Mobilizing the Community to Prevent Older Adult Suicide

Matthew C. Fullen[1]

Abstract

Older adults are at an elevated risk for suicide. A comprehensive framework for preventing older adult suicide should include knowledge about risk factors, a theoretical basis that explains the high prevalence of older adult suicide, and a transdisciplinary prevention strategy that shares responsibility for suicide prevention among professional and lay members of the community. The author introduces a community-based suicide prevention strategy that employs health and mental health professionals, aging sector professionals, caregivers, and older adults to recognize and respond to older adults who may be in distress.

Keywords

older adults, suicide, suicide prevention

Prior to his suicide in 1932, George Eastman, age 77, and founder of the Eastman Kodak company, wrote this note: "To my friends: My work is done. Why wait? G.E." (Ward, 2004). Following Eastman's death, the local press characterized the suicide note as a matter of fact explanation of what seemed like a simple and straightforward decision (Conwell, 2013). However, Yeates Conwell, a leading suicidologist, goes on to explain that the press overlooked several complex factors that seem to have precipitated Eastman's suicide—the recent deaths of his mother and several friends; social isolation resulting from the loss of control over his company; development of a degenerative spinal condition that increased Eastman's pain and reduced his ability to walk and control his bladder; a depression that may have resulted from this series of hardships; and ultimately, a lack of meaning and purpose. Conwell's description

[1]The Ohio State University, Columbus, OH, USA

Corresponding Author:
Matthew C. Fullen, The Ohio State University, Columbus, OH, USA.
Email: fullen.33@osu.edu

begs the question: Was Eastman's suicide as straightforward as the press described it or was it a result of complex circumstances that could have been altered if given adequate attention?

Nearly 80 years later, and both globally and nationally, older adults consistently rank as one of the groups most at risk for suicide. Globally, adults over the age of 70 have the highest rate of suicide (World Health Organization [WHO], 2014). In the United States, older adults complete suicide at a rate of 16.1 (per 100,000 people), which exceeds both the national rate (13.0) and the rate of young people aged 15 to 24 (11.1). In 2012, older adults made up 16.37% of all completed suicides, despite only accounting for 13.75% of the population. Remarkably, older adult White males complete suicide at a rate more than double the national average (32.2). This rate increases to 50.7, or nearly four times the national average, for older White males over the age of 85 (American Association of Suicidology, 2014). Across all age-groups, suicide is the 10th leading cause of death in the United States, and it is more common than death due to motor vehicle accidents, poisoning, falls, and homicide (Substance Abuse and Mental Health Services Administration, 2014). As the population ages, age-based suicide trends among older adults may result in significantly higher numbers of deaths by suicide. Preventing older adult suicide requires knowledge of risk factors, a theoretical basis for understanding what precipitates older adult suicide, and a coordinated effort between members of the professional and lay community who have a stake in preventing older adult suicide. Therefore, this article will (a) synthesize what is known about older adult suicide, (b) identify two theoretical models that explain the high rates of older adult suicide, and (c) introduce a community-based suicide prevention model that has potential to strengthen efforts to connect older adults to care.

Older Adult Suicide: Risk Factors

Several demographic variables serve as suicide risk factors in the older adult population. First, there are significant trends based on the combination of age and sex. Phillips (2014) collected suicide death counts from every 5-year group between 1935 and 2010 and determined that 83.6% of older adult suicides were completed by men. The author went on to state that across numerous cohorts, suicide rates in males tend to follow the trend of increasing in adolescence, leveling off through middle age, and increasing once again in old age. For females, there is an initial increase in adolescence, followed by a leveling off, then another increase in middle age, only to level off once again in old age. Older White and American Indian males are at highest risk, whereas African American, Latino, and Asian American elders have significantly lower rates of suicide (Hooyman, Kawamoto, & Kiyak, 2014).

