Disclaimer

This webinar was developed [in part] under contract number HHSS283201200021I/HHS28342003T from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.
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- ... and many more!

Research funding

- NIMH K23MH096936 (Van Orden, PI)
- CDC U01 CE001942 (Conwell, PI)
- CDC R49 CE002093: E. Caine, PI
- NCATS CTSI Incubator Award, UR University Research Award
- UR University Research Award
Learning Objectives

1. Learners will describe at least two challenges to suicide prevention in later life that illustrate the importance incorporating upstream prevention strategies into a late life suicide prevention program.

2. Learners will be able to state the rationale for targeting social relationships in suicide prevention in older adults.

3. Learners will identify at least two empirically informed strategies for improving relationships for older adults that they can bring to their work.
“My work is done. Why wait?”

George Eastman  
March 14, 1932  
Age 77
Suicide is not an expected or “normal” response to the stressors of aging.
Suicide in Later Life is a Significant Clinical and Public Health Concern.

Social Connections are Key to Suicide Prevention.
Significance

• Older adults are the most rapidly growing segment of the population.
• Older adults have higher rates of suicide than other segments of the population.
• In successive cohorts the problem may be worse.
• Suicidal behavior is more lethal in later life than at other points in the life course.
LETHALITY OF LATE LIFE SUICIDE

• Older people are
  – more frail (more likely to die)
  – more isolated (less likely to be rescued)
  – more planful and determined

• Implying
  – Interventions must be aggressive (indicated)
  – More distal prevention is key (selective and universal)
OPTIMAL SUICIDE PREVENTION =

Indicated – *detect and treat depression*

+ 

Selective – *optimize independent functioning, increase social connectedness*

+ 

Universal – *education to reduce ageism, promote gun safety*
A problem of social disconnectedness

- Indices of social disconnection in later life:
  - **Loss of a spouse**
    (Conwell et al, 1990; Erlangsen et al, 2004)
  - **Loneliness**
    (Rubenowitz et al, 2001)
  - **Interpersonal discord**
    (Harwood et al, 2006; Beautrais, 2002; Duberstein et al, 2004)
  - **Low social support**
    (Turvey et al, 2002)
  - **Fewer people in whom to confide**
    (Miller, 1978)
  - **Less community engagement**
    (Duberstein et al, 2004)
  - **Living alone**
    (Waern et al, 2002; Barraclough, 1971)
Social Connection:
A target for health promotion and distal suicide prevention

Mental Health:
depression, hopelessness, Well-being, suicide

Physical Health:
Subjective perceptions; Presence of disease

Cognition:
Better memory & planning; Lower risk for dementia

Functional Status:
Mobility, Self-care, Strength

Social Connection:

SAMHSA
Substance Abuse and Mental Health Services Administration
There is nothing so practical as a good theory...

Kurt Lewin (1951)
INTERPERSONAL THEORY OF SUICIDE

Thwarted Belonging

Perceived Burden

Capability

Suicide

Joiner (2005); Van Orden et al. (2010)
Intervention Mechanisms Grounded in The Interpersonal Theory of Suicide

**Intervention target**
- Social engagement (behavior)

**Behavioral risk factor**
- Belonging and perceived burden (cognition/emotions)

**Clinical outcomes**
- Suicide risk indicators: suicide ideation/behavior, quality of life, meaning in life
• Ed is a 72 y/o white male who lives alone:
  – increasing disability (can no longer drive), possible depression, and social isolation
• Therapist visited his home:
  – He reported a few acquaintances, but no close friends
  – Mild depression symptoms on depression screen
  – Smiles were rare; flat affect, monotone, minimal speech, long pauses, stooped over, fidgeted with hands, negative content in conversations.

HOW DO WE HELP?
Strategy 1: Peer Companionship
The Senior Connection
A Randomized Trial of Companionship

“The Senior Connection” U01 CE001942 from CDC (Conwell PI)
### “DOSE” – Monthly average

<table>
<thead>
<tr>
<th>Phone calls</th>
<th>Phone mins</th>
<th>Meetings</th>
<th>Mtg time</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0</td>
<td>31 mins</td>
<td>1</td>
<td>1.75 hrs</td>
</tr>
</tbody>
</table>

### “DOSE” – Monthly range

<table>
<thead>
<tr>
<th>Phone calls</th>
<th>Phone time</th>
<th>Meetings</th>
<th>Mtg time</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 6</td>
<td>0 - 3.5 hours</td>
<td>0 - 5</td>
<td>0 – 19 hours</td>
</tr>
</tbody>
</table>
PHQ-9 Depressive Symptoms (0-27)

Least squares means
Interaction*

TSC = The Senior Connection (peer companionship)

CAU = Care as Usual (control)
GAD-7 Anxiety Symptoms (0-21)

Least squares means
Interaction*

TSC = The Senior Connection (peer companionship)
CAU = Care as Usual (control)

TSC = Base
- 8.08
TSC = 12 months
- 6.56

CAU = Base
- 7.86
CAU = 12 months
- 7.58

SAMHSA Substance Abuse and Mental Health Services Administration
What if Ed refuses to let a volunteer visit with him?
Strategy 2: Provide Peer Companionship by volunteering

