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COGNITIVE BEHAVIORAL THERAPY WITH SUICIDAL OLDER ADULTS

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Abstract. This article provides a cognitive-behavioral model for psychotherapeutic interventions with suicidal elders. The approach is based on a general model of cognitive behavioral therapy (CBT) with older adults described in Laidlaw, Thompson, Dick-Siskin and Gallagher-Thompson (2003), with specific application to suicidal older adults (Coon & Gallagher-Thompson, 2001). The appeal of CBT in working with older clients is its practical nature and psychoeducational orientation aimed at empowering elderly clients to utilize the techniques outside the psychotherapeutic relationship, with the goal of helping elders develop skills that lead toward better daily self-management and increased life satisfaction. In addition, CBT can be effective in either an individual or group format (DeVries & Coon, 2002). This article begins with a brief review of the characteristics associated with suicide in this population, then describes a CBT model appropriate for use with elders struggling with affective disorders, suicidal ideation, or suicidal behaviors, and ends with a case example illustrating the model's use with suicidal older adults.

Keywords: Suicide, older adults, cognitive-behavior therapy, assessment, treatment.

Introduction

The need for effective interventions with suicidal older adults is significant. Epidemiological evidence indicates that approximately one fourth of all suicides are carried out by persons age 60 or older (Richardson, Lowenstein, & Weissberg, 1989). In the United States, the number of suicides among those over age 65 increased by 36% from 1980 to 1992, with the largest relative overall increase occurring in 80–84-year-olds (US Centers for Disease Control & Prevention,

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1996). Data indicate that in the United States, the elderly have the highest rate of completed suicides among all age groups (National Center for Health Statistics, 1993; USDHHS, 1995). While the suicide rate for elders in Britain (England, Scotland and Wales) is lower than in the US (Pritchard & Baldwin, 2000), the rate of completed suicides among British elderly is still significant. Even more disconcerting is the probability that the number of actual suicides is much higher, since some officials may report the suicide as an accidental death when possible to save the family from suicide's social stigma (Osgood, 1985; Gallagher-Thompson & Osgood, 1997). Older adults appear more likely to engage in determined and planned self-destructive acts and to give fewer warnings of suicidal intent (Conwell et al., 1998); and there is growing concern about frequently undetected "silent" suicides among older adults who determine to die through self-starvation or noncompliance with essential medical treatment (Simon, 1989; DeVries & Gallagher-Thompson, 2000).

The high rate of suicides among older adults has significant implications for mental health practitioners, since the fastest growing segment of the population is over the age of 75, with the over-85 group increasing over six-fold by the middle of the next century (Belsky, 1999). Given this graying of the population and the general increase in incidence of depression in present-day cohorts of young and middle-aged adults (Blazer, 2002), elder suicide rates may rise in the decades to come, pointing toward an increased need for effective psychotherapeutic interventions for suicidal elders. Yet, few clinicians are prepared by their academic or clinical training to treat this unique population.

Characteristics of suicidal elders

"Normal" aging is not characterized by pathological reactions, hopelessness and despair; and most older adults do adapt and do not exhibit psychiatric symptoms despite confronting multiple stressors. However, coping is a process that must take place over time. Differentiating normal patterns of reaction to stressful events from pathological reactions is critical in anticipating and intervening in crisis situations. Awareness of psychosocial and demographic risk factors interacting with age to increase the possibility of suicidal behavior is a first step toward effective assessment and intervention.

Although younger people attempt suicide more frequently, older adults are more "successful" leading some suicidologists to believe that elders do not attempt suicide to get attention, but rather are clearly interested in taking their own lives and are more lethal in their methods (Osgood, 1985). For example, firearms are related to most elderly suicides, followed by hanging, gas, and poison methods (Alexopoulos, 1996). Woods (1996) discusses data from a large number of countries including Japan, Hungary, Ireland and the United States that show that elderly males have the highest rate of suicide. Even though more women than men attempt suicide in the United States, men are more "successful" with those attempts, making gender the demographic variable with the greatest predictive power for completed suicide.