The link between mental health disorders and suicide is strong across all age categories (National Institute of Mental Health, 2013). Approximately 95% of

those who die by suicide suffer from one or more mental disorders, including untreated anxiety or depression (Van Orden et al., 2010). In a recent sample of suicide deaths, several mental health disorders were found, including mood disorders (54.4%), substance use disorders (29.1%), anxiety disorders (22.2%), and psychotic disorders (6.1%) (Draper, Kolves, De Leo, & Snowdon, 2014). Depression is currently the leading cause of disability in the world (WHO, 2012), and it is estimated that by 2030 it will have the greatest disease burden worldwide (WHO, 2011). Moreover, it is believed that older adults' depression symptoms may be underdiagnosed and undertreated (Center for Disease Control [CDC], 2012). Older adults' depression symptoms may be experienced somatically, leading healthcare providers to incorrectly assume that aches, pains, or sleep disturbances are part of normal aging (Hooyman et al., 2014). For instance, 43–70% of older persons visited a primary care provider within one month of their suicide (Luoma, Martin, & Pearson, 2002) and 20% saw their doctor the day of their death (National Alliance for the Mentally Ill, 2009). Although the majority of older adults report adequate levels of life satisfaction (National Institute of Mental Health, 2013), depression rates in older adult samples range between 3% and 4.5% in community settings (Hooyman et al., 2014); 6% to 9% in primary care settings (U.S. Preventive Services Task Force, 2009); 11.5% in older hospital patients (CDC, 2012); and 13.5% in those who require home healthcare (CDC, 2012). Furthermore, when depression is properly diagnosed, treatment is effective with older adults. Meta-analyses show that both psychotherapy and antidepressant medication are effective treatments for depressed older adults (U.S. Preventive Services Task Force, 2009).

Another key risk factor for suicide is access to firearms. Older adults have the highest rate of gun ownership in America, and between 2005 and 2010, 80% of older adult suicide deaths were by firearm (Pinholt, Mitchell, Butler, & Kumar, 2014). The ratio of older adults' suicide attempts to suicide deaths is 4:1, which indicates that attempts within this age-group are far more lethal than other age-groups (Conwell, 2014). Pinholt et al. (2014) provide five questions that guide how to discuss gun ownership with an older adult: Is the firearm Locked? is it Loaded? are Little children present in the home? is the gun owner feeling Low? and is the owner Learned about gun safety? Each of these questions refers to red flags that health care providers or loved ones may assess if concerned about an at-risk older adult.

Although sex, mental health, and access to firearms account for substantial variance in older adult suicide risk, additional variables are involved. These include the following: a major physical illness accompanied by severe pain, the sudden death of a loved one, a major loss of independence, financial instability, persistent depression, chronic pain, cardiopulmonary disease, cancer, and drug and alcohol abuse. Furthermore, widowers are more than five times as likely to die by suicide as men who are married (Hooyman et al., 2014). Warning signs for older adult suicide include direct or indirect statements indicating frustration with life and a desire to die, a sudden decision to give away

prized possessions, a general loss of interest in one's environment, and isolation or feeling cut off from others (Hooyman et al., 2014).

There is cause for concern about potential suicide risk in the emerging cohort of older adults. Currently, more than one-third of suicide deaths are individuals aged 45 to 64 (Drapeau & McIntosh, 2015). The majority of this age bracket consists of baby boomers, a group that has been identified as having an elevated risk of mental health disorders, substance use, and suicidality. For instance, a greater number of baby boomers have experienced a depressive disorder, although it is unclear why this is the case (American Psychological Association, 2009). Additionally, illicit drug use nearly doubled (5.1%–9.4%) among 50 to 59 year olds between 2002 and 2007 (Institute of Medicine, 2012), indicating that those aging into older adulthood may be more likely to use substances. Depression and substance abuse are general risk factors for suicide, and between 1999 and 2004, suicide rates increased by 19.5% for those aged 45 to 54 (CDC, 2007), a subset of the boomer cohort. However, Phillips (2014) used age-period-cohort analysis and concluded that early boomers (born between 1946 and 1954) have a lower than average rate of suicide, whereas late boomers have a rate comparable to the overall average. Although it remains to be seen how these trends will continue into the future, geriatric mental health experts speculate that baby boomers will be more likely to utilize mental health services, including psychotherapy (Bartels, Blow, Brockmann, & Van Citters, 2005).

The Role of Theory in Understanding Older Adult Suicide

Leaders in gerontology have identified the need for more thoughtful connections between gerontological practice and theories of adult development (Alley, Putney, Rice, & Bengtson, 2010). The need for theoretical models is particularly salient for understanding older adult suicide, due to the challenges associated with the empirical study of suicide (Van Orden et al., 2010). Therefore, two theories, social phenomenology and the interpersonal theory of suicide, will be used to provide a conceptual framework for what causes older adult suicide, as well as what can be done to prevent it.

