated attempt. Two additional items record incidence and frequency of previous suicide attempts. The SSI takes approximately 10 minutes to administer and has been found to be predictive of future suicide attempts and suicide (Brown, Beck, Steer, & Grisham, 2000).

A comprehensive assessment of suicide risk entails more than an evaluation of the severity or frequency of suicide ideation. As outlined in the *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors* (American Psychiatric Association, 2003), a variety of other factors signal an increase in the risk for suicide. These include high levels of hopelessness, purposelessness, anxiety, feelings of being trapped, substance use, anger, recklessness, as well as the absence of social supports, and evidence of mood changes. In addition, the presence of handguns, access to other lethal means of suicide, a recent suicide attempt and a history of multiple suicide attempts are also associated with suicide risk. These factors can be assessed by the clinician, through the use of empirically validated self-report measures or when taking the client’s history.
Total scores greater than 19 on the BDI-II, greater than 8 on the Beck Hopelessness Scale (BHS; Beck & Steer, 1993), or greater than 0 on the SSI have all been found to predict suicide (Brown et al., 2000). Protective factors or deterrents to suicide should also be assessed (e.g., religious beliefs, fear of disapproval, fantasies about their legacy if the death is by suicide, obligations, etc.).

Jim denied owning a handgun, although admitted having access to a lethal means of ending his life (i.e., medication). Furthermore, he presented with several other risk factors for suicide, including feelings of purposelessness, hopelessness, isolation and being “trapped.” Jim’s intake scores were as follows: BDI Total Score = 15, BHS Total Score = 9, and SSI Total Score = 13, indicating high levels of depression, hopelessness and suicide ideation, respectively. However, due to his reluctance to abandon his pet cat, he had not developed a detailed plan for suicide or made any preparations to commit suicide. Jim was evaluated as having high but not imminent risk for suicide.

**Developing a Cognitive Case Conceptualization**

A fundamental principle of CBT is identifying the activating events, cognitions, behaviors, emotions and situations as they relate to patients’ suicidal ideation or acts. Therefore, one task of the early sessions is helping patients with suicidal desire “tell their story.” The clinician asks the patient to talk about the events that led up the suicidal crisis. While doing so, the clinician empathically listens and questions the patient to elicit the life problems, thoughts, images, and feelings that led to the crisis. We have found that this activity not only also facilitates rapport, but also allows the clinician to identify key automatic thoughts central to the suicidal crisis. These identified thoughts can be integrated into a cognitive case conceptualization of the presenting depression or suicidal
ideation, with takes into account early childhood experiences, core and intermediate beliefs, key automatic thoughts and activating situations (e.g., Figure 1).

The automatic beliefs that most frequently prefaced Jim’s suicide desire were: “I don’t know what do with my time” and “No one wants me.” These thoughts occurred when Jim felt isolated or rejected. The clinician explored the implications of these beliefs: “What’s so bad about having nothing to do during the day or being alone some of the time?” The patient explained that “in order to be worthwhile, I must be productive and accepted.” He explained that his mother had died when he was very young and that he was raised by his stepmother. His stepmother had a daughter and the patient developed the belief that he was “second rate” to his stepsister. He believed that he had to achieve high standards (e.g., obtain high grades in school), to win his stepmother’s approval.

Guided by this formulation, treatment was planned to (a) provide the patient with more structured activities during the day to help him feel more productive, (b) assist him evaluate and challenge his appraisal that he was unwanted, and (c) to widen opportunities for establishing and maintaining self-worth.

**Developing a Safety Plan**

The safety plan is a hierarchically arranged written list of coping strategies developed collaboratively with the patient and clinician (Stanley & Brown, 2010; Wenzel et al., 2009). At a minimum, the safety plan includes a description of warning signs that are associated with suicidal crisis, a list of coping strategies that the patient can implement when alone, telephone numbers of social contacts (for distraction or to receive support), and professionals that can be contacted in times of crisis. The safety plan is developed early in therapy. The best safety plans are brief, use an easy-to-read format,
and generally consist of the patients’ own words (Wenzel et al.). This is particularly true for older adults, who may have some difficulties in reading detailed written instructions. Many older patients in our trial found it easier to store and retrieve (e.g., from wallet) safety plans that were the size of a business card (while keeping fonts reasonably large).