While a full description of assessment approaches for recognizing suicidality in older adults is beyond the scope of this article, clinicians should, at a minimum, be able to recognize the factors that put elders at risk for suicide. In particular, the following situations warrant particular attention: depression, chronic or serious illness, social isolation, complicated bereavement, alcohol or drug abuse, cognitive impairment, and recent changes or chronic stress in family roles/dynamics (DeVries & Gallagher-Thompson, 2000). Clinicians are encouraged to explore

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the impact of these factors by noting affective, verbal, behavioral and situational clues provided by the potentially suicidal client. Readers interested in in-depth reviews of interviewing and assessment issues with late-life clients are referred to Edelstein, Staats, Kalish and Northrop (1996), Edelstein and Semenchuk (1996), Futterman, Thompson, Gallagher-Thompson and Ferris (1995), and Pachana, Thompson and Gallagher-Thompson (1994).

Model of CBT for use with distressed or suicidal elders

This section presents components of a model of CBT appropriate for intervening with suicidal older adults, or those suffering from late life affective disorders or distress including: a) a rationale for adapting CBT to intervene with this population; b) a description of CBT approaches to intervention with suicidal elders; c) exclusion criteria for identifying which clients might *not* benefit from CBT; and d) suggestions for modifications to help address diverse groups of elders.

Rationale

Given the growing amount of evidence demonstrating the effectiveness and utility of *cognitive therapy* (e.g. Gallagher & Thompson, 1982; Scogin, Hamblin, & Beutler, 1987; Thompson, Gallagher, & Breckenridge, 1987), *behavior therapy* (Gallagher & Thompson, 1982; Scogin et al., 1987; Thompson et al., 1987) and *combined cognitive-behavioral* interventions (CBT) (Gallagher-Thompson & Steffen, 1994; Steuer et al., 1984; Thompson, Coon, Gallagher-Thompson, Sommer, & Koin, 2001) in the treatment of older adults suffering psychological distress, CBT offers a promising approach for intervening with suicidal older adults. Unfortunately, the clinical and research literatures have paid little attention to the use of CBT to treat suicidal elders and the successful outcome studies using CBT with depressed elders have typically ruled out clients with suicidal ideation or intent.

Despite the lack of outcome studies with suicidal older clients, the widely documented effectiveness of CBT with depressed older adults supports its potential utility with suicidal elders. In addition, models of CBT with suicidal younger adults have been described as showing promise in reducing suicide risk (Rudd, Joiner, & Rajab, 2001). The model presented in this article is based on a manualized 16–20 session clinical protocol designed by Thompson and Gallagher-Thompson and their colleagues at the Older Adult and Family Center (OAFC) of the VA Palo Alto Health Care System and Stanford University School of Medicine (Thompson et al., 2001). It has been used successfully both clinically and in research with hundreds of distressed elderly outpatients at the OAFC. This protocol reflects adaptations and extensions of the work of Beck (Beck, Rush, Shaw, & Emery, 1979), Burns (1980, 1989), Lewinsohn (Lewinsohn, Munoz, Youngren, & Zeiss, 1986) and Young (1990). This CBT protocol is characterized by a directive, time-limited, structured approach designed to give older adults skills applicable to their daily lives by identifying and challenging negative, unrealistic or unhelpful cognitions, and by various behavioral techniques, most notably, identifying and engaging in daily pleasant events or activities. This article assumes readers have basic familiarity with CBT theory and therefore concentrates on key strategies and techniques relevant to suicidal elders. Readers are referred to Coon, Rider, Gallagher-Thompson and Thompson (1999), Thompson et al. (1991), Thompson (1996), and Laidlaw et al. (2003)

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for more thorough discussions of techniques and useful adaptations of traditional cognitive-behavioral therapy for older adults.

Exclusion criteria

CBT places cognitive demands on clients, asking them to read, write, and comprehend concepts and engage in activities requiring memorization, problem-solving, and learning new material. Consequently, older clients should be screened for cognitive impairment, using an instrument such as the Mini-Mental Status Examination (Folstein, Folstein, & McHugh, 1975) or other culturally appropriate instrument (e.g. Teng et al., 1994). If cognitive screening suggests a significant cognitive problem, the older client should be referred for a neuropsychological evaluation prior to determining the suitability of CBT or introducing particular CBT strategies and techniques. Elders should also be asked about their current alcohol and drug use, including their use of prescription, over-the-counter and recreational drugs since abuse or misuse of these substances can increase suicidal risk and complicate treatment.