The first theory, social phenomenology, explains how individuals construct life meaning within a social context (Gubrium & Holstein, 1999). When it is used to understand gerontology, social phenomenology explains how a society ascribes meaning to various aspects of the aging process. For instance, retirement has traditionally been viewed as a milestone that indicates one's transition from midlife to late-life. Although this understanding of retirement is evolving, the social phenomenology perspective provides a framework to ask questions about what retirement symbolizes to society and individual members of that society. At the societal level, one might ask, "How does society's definition of work impact its understanding of retirement?" For the individual within this

society, the question shifts to, "What does retirement mean to me in this particular context?" Additional questions might stem from the relationship between work and personal value. At the societal level one might ask, "How does one's ability to work contribute to his or her value in a given society?" At the individual level, the question may be, "What is my purpose now that I no longer work?"

It is worth noting that social phenomenology assumes that meaning is not statically based on an objective reality but rather changes based on context. Therefore, a milestone like retirement does not have a single, unchanging definition but instead represents a constructed reality that combines the definitions created by each society and interpreted by each individual. The constellation of meaning created by the social phenomenological perspective may shed light on the elevated rate of suicide among older White males in the United States. Some have argued that depressive symptoms and suicide risk in older adults are mediated by how much value an individual places on autonomy (Bamonti, Price, & Fiske, 2014). A social phenomenological perspective might suggest that autonomy, a socially constructed value for Americans, is especially pertinent when ascribing worth to males. In cases where older adulthood introduces a challenge to one's autonomy—whether due to leaving the workforce, facing functional changes associated with health, or additional adaptations that are associated with this life phase—an individual who is adapting to these changes may perceive himself as less autonomous in a society that places great value on autonomy. To the extent that he interprets reduced autonomy as shameful or burdensome, depression and suicidality may result.

A second theory, the interpersonal theory of suicide (Joiner, Van Orden, Witte, & Rudd, 2009; Van Orden et al., 2010), proposes that suicidality in older adults is influenced by two underlying constructs: thwarted belonging and perceived burdensomeness. Thwarted belonging refers to the consequence of unmet needs for social integration among older adults. The authors note that social isolation is a strong and reliable predictor of suicidality across all ages. In older adulthood, social isolation may describe why the loss of a spouse or other loved ones predicts increased suicide risk. Van Orden et al. (2010) propose that the thwarted "need to belong is the need central to the development of suicidal desire" (p. 583). Building off Shneidman's (1987) famous work on suicidality as a result of "psychache," the authors posit that when social needs for belonging are thwarted, the individual experiences intense emotional pain that may result in an increased openness to suicide.

The second construct in the theory is perceived burdensomeness. Van Orden et al. (2010) describe previous theories that describe perceptions about being burdensome or "expendable" (p. 586) as suicide risk factors in adolescents (Woznica & Shapiro, 1990 in Van Orden et al., 2010). The authors provide the example of an individual whose dominant cognitive schema becomes: "I make things worse for the people in my life" (p. 586). This may include family

members who are burdened by the older adult's needs but may also extend to
nonfamily members who are involved in their care. Perceived burdensomeness
may explain why risk factors like family conflict, unemployment, and physical
illness are predictive of older adult suicide.

A synthesis of social phenomenology and the interpersonal theory of suicide
provides an explanatory framework to understand older adult suicide and guide
suicide prevention efforts. Older adults make meaning of their lives within a
social context (social phenomenology). When this social context fails to provide
older adults with ongoing resources for meaning-making, older adults may be at
greater risk for psychological distress. Furthermore, when the social context
thwarts older adults' need to belong, or communicates directly or indirectly
that they are burdensome (interpersonal theory of suicide), older adults may
interpret their lives as either meaningless or detrimental to those in their lives.
These factors may combine with other known risk factors—age, sex, mental
health, access to means—and influence suicidality.