Jim acknowledged that a key warning sign was being alone at home in the mornings. He found that this situation triggered feelings of depression, loneliness, and the desire for suicide. As part of his safety plan, he listed coping strategies such as going for a walk and reading the financial sections of the newspaper. He found these activities lessened his loneliness and made him feel productive. He also wrote down the telephone number of a close friend whom he felt comfortable contacting when he felt lonely and the numbers of his clinician, a 24-hour telephone emergency hot line and the emergency services.

**Increasing Hope and Reasons for Living**

Hopelessness is one of the strongest predictors for future suicide in younger (Brown et al., 2000) and older adults (Rifai, George, Stack, Mann, & Reynolds, 1994). Identifying reasons for living and finding evidence for refuting hopeless cognitions were key strategies in our suicide prevention protocol. A relatively simple exercise is to ask patients to list their reasons for living and to record them on a coping card, or a sheet of paper. Many older patients (like younger patients), however, require more vivid portrayals of these reminders than simple entries on a coping card or sheet of paper. The development of a Hope Kit can be very useful in reminding older patients of the reasons for living. The Hope Kit is a memory aid consisting of a collection of meaningful items that remind patients of reasons to live and that can be reviewed during times of crisis.
Patients are asked to store mementos such as pictures, postcards, letters, inspirational or religious sayings or poems. This exercise can be enjoyable for patients and is one of the most meaningful strategies patients learn in therapy to address their suicidal thoughts and behaviors. During the course of constructing a Hope Kit, patients often find that they identify reasons for living that they had previously overlooked.

For example, Jim was asked to construct a collection of items that reminded him of his accomplishments or acceptance. He compiled letters from friends or family members, invitation cards to social gatherings and a positive assessment report of his physical health from his primary care physician. He also included an essay that he had written some years ago for a class, in which he had received an “A+” grade. A photograph of his late spouse was also included, which served as a reminder that he was loved, and was lovable.

**Improving Social Resources**

High levels of social isolation and poor social support networks are related to suicide ideation in older adults (Alexopoulos et al., 1999). Thus, helping patients to mobilize their social support system is an important component of suicide prevention intervention. For some patients, it may be necessary to build a support system. Patients can be encouraged to schedule activities in order to expand their network of social support. For example, older patients can be encouraged to participate in structured activities or classes offered by senior citizen organizations or neighborhood community groups. For other patients, helping to improve social resources may simply mean turning their attention toward the people who are the most caring in their lives and who would be
glad to help if only patients would be more forthcoming and responsive. Patients can be urged to contact old friends, neighbors, members of their church, and other community resources. A useful homework assignment involves asking patients to make a list of individuals who already are or could be part of their support system; then using a calendar, patients can then be encouraged to schedule as many positive social activities as possible with individuals on their list (Wenzel et al., 2009).

Jim was encouraged to seek a structured activity that would help him meet other people in his neighborhood. After brainstorming about such opportunities, Jim decided that he would investigate teaching English as a volunteer for a neighborhood migrant resource organization. He had previously worked as an English school teacher and enjoyed working with younger people. He succeeded in finding such an opportunity and found that he was able to expand his social network. Jim was also helped to recognize that he had several close friends in his life, and that he could arrange to meet some of them during the mornings. Although he protested that they “had their own lives,” he agreed to experiment by asking one of his friends to join him for breakfast. The friend agreed, and Jim found that his subjective sense of isolation was reduced by having more structured social activities and the option of socializing during the mornings.

