Caregiving for Frail Elders: A Comprehensive Bibliography

Including both citations and abstracts, this bibliography is a valuable reference tool for researchers and students in the field of aging. It includes a total of 340 abstracts from over 60 journals dated from 1980 to mid-1993 covering topics such as Impacts of Caregiving, Patterns and Predictors of Informal Care, Interface of Informal Care and Formal Services, and Design and Methodological Issues. The cost is $20.00. To purchase a copy, please direct requests and payment to: New England Research Institutes, Institute for Studies on Aging, 9 Galen Street, Watertown, MA 02172, Attn. Ginger Quinn. Or phone (617) 923-7747, Ext. 361 for more information.

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Facts on Elderly Suicide

Jane L. Pearson

National Institute of Mental Health

In the U.S. and nearly every other industrialized nation, older age and male gender are the most consistent demographic factors related to suicide patterns. In the U.S., older white males have the highest rates of any age, gender or racial group; White males aged 80 and older have 6 times the overall national rate.

Research focused on risk factors for elderly suicide has been slowing developing. We have learned that almost all people who have committed suicide have at least one diagnosable mental or substance abuse disorder. We know this from data gathered through the psychological autopsy method, which is comparable to physical autopsy, where organ systems are examined to establish diagnoses or failures of systems. In psychological autopsy studies, interviews from family, friends, coworkers, and classmates, along with health professionals, are used to establish diagnoses of mental disorders. Among the elderly, depression is the most common diagnosis, and it is typically uncomplicated by other mental disorders, and is of recent onset. This is in contrast to younger- and middle-aged groups, where substance use and other mental disorders are more common (see Conwell, 1996).

A second finding is that most elderly suicide victims have seen a primary care provider within a month of the suicide. Too frequently, their depression was not recognized or treated. They typically have had little or no consultation with mental health professionals. Elderly persons rarely seek help from telephone hotlines.

Two other findings challenge myths that elderly suicides are due primarily to isolation and physical illness: Most elderly suicide victims either live with family members or are in frequent contact with family or friends. Although physical illness is more common among older suicides compared to younger suicides, there is little evidence to suggest that physical illness, in the absence of depression, is a risk factor for suicide (see Clark, 1992).

In addition to these findings on psychiatric diagnosis and service use patterns, there is some suggestion that older suicides, in contrast to younger suicide victims, have some personality traits that may also place them at risk. A lack of openness to new experience and the inability or willingness to adapt to anticipated or actual physical limitations may contribute to suicide risk in late life (see DuBerstein, 1995; Clark, 1993). Assessment of hopelessness and perfectionism may also be useful ways of exploring risk for suicidal ideation among the depressed elderly.

Associations between alterations in the serotonin system and completed suicide violent suicide attempts, and impulsive disorders and depression would suggest that there may also be biological vulnerabilities to be explored.

An ongoing Program Announcement, "Studies of Suicide and Suicidal Behavior," updated in 1995, describes a broad range of topics in suicide research on interest to NIMH.

References


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News from the Human Factors and Ergonomics Society (HFES)

submitted by Wendy A. Rogers

The HFES Meeting was held in Philadelphia September 2-6 and there were a number of activities relevant to research on aging. Tim Salthouse and Dan Morrow gave invited addresses in a session entitled "Expertise and Aging Effects in the Aviation Domain". There were also two paper sessions devoted to aging research: "Aging and Cognitive Processes" and "Aging and Technology". The Arnold M. Small Student Paper Award for the Aging Technical Group was awarded to Richard A. Sit for his paper entitled "Retention of multiple task performance: Age-related differences". Richard is a graduate student in the Engineering Psychology Program at Georgia Institute of Technology.

The 1997 HFES annual meeting will be held in Albuqurque, NM, September 22-26. Paper proposals will be due on February 7 and poster proposals will be due on March 17. If you wish to receive a call for proposals, contact the HFES Central Office at P.O. Box 1369, Santa Monica, CA, 90406-1369. Telephone is 310-394-1811; email is 72133.1474@compuserve.com. It is possible to be a member of the Aging Technical Group without being a member of HFES. The TGs function somewhat like divisions in APA. The cost is only $5. For an application form, contact the HFES Central Office at the address above.