Preventing Older Adult Suicide

Despite its complex nature, suicide is preventable (WHO, 2014). The leading
suicide prevention strategies are based on a public health model, which stipulates
that prevention programs should provide comprehensive, transdisciplinary stra-
tegies that reach out to both at-risk individuals and the communities in which
they live. Furthermore, the use of theory has been a helpful guide to inform
suicide prevention efforts (Shneidman, 1987; Van Orden et al., 2010). Therefore,
suicide prevention strategies that are geared toward older adults should build on
adult development and aging theories, such as social phenomenology and the
interpersonal theory of suicide. The remainder of this article will propose how
the gerontology community, including practitioners, educators, caregivers, and
older adults themselves can build a comprehensive, transdisciplinary prevention
strategy that mobilizes diverse community stakeholders to share the responsibil-
ity of older adult suicide prevention (Table 1).

The public health approach to suicide prevention describes the need for indi-
cated, selected, and universal approaches. First, indicated prevention targets
individuals who are experiencing signs of distress, including suicidal thoughts
or behaviors, or symptoms of mental disorders that are correlated with suicid-
ality, including depression, substance abuse, or psychosis. Next, selected preven-
tion identifies groups that may be at an elevated risk based on demographic
characteristics, circumstances, or other factors. In the case of suicide prevention,
this may include being White, being male, having a physical illness, dealing with
loss, facing a significant life adjustment, or adjusting to diminished independ-
ence (Hooyman et al., 2014). Finally, universal prevention describes efforts made
to reach an entire population. In the case of suicide prevention, this might
include mental health or suicide education training for older adults, caregivers,

Table 1. A Comprehensive Framework of Community Suicide Prevention.

	Health/mental health professionals	Age-sector providers	Gerontology educators	Caregivers	Older adults
Indicated/ selected	Training in suicide assessment Training in referrals for mental health treatment Interdisciplinary treatment Reciprocal referrals	Work with staff to: Promote help-seeking behavior Destigmatize mental health concerns Refer to health providers Implement depression screenings in residential settings or at community gatherings	Train students who will provide direct or indirect roles as health care/age-sector providers Coordinate community partnerships to increase direct interventions Research how gerontological theory informs suicide prevention	Work with other caregivers and older adults in their lives to: Promote help-seeking behavior Destigmatize mental health concerns Refer to health providers Learn warning signs and risk factors Promote protective factors	Work with other caregivers and older adults in their lives to: Promote help-seeking behavior Destigmatize mental health concerns Refer to health providers Learn warning signs and risk factors Promote protective factors
Universal	Partner with age-sector providers on: Mental health promotion Community education (including gatekeeper trainings)	Partner with health providers on: Mental health promotion Community education (including gatekeeper trainings)	Partner on: Mental health promotion Community education (including gatekeeper trainings) Promoting help-seeking behavior Destigmatizing mental health concerns	Promote help-seeking behavior Destigmatize mental health concerns	Promote help-seeking behavior Destigmatize mental health concerns

or professionals who work with older adults. These efforts are intended to reduce stigma, promote help-seeking, and train a broad audience of individuals to recognize older adults who may be at more acute risk of suicide (Heisel & Duberstein, 2006).

Comprehensive suicide prevention takes place when efforts are implemented at both the individual and community levels (Conwell, 2014). For instance, although it is important for health and mental health professionals to have training in assessment of suicide risk in patients or clients, best practices in comprehensive suicide prevention include gatekeeper trainings, or efforts to educate entire communities about suicide warning signs, subclinical intervention strategies, and referrals for additional health services (Suicide Prevention Resource Center, 2015). Promising suicide prevention strategies have been implemented with at-risk groups like college students (Jed Foundation, 2014) and the military (Knox, Litts, Talcott, Feig, & Caine, 2003)—two populations where suicide rates and prevention efforts have received significant attention. The strategies include the following directions to shape community efforts to prevent suicide: (a) provide adequate mental health services, (b) identify individuals at risk, (c) increase help-seeking behavior, (d) promote social connectedness, (e) develop life skills for dealing with mental health conditions, (f) restrict access to potentially lethal means, and (g) follow crisis management procedures (Jed Foundation, 2014).

Similar strategies have been recommended to prevent older adult suicide. Conwell (2014) outlines the need for a comprehensive public health model to preventing suicide in older adults. He notes that older adults have a much higher rate of lethality when attempting suicide, meaning that prevention strategies must identify distal risk factors that may predict increased likelihood of a future attempt. Conwell categorizes these factors within five areas: psychiatric illness, personality traits, physical illness, social context, and overall functioning. He then recommends that intervention efforts take place at both the community and health practitioner levels.