**Improving Problem-Solving Skills and Efficacy**

Individuals with underdeveloped problem-solving skills are more likely to respond to stressful events adversely, compared to individuals with more positive attitudes and approaches (D’Zurilla, Nezu, & Maydeu-Olivares, 2002). Therefore, teaching patients to approach problems in a systematic sequential manner is helpful in reducing the likelihood of reacting negatively to problems (Eskin, Ertekin, & Demir,
2008; Nezu, Nezu, & Perri, 1989). Such an approach has been found to be efficacious for late-life depression (Arean, Hegel, Vannoy, Fan, & Unuzter, 2008). In this approach, patients are encouraged to describe the problem and generate an abundance of alternative solutions to their problems. Together with their clinician, they explore the various possibilities, listing the pros and cons of each solution until a suitable and concrete plan is created. The plan is implemented and results examined. Emphasis is placed upon flexible thinking and defining new goals as necessary. Coping cards can be created to list the steps of effective problem solving or to evaluate negative cognitions that prevent the patient from actively addressing a problem in the first place.

In our experience, older suicidal patients also have poor perceptions of their ability to solve problems (Dixon, Heppner, & Anderson, 1991). Consistent with findings in the research literature (Wenzel et al., 2009), we found that our patients’ subjective sense of incompetence appeared to contribute to their depression, hopelessness, and suicide ideation. For example, many of our older male patients described themselves as worthless or useless, because they could no longer work in paid employment or meet personal standards of performance. Restoring their sense of efficacy for solving problems was pivotal for helping them have a sense of mastery, meaning, and worthiness. One strategy that appeared to accomplish this goal was to have patients schedule a list of activities that involved graduated degrees of effort or mastery.

Jim reported that he used to enjoy exploring his neighborhood, but had not done this in a while. Jim and his therapist planned the steps needed to ride a bus around his neighborhood (e.g., look up bus schedule, catch a bus to a nearby shopping district, take a cell phone in case of emergency). As homework, Jim caught a bus to a nearby shopping
mall, and then gradually took longer expeditions. He enjoyed these outings and the associated sense of accomplishment. Over time, Jim reported feeling more efficacious.

The development of efficacy may require additional methods, such as reminiscing about previous accomplishments. Reminiscence has been used in other CBT programs to assist patients rediscover old skills and solutions (Thompson, 1996). Such techniques have been associated with improvements in depression and subjective well-being among older adults (Bohlmeijer, Roemer, Cuijpers, & Smit, 2007). Consistent with such research, we found that some older patients in our trial who reminisced about past mastery experiences were able to remember the skills and personal resources they used to overcome challenging situations.

For instance, Jim found that talking about the past helped him recognize two “ingredients in life” that helped him feel special. The first ingredient was that he had a partner who cherished and supported him and the second was that he was a teacher. He was able to understand that both these elements helped him cope with stressors and avoid feeling rejected or ignored. Since his retirement, he had not realized the extent to which the absence of teaching had affected his sense of self-value and purpose. By joining a volunteer organization for teaching English to migrants (see above), Jim was able to recognize that he still had qualities (e.g., being able to teach) that he valued in himself when younger, and therefore to feel an increased level of efficacy in addressing current challenges.

**Improving Adherence to Medical Regime**

Depression, hopelessness, and suicide ideation may interfere with medical compliance, thus worsening health outcomes (Montano, 1999). The refusal to comply
with medical procedures can be construed as indirect means of self-harm. Thus, at the onset of each therapy appointment, the clinician should assess the patient’s adherence to their medical regimen (such as keeping medical appointments or taking medication as prescribed). If treatment adherence is identified as a problem, the clinician can use cognitive strategies to examine negative beliefs and behaviors regarding noncompliance with medical treatment. Once these beliefs are examined, maladaptive thoughts can be challenged and a solution may be generated.

Jim lamented that it was futile attending his medical appointments (“My problems will never get better”). To address such thoughts, the clinician used a role-play strategy: The clinician played the role of the patient, while Jim played the role of patient advocate. In context of this exercise, Jim was able identify an important reason for complying with medical appointments. He said that although his health would not improve, at least he could attend the appointment to help maintain his current health level. He recognized that “at least I can walk” and wanted to be able to continue to do so. Following this exercise, he felt more motivated to attend his medical appointments.