CBT intervention approach for use with suicidal elders

We expand upon Ellis's CBT Model with Suicidal Patients (1998) by grouping interventions for suicidal older adults into four types: 1) *Symptom reduction and stabilization techniques* such as hospitalization, pharmacotherapy, complimentary medicine, and distraction; 2) *Behavioral interventions* including behavioral contracts, stress management training, pleasant event schedules, and social and communication skills training; 3) *Cognitive interventions* such as Daily Thought Records and problem-solving techniques; and 4) *Situational interventions* including social service interventions, informal support mobilization, conflict management, and occupational enhancement (when applicable). These interventions should work hand-in-hand to mobilize internal coping mechanisms and external supports. Central to all of these interventions is the need to establish rapport quickly, to actively reduce the patient's hopelessness by demonstrating that someone cares, and to establish concrete and specific goals for change. This is even more important with suicidal elders than those who suffer from psychological problems without suicidal ideation or intent. Older clients often require more reassurance and information about the process of therapy, as well as more rewards for taking risks in therapy, and therefore treatment needs to include measurement of treatment outcomes across the course of treatment to provide clients with regular feedback (McIntosh, Santos, Hubbard, & Overholser, 1994).

Symptom reduction and stabilization techniques. Patient stabilization and resolution of immediate crises are typically necessary before embarking on a full course of CBT with suicidal elders. However, key CBT strategies (e.g. behavioral contracts or negative thought stopping) may be particularly appropriate during a crisis if used in conjunction with direct crisis intervention methods implemented in consultation with chief colleagues (e.g. the elder's physician). In most jurisdictions, confidentiality *must* be broken if patients are a danger to themselves or others and, as a result, providers must take steps to inform family members and/or facilitate hospitalization. Medication and other symptom reduction techniques, both during and after crisis resolution, may also be appropriate and need to be combined with some of the following strategies.

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Behavioral interventions. Behavioral "no suicide" contracts can be a useful intervention for suicidal elders, especially if they delineate steps to take when suicidal impulses arise, including phone numbers to call for assistance and when and how to use them appropriately. Ellis and Newman (1996) effectively expand contracts by declaring them "A Therapy Contract with Myself ", in which patients a) state that their goal is really to take care of their pain, *not* to die, b) declare that their goal is to live with less unhappiness than they currently experience, and c) proclaim that they are worth the time and effort to achieve their therapeutic goals. Since recovery from their pain typically takes time, clients are encouraged to commit to resisting any self-destructive behavior in the interim. Contracts can be a part of the client's therapy manual or notebook and can be updated and revised as warranted. Behavioral techniques might also include stress management, anger management, or assertive communication skill training. Therapists may need to teach suicidal clients how to structure their hours, days or weeks, and then identify tools and strategies to follow through on that plan of action. Ongoing, structured activity schedules, especially those schedules that identify and incorporate pleasant events, can prove particularly effective. Finally, suicidal elders often benefit from learning brief problem-solving strategies that teach them how to cope with less-than-perfect results through the following cognitive intervention techniques (Ellis & Newman, 1996; Freeman & White, 1989).

Cognitive interventions. Cognitive interventions with suicidal elders demand that negative thoughts and beliefs be quickly brought into the open and confronted by using Daily Thought Records or other exercises that examine the evidence or weigh the advantages or disadvantages of maintaining negative outlooks. Many patients remain convinced of their rationales for suicides, and can be asked to list these beliefs and then construct at least one counter-argument for each reason to discuss in therapy. For example, Table 1 presents some beliefs often held by suicidal elders, as well as potential counter-arguments to those beliefs. Humor can prove a useful tool in dealing with suicide (Richman, 1993, 1999), and clients often identify humorous elements in their counter-arguments.

Frequently, suicidal older clients can be encouraged to construct an ongoing list of reasons for living, beginning with reasons that worked prior to entering therapy and then adding another reason every day (Ellis & Newman, 1996; Linehan, Goostein, Neilson, & Chiles, 1983). Therapists can extend this exercise by comparing daily mood ratings of clients with their ratings of how easy or difficult it was for them to identify yet another reason for living. This exercise is usually rated by clients as more difficult when they are more distressed, thus functioning as a powerful tool to demonstrate how negative mood states can distort one's outlook. Similarly, elders can also be encouraged to develop an inventory of "unfinished business" or a list of items they have been meaning to complete, and then state the important reasons to stay alive to complete them, and identify key items to work on immediately.