Once a community implements a comprehensive, public health framework for suicide prevention, a transdisciplinary approach is imperative. A transdisciplinary approach includes collaboration between a variety of parties, including health professionals, aging sector professionals, gerontology educators, caregivers, and older adults themselves. This model assumes that identifying and supporting older adults who may be at risk for suicide is a responsibility shared by members of a community, regardless of professional boundaries or discipline-based training paradigms. In practice, this means that anyone who may interact with an at-risk older adult—whether a health professional, aging sector professional, educator, student, or family member—should have core knowledge about the risk factors for older adult suicide. A description of how each group might consider suicide prevention at both individual and community levels will improve efforts to prevent suicide within the older adult population.

Health Professionals

At the health professional level, there are numerous considerations for how to prevent suicide at both the individual (indicated/selected) and community (universal) levels. At the individual level, health and mental health professionals provide assessment, diagnosis, and treatment to older adults in a variety of settings. To improve risk assessment and intervention skills, health professionals should seek specific training in geriatric mental health, including the unique manner in which depression and suicidality are manifested in older adults. For instance, research indicates that when compared with younger groups, older adults who died by suicide were less likely to admit to suicidal thoughts (Heisel & Duberstein, 2006), less likely to have a history of psychiatric treatment (Heisel & Duberstein, 2006), more likely to die during their first suicide attempt (Hooyman et al., 2014; Podgorski, Langford, Pearson, & Conwell, 2010; Zweig, 2006), more likely to use a firearm when attempting suicide (Pinholt et al., 2014; Podgorski et al., 2010), and more likely to seek help from a primary care provider rather than a mental health professional (Heisel & Duberstein, 2006). As previously stated, 43–70% of older adults who died by suicide had seen a primary care provider in the preceding month (Luoma et al., 2002), and 35% to 50% had visited a primary care provider in the preceding week (Heisel & Duberstein, 2006). Therefore, primary care providers must ensure that suicide and depression assessment are integrated into other primary care assessments. Both primary care and mental health professionals should consider asking patients with elevated risk levels about whether they have access to firearms (Heisel & Duberstein, 2006; Pinholt et al., 2014). Moreover, both primary care and mental health providers should construct reciprocal referral practices that acknowledge the close link between physical and mental health in the older adult population (Heisel & Duberstein, 2006).

At the community level, health and mental health professionals should be aware of public health campaigns related to mental health, suicide prevention, and the health care needs of older adults. Due to societal myths that depression and frequent thoughts of death are normal parts of aging, educating the public about suicide and depression is particularly important when working with older adults. Although health professionals may focus on treating individuals, they should consider partnering on universal prevention strategies. By lending their expertise to public health campaigns related to older adults' mental health, health professionals might spur public support to reduce mental health stigma, increase funding for mental health services, and promote help-seeking behavior among older adults (Heisel & Duberstein, 2006).

Aging Sector Professionals

Aging sector professionals share responsibility for promoting suicide prevention for older adults. Employees of independent living communities, assisted living facilities, long-term care facilities, and adult day centers have numerous day-to-day interactions with older adults and should be considered as front line gatekeepers when it comes to suicide prevention. Many aging sector professionals have direct daily contact with both older adults and those charged with their care. These include the following: (a) on-site health care staff such as nurses, occupational or physical therapy providers, or other employees who provide direct health services; (b) site administrators, including nursing home administration and related personnel; (c) support service professionals, such as social workers, social work assistants, or service coordinators; (d) direct care workers, including State Tested Nursing Assistants, personal care aides, and home health aides; and (e) adjunct service providers, such as activities staff, chaplains, transportation staff, food staff, and other employees.

Given the frequency and type of contact that each of these groups may have with older adults, it is possible that an older adult in distress may confide in one of these aging sector professionals prior to, or instead of, confiding in a primary care provider or mental health professional. Therefore, suicide prevention efforts should include members of these groups. Regarding indicated prevention, members of these groups should be aware of risk factors and warning signs associated with older adult mental health and suicidality. Clear referral guidelines should be provided to link the employee's concerns with a call to the site's social service provider, who will then set-up an immediate suicide risk assessment. Selected prevention efforts might include training aging sector professionals on the risk factors of suicide, breaking down myths about mental health, and encouraging staff to promote help-seeking behavior among the older adults with whom they work. Finally, universal prevention might include partnering with community leaders to bring awareness about older adults' mental health needs, identifying impediments to help-seeking behavior, including stigma, and ensuring that aging sector employees are provided with similar support for their own psychosocial needs.