**Cognitive Restructuring**

Cognitive restructuring strategies aim to help the patient identify, evaluate, and replace thoughts and images that are associated with depressed mood and maladaptive behavior responses. Negative thoughts are examined for their reality and validity using simple questions such as, “What is the evidence for and against this thought?” and “What is an alternative way to think about this situation?” (Greenberger & Padesky, 1995). By asking these questions, the negative thought is cognitively restructured so that patients are better able to regulate their mood. We used thought records to allow patients practice
at cognitive restructuring. However, we simplified the traditional 5-column thought record to three columns (catch, check, change). Patients were asked to “catch” their negative automatic thoughts, “check” their empirical basis, and “change” the beliefs accordingly.

Jim reported that he became depressed and suicidal when he was not invited to a dinner party by some of his closest friends. He was convinced that he was excluded because they no longer liked him. He also thought that if he did take his life, his friends would not miss him. His clinician gently probed for the accuracy of his conclusions that he was not liked and that he would not be missed. She asked him whether he had any additional evidence to support or refute these claims. Through this conversation, Jim realized that this was the first time he had been excluded from any function hosted by his friends. However, he remained puzzled as to why he had been excluded this time and wondered if he was no longer seen by them as being part of their social group. The clinician agreed that this was puzzling and asked the patient how he could “solve the mystery.” Jim decided to call one of these friends. When he did, he discovered that he had in fact not been deliberately excluded from the party, but rather that a friend had attempted to contact him the night before. Through this data-gathering exercise, the patient was able to dispute his negative conclusion about his social value.

**Activity Scheduling**

Scheduling activities that include mastery and pleasure exercises is frequently used in early stages of CBT to counteract the loss of motivation, hopelessness, and excessive rumination (Beck, Rush, & Shaw, 1979). The clinician uses an activity schedule for planning activities on an hourly basis. The schedule helps patients to restore
a routine or structure in their daily lives. In addition, the schedule encourages patients to engage in a mixture of pleasurable and mastery exercises, and thus to derive from these activities a sense of accomplishment and enjoyment. For Jim, the schedule was an important component of treatment. With the help of the Older Persons’ Pleasant Events Schedule (Gallagher & Thompson, 1981), Jim identified several activities that he enjoyed but no longer did. For example, he remembered that he used to enjoy singing in the church choir when he was younger, but had stopped going to church in the last few years. He did not consider himself religious and therefore had drifted away from church after the death of his wife. However, he missed the singing, and decided to schedule a visit to his local church that week. In addition, Jim nominated other activities for his schedule: going to the theatre with a friend, meeting his stepsister for lunch, and volunteering at his local library. The therapist and Jim planned his week in advance. When Jim returned to therapy the following week, he reported that the schedule had helped him feel less adrift in the mornings. He also felt less depressed and isolated because he was more active. In contrast to the past, where he would feel anxious during unscheduled times of the day, he now felt more relaxed because he knew that such times were limited.

**Homework**

Homework was used to support the various interventions in the protocol. Consistent with the recommendations by Coon and colleagues (Coon & Gallagher-Thompson, 2002; Coon, Thompson, & Gallagher-Thompson, 2007) for encouraging homework completion among older adults in therapy, simple and step-by-step instructions were provided for new homework assignments. Homework reminders and materials were inserted into a central notebook provided to the patient. When required,
caregivers or case managers were enlisted to help the patient complete homework. For example, one patient in the early stages of dementia was asked to construct a Hope Kit. He needed help remembering the important people in past. With the patient’s consent, the therapist communicated with the patients’ nurse at his residential unit and she agreed to help him complete this assignment. The nurse helped the patient build a collage of photographs depicting the patient’s significant social and family networks.

Homework assignments were frequently the result of collaborative efforts between the patient and therapist. For example, Jim complained to this therapist in the early phase of treatment that he felt his life did not mean anything—that is, that his actions did not reflect his values, or more specifically his desire to contribute to the well-being of other people. The therapist asked Jim how he could work towards implementing this value in this life. Jim could not come up with an answer in session. As homework, Jim agreed to brainstorm some ideas. At the next session, Jim brought his list of ideas, and these became the basis of discussion for that session.