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From the Postdoctoral Perspective

Lisa Jenkins

Washington University in St. Louis

In the last postdoctoral perspective, I urged students at all levels to examine an article (The Journal of NIH Research, 1996, Vol. 8) which provided information about how to apply for federal grant money for research. However, federal grants are only one source of funding for students.

State and local government agencies often provide small grants to individuals conducting research in the community. Typically, these grants involve smaller amounts of money and are shorter in term than federal grants, but are often easier to obtain. Information about these types of grants can be found at your college or university funding office or at your local library. For some states, limited information can also be found under Community Foundations on the Grantmaker Information web cite, http://fdncener.org/grantmaker/contents.html.

Public and private corporations as well as profit and nonprofit organizations provide an enormous amounts of money for research each year. The amount and term of such grants varies a great deal from corporation to corporation. Information about these grant opportunities can also be obtained from you local college or university, at the Grantmaker Information web cite, and/or at the TRAM web cite, http://tram.rice.edu/TRAM/.

Good luck in your search, and if you have questions or comments on funding, you can email me at ljenkins@artsci.wustl.edu.

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Engage!

John C. Cavanaugh

President, Division 20

To me, the best part of becoming President of Division 20 is having the opportunity to get to know the terrific people who constitute our membership. Throughout the 50-year history of our Division we have been blessed with the individuals who have built the field of adult development and aging, and who have unselfishly given many hours of their time to nurture people like me at critical points in their career, as well as to help shape research and policy issues. Susan Krauss Whitbourne, my predecessor, provided this kind of leadership. My goal this year is to create a climate in which this rich, successful tradition continues, and to initiate projects to ensure that our presence will be felt for years to come. Most important, I will strive to increase the number and diversity of people who are actively engaged in the Division. With your help, the Division will truly go where no Division of our size has gone before.

Over the past year, much progress has been made in providing people with the opportunity to become engaged in Division activities. Our World Wide Web site, shepherded by our resident Webmeister Michael Marsiske, is the best and most comprehensive in APA, and lists a great deal of information about Division activities and resources. Stop by and take a look (http://www.iog.wayne.edu/adadiv20/apadiv20.htm). Of special note is the educational section, which includes course syllabi and resources. (Thanks are due especially to Rosemary Blieszner and her committee for this extraordinary job! Cynthia Berg, the new committee chair, will be continuing this effort.)

Additionally, our membership continues to grow, especially among students. With roughly 2,000 members, Division 20 has a large talent pool. We are currently working on ways to make engaging in dialogue among the membership even easier. Plans include creating a more inclusive list of members on the Web so that finding people with similar research interests can be done more readily.

Numerous other efforts will also be undertaken. Chief among these will be our continuing advocacy concerning research funding and public policy issues concerning clinical practice, long-term care, Medicare and Social Security reform, and other related matters. Our close working relationships with the APA Directorates, coupled with the many areas of expertise represented in our membership, makes us an important partner with APA in advocacy activities. Additionally, we will continue providing support and information for individuals teaching courses on adult development and aging, as well as for those who need this content for other courses. Exploratory steps are being taken on making the excellent content and methods used by our members available through widely read outlets.

In keeping with the theme of being engaged, we are eagerly anticipating APA's return to Chicago next August for the annual meeting. We are planning a program (chaired by Jane Berry) that includes sessions intended to foster the exchange of ideas and data in provocative ways. Suggestions for symposia that bring divergent people or topics together in the same panel or in other unique ways that will facilitate the integration of different points of view are especially welcome.

Our various awards programs will continue. The student awards have been generously funded again by the Retirement Research Foundation, and the Springer Award for a young scientist will showcase another rising star. Information about these awards will be forthcoming. In this issue is a call for nominations for the Distinguished...
Contribution Award. Take the time to consider individuals you think would make strong candidates and submit their names.