Gerontology Educators

Gerontology educators play a unique role in building a comprehensive, community-based approach to older adult suicide prevention. Although suicide risk assessment has historically been viewed as the responsibility of health and mental health professionals alone, gerontology educators have the opportunity to influence students, community leaders, and research. Gerontology educators can provide indicated and selected prevention by training students who will

work directly with at-risk older adults in their future careers. However, the greater role for gerontology educators may be in the arena of universal prevention. Here, they can use their influence in the community to create dialog about older adult suicide prevention. For instance, gerontology educators might host symposia where students, community leaders, and aging sector professionals discuss how to coordinate efforts to decrease risk factors like social isolation and perceived burdensomeness. Furthermore, gerontology educators can promote research that improves society's understanding of the needs of older adults, how to provide meaning throughout the lifespan, and what can be done to improve community-based suicide prevention efforts.

Caregivers

Over 90% of older adults live in independent housing, and 75% of the oldest-old also live in independent units (Hooyman et al., 2014). When older adults receive long-term services and assistance with activities of daily livings at home, approximately 65% of these needs are provided by family caregivers. An additional 26% employ a combination of family care and paid help (Hooyman et al., 2014). Regarding suicidality, one study found that 73% of those who died by suicide had expressed suicidal thoughts to a family member (Waern, Beskow, Runeson, & Skoog, 1999). Therefore, family members, particularly those in a caregiver role, should be involved in suicide prevention at the indicated, selected, and universal levels. For instance, caregivers would benefit from suicide education, increased awareness of the signs and symptoms of depression, and community supports that promote help-seeking behaviors. Caregivers should receive training on recognizing suicide risk factors and responding to a family member in distress. If an older adult is clearly depressed, experiencing suicidal thoughts, or expressing a desire to die, it is important to empower caregivers to seek mental health services from someone qualified to assess suicidality in older adults. Caregivers, themselves, should also have access to psychosocial support.

Older Adults

A comprehensive suicide prevention program should also include prevention efforts geared directly to older adults. Peer-based prevention efforts may be effective for multiple reasons. First, older adults may observe the behaviors and mindsets of their peers through interactions in the community or in a residential setting (Podgorski et al., 2010). This places older adults in the position to identify peers who may be in distress and direct them to resources. Next, older adults may possess insight into cohort effects that limit help-seeking behavior among other people their age. By understanding firsthand why other older adults may be reticent to seek help, older adults can use positive social influence to break down mental health stigma and increase help-seeking behavior among

their peers. Finally, social connectedness may function as a protective factor against suicide risk (Conwell, 2014). Including older adults in prevention efforts may result in increased opportunities to integrate isolated and lonely individuals into a community of peers. Indicated prevention might include teaching older adults how to ask peers about suicidality and refer them directly to appropriate mental health services. A selected prevention strategy would be teaching older adults how to recognize suicide risk factors in their peers and encourage them to seek out supportive services prior to risk increasing. Finally, universal prevention might include community education that focuses on older adults' roles as gatekeepers, mental health promotion campaigns, and efforts to break down mental health stigma.

Conclusion

The leading voices in suicide prevention recommend community-wide strategies that are comprehensive and transdisciplinary (Jed Foundation, 2014; Knox et al., 2003). To stem the tide of older adult suicides, a similarly integrated approach should be used to coordinate prevention efforts among health and mental health professionals, aging sector professionals, gerontology educators, caregivers, and older adults. The transdisciplinary approach requires the expertise and investment of multiple groups, resulting in a more nuanced response to the complexity of suicide. For instance, health care professionals can contribute what they know about older adults' mental health, including assessment, diagnosis, and treatment strategies. Aging sector professionals can contextualize clinical wisdom to the specific locations in which older adults congregate. Gerontology educators can embrace their role as thought leaders, contributing research on how older adults perceive the aging process, and training future practitioners how to recognize and respond to the warning signs of suicide. Caregivers and older adults can also contribute their own firsthand perspectives on the challenges that come with increased age or impaired health.