Homework assignments mirror the different phases of treatment (see below). For instance, in the early phases, homework tends to relate to helping the patient activate mood and behavior. Jim was asked to increase his rate of engagement with activities that were enjoyable and that provided him a sense of mastery. In the middle phase of treatment, homework assignments focus on cognitive restructuring and problem solving. These assignments focus around helping patients identify and evaluate their negative thinking patterns, and to develop more adaptive way of viewing their situation and themselves. For Jim, such homework involved completing thought records in relation to his view that he was unlovable. He was able to gather evidence against this belief and to
replace it with a more adaptive view of himself. In the later phase, homework revolves around helping patients consolidate gains made during treatment. For example, one of Jim’s homework assignments within this phase was to identify the helpful aspects of therapy and to develop a written guide for relapse prevention.

**Relapse Prevention**

Treatment may end when patients have made progress toward goals and are no longer experiencing suicide ideation. When the clinician believes that patients have made gains in therapy, a formal assessment of increased cognitive and behavior skill is indicated. An in-session guided-imagery relapse prevention exercise may serve as this assessment. The objective is to prime as many of the thoughts, images, and feelings associated with the prior suicidal crisis as possible and then to determine if the patient is able to respond to problems in an adaptive way (Wenzel et al., 2009).

The first stage is to describe the task and provide a rationale to the patient. The clinician explains that the imagery exercise serves as chance to practice coping in imagination. The clinician should forewarn patient that they may have a strong emotional response to this experience but that this is to be expected and can be talked through. In the second stage, the patient is asked to imagine the sequence of the events and concomitant thoughts and feelings that led up to the suicidal crisis. The third stage involves imagining the same scene as before, but this time, responding to maladaptive thoughts and images with the skills learned in therapy. This step aims to test whether the patient can, in imagery, produce alternative ways of responding. In the fourth stage, the clinician provides the patient with a scene that the patient might face in the future that would likely lead to suicidal thinking. The clinician asks the patient to imagine this scene
and how he or she might proceed with such a situation. The final stage involves debriefing the patient to determine if the task was helpful and to assess whether there were any unintended consequences, such as increased distress, that resulted from engaging in this task.

For example, following a number of treatment sessions, Jim reported no longer feeling suicidal. After the clinician explained the purpose of the relapse prevention task (Stage 1), Jim agreed to go through the various steps. He was asked to think about past triggers for his suicidal ideation (Stage 2). He recalled that he became suicidal when he felt isolated or rejected. He was then invited to recall a scene in which such feelings were evoked, but this time to respond with coping strategies (Stage 3). Jim imagined himself calling a friend when he felt lonely. He also saw himself being able to review the evidence for and against his belief that he was unlovable. The clinician then provided another scene in which Jim had previously felt suicidal (Stage 4). The clinician asked Jim to imagine that he was suffering from pain in his leg, and was no longer able to go for walks. Jim recognized that this could be a likely trigger for suicide ideation, but was able to remember that in the past, such physical ailments were temporary setbacks, and that with medical attention, he would most likely return to his walks when his health improved. Following these imagery exercises, the clinician and Jim discussed the emotions and thoughts triggered by the images, and made a list of Jim’s key coping statements and behaviors (Stage 5).

**Outline of a Typical Session by Session Protocol**

Under optimal circumstances, patients are motivated for treatment, attend each session and complete all homework assignments. However, these optimal circumstances
are uncommon, particularly for older adults who, compared with younger patients, may present with a more negative or passive attitudes towards mental health professionals, have greater difficulties arranging transportation to sessions, or who face multiple sensory deficits that interfere with homework assignments (Arean & Feliciano, 2008). Therefore, the CBT clinician should individually tailor the treatment protocol to meet the needs of the patient and the conceptualization of the problem.