As you can tell, there are many exciting things occurring in the Division. My goal of engaging more people in the Division reflects my firm belief that only by doing so will our Division continue to prosper. Those of us who have been around awhile (a scary thought, to be sure) genuinely need your comments and ideas, and will welcome your suggestions. Indeed, such openness to experience (to coin a phrase) and willingness to rethink past practices in view of better ideas are the hallmarks of Division 20. It is what convinced me that adult development and aging was a vibrant, dynamic, and growing field. I especially encourage new members to think about becoming involved. Please feel free to contact me or any member of the Executive Board. Besides helping to advance the science and practice of adult development and aging and being part of a most rewarding intellectual exchange, you could have the opportunity to learn the macarena. What other Division makes that kind of offer?

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Student Award Winners
Retirement Research Foundation
1996 Competition

Undergraduate Awards

Research Proposal ($312)

Bridget Redman, The effects of gender, activity level, and reasoning ability on body perception in older adults Allegheny College; Sponsor: L. McGuire

Graduate/Masters Awards

Completed Research ($1250)

Karen Kemtes, Younger and older adults’ working memory and on-line processing of syntactically ambiguous sentences University of Kansas; Sponsor: S. Kemper

Completed Research: Honorable Mention ($200)

Yingye Zheng, Information-processing speed: The interaction of age differences and ability differences Washington University; Sponsors: Joel Myerson and Sandra Hale

Lisa Laumann, Adult age differences in vocabulary acquisition West Virginia University; Sponsor: Raymond Shaw

Elizabeth J. Meinz, Musical experience, musical knowledge, and age effects on memory for music Georgia Institute of Technology; Sponsor: T. Salthouse

Xiaohui Guo, Age and forgetfulness: Manipulating the degree of age stereotypes. Florida International University; Sponsor: J. Erber

Research Proposal ($1000)

Roxanne Thorn, Goal setting, memory performance and self-efficacy in younger and older adults University of Florida; Sponsor: R. West

Research Proposal: Second Prize ($500)

Patricia P. Vignola, Moderating effects of perceived self-efficacy in the relationship between cognitive ability and functional ability in the elderly. Barry University; Sponsor: C. Starratt
**Graduate/Doctoral Awards**

**Completed Research ($1250)**

**Jamila Bookwala**, Perceptions of the care recipient and elderly caregivers’ psychological well-being: The role of neuroticism and mastery. University of Pittsburgh; Sponsor: R. Schulz


**Lisa E. Norris**, Everyday problem solving goals: Contributions of age and individual differences Louisiana State University; Sponsor: K. Cherry

**Research Proposal: Second Prize ($1000)**

**Miriam E. Harthill**, Psychosocial factors and respiratory health: A biopsychosocial investigation. University of California at Riverside; Sponsor: M. R. DiMatteo

**Postdoctoral Awards**

**Completed Research ($1250)**

**Paul Verhaeghen**, Growing slower and less accurate: Adult age differences in time-accuracy functions for recall and recognition University of Leuven; Sponsor: A. Marcoen

**Research Proposal: Tie ($1500)**

**Lisa Jenkins**, Adult age differences in the acquisition of lexical and nonlexical automaticity. Washington University; Sponsors: S. Hale and J. Myerson

**Mary C. Newman**, Awareness of deficit and Parkinson’s disease University of Arizona; Sponsor: A. W. Kaszniak

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To direct comments about the information contained in these pages, please write to marsiske@ufl.edu
Suicide is an important public health problem. In 1993, the most recent available statistics indicate that the total number of suicides in the U.S. was 31,102. Although persons age 65 and older accounted for 13 percent of the population, they accounted for 20 percent, or over 6,000 of the 1993 suicides. The most accurate index for looking at the total number of suicides in the U.S., and those by age group are age adjusted rates. Using these rates, the Centers for Disease Control and Prevention's National Center for Health Statistics reports that there were 12 suicides for every 100,000 persons in 1993. For people 65 and older, the rate of suicide climbs with age: It ranges from 15 per 100,000 among persons aged 65 to 69, and to 24 per 100,000 for persons aged 80 to 85 - double the U.S. rate.