Moreover, the coordinated, community response sends a message that directly addresses the social phenomenological and interpersonal theories about older adult suicide. For instance, a community-based intervention strategy impacts how the community itself constructs meaning around the aging process. When community leaders make older adult suicide prevention a priority, members of that community receive the message that older lives matter. When this effort is shared among numerous professional and lay disciplines—health care, the aging sector, gerontology education, caregivers, and older adults themselves—that message is louder and more consistent. This message then reaches at-risk older adults in whatever context they may be in. For suicidal older adults arriving at the doctor's office, a thorough risk assessment may result in effective treatment for depression. For the recently widowed man living in the long-term care facility, a support group facilitated by a gerontology internship student may

prevent this individual from developing additional risk factors. For the community of older adults at large, a training given by an older adult on how to recognize and respond to the needs of others increases the likelihood that more at-risk individuals will be identified and provided with help. In sum, the comprehensive approach reduces the risk of thwarted belonging and perceived burdensomeness by sending a consistent message that older lives *do* have meaning.

In conclusion, the synthesis of numerous perspectives and paradigms strengthens the community-based approach to suicide prevention. A comprehensive, multidisciplinary approach reconstructs the meaning that society places on the aging process, leading to a consistent message that older lives have a purpose. Employing various professionals and laypeople within the community increases the commitment of all involved and communicates to members of the community, including older adults, that preventing suicide is a responsibility shared by all.

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References

Alley, D. E., Putney, N. M., Rice, M., & Bengtson, V. L. (2010). The increasing use of theory in social gerontology: 1990–2004. *Journal of Gerontology: Social Sciences*, *65B*(5), 583–590. doi:10.1093/geronb/gbq053.

American Association of Suicidology. (2014). *USA state suicide rates and rankings for the nation, elderly, and young, 2013*. Retrieved from http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/StatesTOY_TABLE2013.pdf

American Psychological Association. (2009). *Depression and suicide in older adults resource guide*. Retrieved from http://www.apa.org/pi/aging/resources/guides/depression.aspx

Bamonti, P. M., Price, E. C., & Fiske, A. (2014). Depressive symptoms and suicide risk in older adults: Value placed on autonomy as a moderator for men but not women. *Suicide and Life-Threatening Behavior*, *44*(2), 188–199. doi:10.1111/sltb.12062.

Bartels, S. J., Blow, F. C., Brockmann, L. M., & Van Citters, A. D. (2005). *Substance abuse and mental health among older Americans: The state of the knowledge and future directions*. Rockville, MD: SAMHSA.

Center for Disease Control. (2007). *Increases in age-group-specific injury mortality—United States, 1999–2004*. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5649a1.htm

Center for Disease Control. (2012). *Depression is not a normal part of growing older*. Retrieved from http://www.cdc.gov/aging/mentalhealth/depression.htm

Conwell, Y. (2013). *Suicidal behaviour in older adults* [Video file]. Retrieved from https://www.youtube.com/watch?v=DhOmKsvQNp4

Conwell, Y. (2014). Suicide in later life: Challenges and priorities for prevention. *American Journal of Preventive Medicine*, 47(3), S244–S250. doi:10.1016/j.amepre.2014.05.040.

Drapeau, C. W., & McIntosh, J. L. (2015). *U.S.A. suicide 2013: Official final data.* Washington, DC: American Association of Suicidology. Retrieved from http://www.suicidology.org

Draper, B., Kolves, K., De Leo, D., & Snowdon, J. (2014). A controlled study of suicide in middle-aged and older people: Personality traits, age, and psychiatric disorders. *Suicide and Life-Threatening Behavior*, 44(2), 130–138. doi:10.1111/sltb.12053.

Gubrium, J. F., & Holstein, J. A. (1999). Constructionist perspectives on aging. In V. L. Bengston & K. Warner Schaie (Eds.), *Handbook of theories of aging* (pp. 287–305). New York, NY: Springer Publishing Company.

Heisel, M. J., & Duberstein, P. R. (2006). Suicide prevention in older adults. *Clinical Psychology: Science and Practice*, 12(3), 242–259. doi:10.1093/clipsy.bpi030.

Hooyman, N. R., Kawamoto, K. Y., & Kiyak, H. A. (2014). *Aging matters: An introduction to social gerontology*. Upper Saddle River, NJ: Pearson.

Institute of Medicine. (2012). *The mental health and substance use workforce for older adults: In whose hands?* Washington, DC: The National Academies Press.