With those caveats in mind, different strategies tend to characterize the early, middle, and later phases of the CBT protocol for suicidal older adults. In the early phases of treatment (Sessions 1 – 4), the goals for treatment are to socialize the patient to treatment, conduct a suicide risk assessment, develop a cognitive case conceptualization, construct a safety plan and instill a sense of hope and identify reasons for living. In our protocol, we propose to patients that a goal for treatment is to address problems and feelings contributing to their desire for suicide. In context of that discussion, the therapist and patient identify the targets for treatment. The model of CBT is then presented to patients in a similar way at it is to younger patients (J. Beck, 1995). Using the patient’s experiences and visual diagrams, the therapist draws out links between thoughts, feelings, and behaviors and suggests that changes in one domain can affect outcomes in others. Behavior interventions such as activity scheduling and behavioral activation are typically introduced at this stage to illustrate this point and to help patients feel more efficacious and less depressed.

The middle phase of treatment (Sessions 5 – 9) consists of a focus on developing new skills for reacting to distressing situations with a focus on cognitive restructuring and behavior change. The treatment becomes increasingly focused on the individuals’ beliefs
associated with the suicide desire and develops ways of dealing with them. Often in this phase of treatment the clinician focuses on developing cognitive restructuring skills, improving social resources, improving problem-solving skills and efficacy, and improving adherence to medical regimen. The main focus during the termination phase of treatment (Sessions 10 – 12) is to evaluate whether patients have learned and can apply specific skills that may help to diffuse a suicidal crisis. These sessions include the relapse prevention task, as described above.

**Conclusions and Future Directions**

Epidemiologic data indicate that older adults have relatively higher suicide rates as compared to younger populations, and that older men are especially at high risk. Risk for suicide in older adults is associated with depression, hopelessness, suicide ideation, medical comorbidity, and social isolation. Despite the high prevalence of suicide in older adults, there have been few randomized controlled trials to evaluate the efficacy and effectiveness of treatment in this population. Given that CBT is one of the most widely researched psychotherapies for the treatment of depression in the elderly, the utilization of CBT to target risk factors for suicide in the elderly is promising. Based on the cognitive conceptualization of the suicidal older adult, the application of CBT strategies—increasing pleasurable activities, developing social resources, improving problem-solving skills, developing reasons for living, and improving adherence to medical treatments—may help elders to decrease hopelessness, depression, and suicidal ideation.

Three issues in particular require further exploration. First, more research is required to examine whether a CBT protocol that focuses on reducing depression is
sufficient for addressing suicide risk in older adults. Currently, there is limited data available on whether incremental efficacy is provided by augmenting of depression protocols (Bruce et al., 2004) with strategies for suicide prevention as outlined in this article.

Second, given that our approach was multifaceted, which aspects might be expected to be the primary active ingredients? Jim’s BDI, BHS and SSI scores reduced from 15, 9, and 13 at intake to 10, 4, and 0 at the close of treatment (20 sessions). The treatment appeared helpful for Jim, but as yet, we do not know which aspects of the treatment were most helpful. The research literature on this issue remains inconclusive (Scogin, Welsh, Hanson, Stump, & Coates, 2005). Some research suggests that behavioral activation is a crucial intervention for geriatric depression (Yon & Scogin, 2009) while other research suggests that the cognitive and problem-solving interventions (Arean et al., 2008) are the critical elements (Scogin et al., 2005). A body of research has also suggested that homework assignments facilitated positive outcomes for older adults (Coon & Gallagher-Thompson, 2002). More investigations of dismantled treatment protocols are needed to identify the active ingredients for older suicidal adults.

Third, further studies are needed to investigate whether certain techniques for suicide prevention are more useful for older adults compared to younger adults. For example, in our experience in treating older suicidal men, we found that engaging some patients to reminisce about the past was helpful for improving their perceived self-efficacy and motivation for addressing their current problems. Very little research is available about reminiscing as a therapeutic tool, when used in conjunction with other
CBT techniques. This is an area that can be further embellished and researched within a CBT framework.
References


Author Note

This research was supported by the National Institute of Mental Health (P30 MH45178).

Address correspondence to Sunil Bhar, Ph.D., Faculty of Life & Social Sciences, Swinburne University of Technology, Mail H31, PO Box 218, Hawthorn, VIC 3122, Australia; e-mail: sbhar@swin.edu.au
Footnote

¹ Details about the case have been modified to protect the identity of the client.
Figure 1. Conceptualization Diagram for Jim