In the U.S. and other industrialized nations, older age and male gender are consistent demographic factors related to suicide patterns. With few exceptions, the most recent World Health Organization Statistics from over 30 industrialized nations (1994-94) indicate that men who are 75 years and older have the highest rates of suicide. In the U.S., older white males have the highest rates of any age, gender, or racial group. Suicide rates for white males among the "oldest-old", age 80 and older, have been consistently in the range of 60 to 70 per 100,000 since 1985. This is 6 times the current overall national rate, 3 times the rate of same-aged African-American males, twice the rate of Indian and Alaskan Natives, and Hispanic, Asian and Pacific Islander elderly males.

This high risk group has not been ignored by public health officials. Healthy People 2000, a document establishing a National health promotion and disease prevention agenda in 1990, targeted older white men among the groups most at risk for suicide. Although objectives to reduce suicides by 15 percent in this group by the year 2000 were set, they are, unfortunately, far from being met.

The NIMH, as part of its mission to understand, treat, and prevent mental disorders, regards suicide as an important public health issue. Research aimed at improving our understanding of ways to prevent suicide is a significant priority for the National Institute on Mental Health. In fiscal year 1995, NIMH spent approximately $9 million for support of studies focused primarily on suicide and suicidal behavior. This represents a nearly eight-fold increase over the last decade.

Along with several other NIH components and Federal agencies NIMH is a co-sponsor of the Centers for Disease Control and Prevention's National Mortality Followback Survey. NIMH is supporting the inclusion of an over sampling of elderly suicide cases, and questions regarding depressive symptoms to be asked of informants about all suicides. This will be the first study of a national sample of elderly suicides that documents their possible depression and their health service use.

In addition to serving as the NIMH contact for this survey, I serve as Chair of the NIMH Suicide Consortium. The purposes of this consortium are to monitor and encourage research program development in suicide across the life
span, keep abreast of scientific developments in suicide research, convene workshops to help the field determine new directions to go, and to disseminate scientific knowledge to the public, media, and policy makers. Two NIMH Fact Sheets, one describing current statistics and risk factors for all age groups, and a second focused on elderly suicide are examples of the type of public information documents and Internet web--site pages that have bee prepared for public dissemination. These documents are in the public domain, and are freely reproduced for use by clinicians, social service providers, professional and lay organizations, and the general public.

I would now like to highlight some of what we have learned about suicide. Research has clearly demonstrated that almost all people who kill themselves have at least one diagnosable mental or substance abuse disorder. We know this from data gathered through the use of the psychological autopsy method. Analogous to the physical autopsy, where organ systems are examined for the purpose of establishing diagnoses of major physical illness the psychological autopsy uses interview data from family, friends, co-workers, classmates, and others to develop a psychological profile and to establish diagnoses of mental disorders. Studies using the psychological autopsy method have consistently documented that nearly 90 percent of those who commit suicide have at least one diagnosable psychiatric condition.

From physical autopsy studies, altered levels of neurotransmitter serotonin have been found in suicide completers. Similarly, depressed persons, those with extreme impulsivity, and persons who have made violent suicide attempts also have altered serotonin. Psychological autopsy results have also indicated that adverse life events can contribute to suicide risk. Other risk factors that have been identified include family history of violent behavior, mental disorder, or suicide, and exposure to the suicidal behaviors of others. Therefore, our current scientific picture of suicide risk suggests that acute stress, in combination with mental disorder, family history, exposure to suicide, and biological risk factors, can result in significant risk profile.

It is important to note that these are statistical associations only. Suicidal behavior is not the typical response to stress. Many people experience a number of these risk factors, and do not kill themselves.