Jed Foundation. (2014). *Comprehensive approach to mental health promotion and suicide prevention*. Retrieved from https://www.jedfoundation.org/professionals/comprehensive-approach

Joiner, T. E., Van Orden, K. A., Witte, T. K., & Rudd, M. D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients*. Washington, DC: American Psychological Association.

Knox, K. L., Litts, D. A., Talcott, G. W., Feig, J. C., & Caine, E. D. (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: Cohort study. *British Medical Journal*, 327(7428), 1376.

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *The American Journal of Psychiatry*, 159, 909–916.

National Alliance for the Mentally Ill. (2009). *Depression in older persons fact sheet*. Retrieved from www2.nami.org/Content/NavigationMenu/Mental_Illnesses/Depression/Depression_Older_Persons_FactSheet_2009.pdf

National Institute of Mental Health. (2013). *About depression*. Retrieved from http://nihseniorhealth.gov/depression/aboutdepression/01.html

Phillips, J. (2014). A changing epidemiology of suicide? The influence of birth cohorts on suicide rates in the United States. *Social Science & Medicine*, 114, 151–160. doi:10.1016/j.socscimed.2014.05.038.

Pinholt, E. M., Mitchell, J. D., Butler, J. H., & Kumar, H. (2014). "Is there a gun in the home?" Assessing the risks of gun ownership in older adults. *Journal of the American Geriatrics Society*, 62(6), 1142–1146. doi:10.1111/jgs.12836.

Podgorski, C. A., Langford, L., Pearson, J. L., & Conwell, Y. (2010). Suicide prevention for older adults in residential communities: Implications for policy and practice. *PLoS Medicine*, 7(5), e1000254. doi:10.1371/journal.pmed.1000254.

Shneidman, E. S. (1987). A psychological approach to suicide. In G. R. VandenBos & B. K. Bryant (Eds.), *Cataclysms, crises, and catastrophes: Psychology in action* (pp. 147–183). Washington, DC: American Psychological Association.

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2014, August 7). *The DAWN report: Emergency department visits for drug-related suicide attempts among middle-aged adults aged 45 to 64*. Rockville, MD: Author.

Suicide Prevention Resource Center. (2015). *Best practices registry*. Retrieved from http://www.sprc.org/bpr/using-bpr

U.S. Preventive Services Task Force. (2009). *Screening for depression in adults*. Retrieved from http://www.uspreventiveservicestaskforce.org/uspstf09/adultdepression/addeprrs.htm

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S., Selby, E. A., & Joiner, Jr., T. A. (2010). The interpersonal theory of suicide. *Psychological Review*, *117*(2), 575–600. doi:10.1037/a0018697.

Waern, M., Beskow, J., Runeson, B., & Skoog, I. (1999). Suicidal feelings in the last year of life in elderly people who commit suicide. *The Lancet*, *354*(9182), 917–918.

Ward, L. (2004). *Famous last words: The ultimate collection of finales and farewells*. New York, NY: Sterling Publishing Company.

World Health Organization. (2011). *Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level*. Retrieved from http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_9-en.pdf

World Health Organization. (2012). *Depression*. Retrieved from http://www.who.int/mediacentre/factsheets/fs369/en/

World Health Organization. (2014). *First WHO report on suicide prevention*. Retrieved from http://www.who.int/mediacentre/news/releases/2014/suicide-prevention-report/en/

Woznica, J. G., & Shapiro, J. R. (1990). An analysis of adolescent suicide attempts: The expendable child. *Journal of Pediatric Psychology*, *15*, 789–796.

Zweig, R. A. (2006). Suicide prevention in older adults: An interdisciplinary challenge. *Clinical Psychology: Science and Practice*, *12*(3), 260–263. doi:10.1093/clipsy.bpi030.

Author Biography

Matthew Fullen, MA, MDiv, LPC is a licensed professional counselor working with The Ohio State University Suicide Prevention program. He has provided mental health counseling to adults in diverse settings that include a community-based agency, long-term care facilities, an adult day center, and private practice. He has researched and presented on a variety of topics related to older adults' mental health, ranging from suicide prevention to promoting resilience and wellness. He was recently awarded an Albert Schweitzer Fellowship to support his work promoting mental health and wellness in older adults and their care providers.