“Volunteering [as a peer companion] helped me get out of myself. I think for men it is particularly difficult when you just stop working. This has given me a wonderful opportunity to talk and interact. I’m grateful; I know I gained as much as anything I have given anyone else. The worse thing for me is to be by myself in my living room, it feels like the walls start closing in... this is a wonderful thing for that.”
The Getting Active Project (GAP)
A randomized trial to reduce loneliness in later life (R01AG054457)

60+
Lonely

N=150

SENIOR CORPS

N=150

Writing YOUR LEGACY
The Step-by-Step Guide to Crafting Your Life Story
Richard Campbell, M.Ed.
Cheryl Swansson, Ph.D.
What if Ed’s depression and isolation are feeding off each other – and he’s not motivated to leave the house?
OBJECTIVE: To examine whether ENGAGE psychotherapy (that targets social engagement) is effective in reducing risk for suicide.

- Randomized trial: ENGAGE vs. CAU
- Inclusion: Endorse loneliness/perceived burden
- Hypotheses: (1) Targeting social engagement will indirectly reduce suicide risk by increasing belonging and reducing perceived burden, (2) Changes in belonging & burden will temporally precede (pilot) or mediate (full study) changes in suicide risk.
Demographics

Sex
- Randomized n=62 (32% male)
  - N=30 CAU (33% male)
  - N=32 ENG (31% male)

Age
- Mean age = 72.14, sd=9.07
- Age range: 60.55 – 92.75

Marital status
- Married: n=14 (23%)
- Divorced n=19 (31%)
- Widowed n=19 (31%)

Living alone
- 70% living alone
- 34% with 1 other

Education
- At least some college: 70%
- Range: less than HS to grad

Race
- 6% non white
Attrition & Compliance

• N=57 completed final assessment (92%)
• Mean number of completed sessions: 8.5
  – Range: 1-10
  – 66% completed all 10 sessions
  – 88% completed 6 or more sessions
"Baby Steps"
Depression Symptom Severity

n=57 completed 10 week assessment (92%)

condXtime: F(3, 154) = 28.43, p = .002
Behavioral Activation Scale: Social
Geriatric Suicide Ideation Scale

The graph illustrates the change in Geriatric Suicide Ideation Total Score over time, comparing baseline and 10 weeks. The graph shows a downward trend, indicating a decrease in suicide ideation scores. Two lines are present, one for 'cau' and another for 'eng', representing different groups or conditions.
Self-awareness/Insight about their social world

• “I really do want & need communication with people.”
• “I want just a few deep relationships”
• “Asking "how can I fit here" instead of thinking I don’t.”
• “Learning how I valued my sons & husband's relationship.”
• “I can become more proactive/active in seeking connections within the community and beyond.”
• “I learned I can get out and be accepted by others.”
• "I'm worthy of interacting with other people.”
• “I’m not as much of a loner as I thought; more influenced by people around me than I realized"
“Once you start doing it, it becomes habit - reaching out and being with people and engaging in activities.”

“Action plan - if isolating or feeling overwhelmed.”

“Action plans helped with accountability (got me out to different programs - osher maplewood) rec centers.”

“Try to make an action plan each week.”

“I was dealing with inertia because of grief...Now on my own & retired - need to make a plan: it helped kick me in the ass a little bit."
Ed does well with Engage and visits a senior center, but feels left out.

Maybe his social skills make it hard for him to connect?
• Effective nonverbal communication (NC) is essential for forming and maintaining positive, supportive relationships.
  – Up to 20% of community-dwelling older adults demonstrate difficulties with nonverbal communication.⁶
Study
**Eye Contact**
- You maintained good eye contact. You looked at me directly.
- Try making eye contact with me more often.

**Speaking Volume**
- Your speaking voice is good. Try to keep it up.
- Like I mentioned before, try speaking louder.

**Smile**
- You smiled frequently with a genuine smile. Keep it up.
- Try smiling more. Use your whole face to smile, including your eyes.

**Content**
- You kept the conversation positive. Keep it up, because this will help you engage with other people.
- Consider talking about yourself in a positive light. Try paying attention to whether you are saying negative things.
Study

Conversation

Feedback

Conversation

Feedback

Final Feedback

Positive Feedback

Negative Feedback
% of Participants received positive feedback per conversation.
A multifaceted intervention model

- Social disconnection
  - Social skills
  - Losses: bereavement, retirement, relocation
  - Disability, homebound
  - Depression
  - Collaborative care models (e.g., PEARLS)
  - Peer companionship
  - Senior Centers
  - Transportation
  - Volunteering
  - Care management
• Positive connections that involve **caring** and **contribution** may save lives.

• Dose, amount of time to change loneliness vs. social engagement:
  – “I’m not as much of a loner as I thought; more influenced by people around me than I realized.”

• Understanding pathways to isolation, loneliness, and feeling like a burden and tailoring intervention strategies.
Thank you!

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