In a 1992 NIMH workshop on suicide across the life course, researchers further focused on what may be unique among older suicides relative to middle-aged and younger suicides. A key finding was that the most common psychiatric disorder among elderly suicides is major depression, most often a first episode. This is in striking contrast to younger suicides, where substance abuse and other psychiatric disorders are more common. Moreover, this first episode of depression is typically characterized by the absence of complicating factors such as psychosis or mania, and it tends to be of moderate severity. This type of depression is, classically, the most amenable to treatment.

Tragically, however, recognition of depression and initiation of treatment among elderly suicide victims has been rare. This is not due to social isolation or withdrawal. Research has shown that most elderly suicide victims either live with family members or are in contact with family members and friends. We also know that access to health care is not a problem among elderly suicides: At least 70 percent of these older suicide victims have visited primary care providers within a month of the suicide. Virtually none have seen mental health professional, and very few have ever received mental health treatment, including treatment for depression from their primary care physicians.

The clear implication from these findings is that a great opportunity to prevent suicide lies at the primary care office doorstep. Unfortunately, we know that primary care physicians tend to allot less time with older patients on average, and that they frequently do not recognize nor adequately treat depression in their older patients. But physicians should not get all of the blame: Older patients are less likely than their younger counterparts to tell their doctor that they feel depressed. There may be many reasons for this pattern: stigma over mental illness or a tendency to verbalize physical pain more easily than emotional pain. In addition, older persons, as well as their family members, may hold "ageist" attitudes that consider depression a normal reaction to growing old.

Fortunately the ground work establishing the fact that depression in late life is not normal, and that it is treatable, is in place. The 1991 NIH Consensus Development Conference on Late Life Depression identified effective treatments, which have been incorporated into the Clinical Practice Guidelines for Depression for Primary Care Physicians. One of the next policy and practice challenges is similar to that of all mental health treatments: How to integrate effective treatment in health care settings where primary care physicians are increasingly asked to take on more responsibilities. This task is particularly critical for the recognition and treatment of depression in the elderly, as most elderly seek help from primary care physicians and not mental health professionals.
In addition to examining the mental disorders and service use patterns among older persons who suicide, the HIMH is also supporting research to help build a basic and clinical research base about the neurobiology of aging, depression, and suicide. NIMH is not alone in these efforts: We work in a coordinated manner with other HIM components in a concerted effort to apply the basic and behavioral neurosciences to disorders of brain and behavior. New technologies are helping us understand the possible biological and neurobehavioral vulnerabilities that increase risk for depression and suicide. New approaches to brain imaging are allowing us to characterize the structure and function of specific neurotransmitter systems. New approaches in molecular biology and behavioral pharmacology are allowing us to develop experimental models of these self-destructive behaviors and to pilot test potential treatments. Associations between alterations in the serotonin system and completed suicide, violent suicide attempts, impulsive disorders, and depression continue to be important avenues of investigation. Alterations in the serotonin system have also been proposed to occur with normal aging, raising the question as to whether a neurobiological vulnerability occurs with aging, which may interact with other vulnerabilities and stressors.

Suicide research must continue on many fronts. More studies utilizing the psychological autopsy method can help clarify what factors converge to create suicide risk. More research from the laboratory should help us better understand the contribution of serotonin. Studies based in hospitals and outpatient clinics, where the psychiatric diagnoses can be best characterized and where older suicide attempters can be studied are needed. In the community setting, more research on the role of life events, service use, and patterns of depressive symptoms that appear in the elderly should be done. Finally, given our current state of knowledge about the role of major depression in late life suicide, we need to urgently find effective ways to educate older persons and their families, and health care providers who are most likely to interface with older persons (i.e., primary care physicians), about how to detect and treat late life depression.

In closing I would like to emphasize that suicide is a multi-dimensional event. We are still unable to adequately predict who will and who won't commit suicide. We do not know enough about what protects people from acting on suicidal thoughts. We do know, however, that most elderly suicide attempts and completions are expressions of extreme distress, and that they rarely occur in the absence of depression. Suicide is a public health issue of concern for the individual, the family, and the community. It deserves our full and active attention as researchers clinicians, educators, and public policy makers. The NIH is committed to continue to pursue an aggressive program of research in this area.

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