Therapists frequently need to take a strong assertive stance with suicidal elders and help them vigorously challenge negative and self-defeating thoughts (DeVries & Gallagher-Thompson, 2000). This stance helps both therapists and elders identify concerns in a simple and direct manner to help elders identify positive reasons to live and begin to view their current difficulties as only a part not the whole of their life story. However, given physical, social and economic challenges facing many elderly, cognitive interventions often demand that therapists watch more closely their clients' balance of objective reality versus subjective interpretation

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Table 1. Cognitive intervention: suicidal beliefs and counter-arguments

Belief	Counter-argument
Suicide is an end to all my suffering and there will be rest.	This comes at a serious cost to others in my life who still care about me, as well as at a serious cost to me. What if there is work in the afterlife?
Suicide represents a way for me to be reunited with deceased loved ones.	I run the risk that my concept of the afterlife is totally wrong. I have no guarantees I will be reunited. Currently, I have my memories and pictures of them.
Suicide is a form of retribution to make others suffer, just as I have suffered.	I can't control how others will suffer or how they will feel. Is this really the way I want to communicate how I feel? There are more effective ways to communicate. If I kill myself now, I won't be around to enjoy my revenge!
Suicide is my only choice since I am totally alone and no one cares about me.	There really are some people who might miss me and who care about me. There are others who might be lonely that I can help, and then I won't feel so alone.
Suicide seems better than living with these health problems or disabilities that keep me from doing the activities I like. If I can't do what I used to do, I'd rather be dead.	I may not be able to do all the things I used to, but I can find ways to do some of them or a modified version of them. There are still many things I still enjoy.

(Gallagher-Thompson & Osgood, 1997). Cognitive interventions help reinforce the value of working through and coping with adversities so that significant others in the client's life might have a positive model when faced with their own adversities and challenges. Appealing to clients' religious values, beliefs and practices as deterrents and coordinating with clergy and pastoral counselors as adjuncts to therapy to provide counterarguments to suicidal rationales may be particularly successful with our current cohort of elders who were often raised with strong suicide taboos (McIntosh et al., 1994).

Situational interventions. Situational interventions help elders mobilize their external resources by getting people reconnected with both formal and informal support networks, with many of these interventions resembling case management functions. Situational interventions can range from assisting elders in re-establishing family and friendship networks or locating interesting organizations to join, to helping manage transportation problems and resolving financial crises. When economic, emotional or social interdependence is already present in the suicidal elder's network, integrating informal support mobilization into the treatment plan becomes particularly important. Still, therapists must be ready to challenge the unhelpful thinking that often accompanies the notion of support mobilization, particularly when the older adult's networks truly lacks responsiveness. The cognitive and behavioral interventions reviewed earlier can help address these negative thoughts and obstacles with the ultimate goal of restoring at least *some* positive support. Moreover, many of the techniques already discussed rely at least in part on the positive involvement or support of the elder's social network. While situational interventions are similar to case management activities, their goal is to help empower elders to perform these activities themselves

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through active skill-training (e.g. problem-solving skills, assertiveness skills, or social skills training).

Modifications for diverse populations of elders

The intervention strategies and techniques introduced to this point are part of a standard protocol applicable to many of elders. However, the diversity represented in the world's population of older adults today is considerable and requires therapist sensitivity to varying sociocultural contexts and a willingness to adapt conventional treatment models to accommodate the needs of different cultural groups. The following section raises issues relevant to the cultural contexts of today's older adult clients. This section is followed by examples of adaptations to CBT that might be helpful when working with two subpopulations of depressed or suicidal elders – the medically ill and the cognitively impaired.

Cultural contexts of minority or disadvantaged elders. The diversity of today's elders reflects not only their current physical condition, mental health and socioeconomic situations, but also their individual sociocultural contexts and personal histories. These histories ultimately modify their help-seeking behavior, substantially impact on the enactment of prevention, surveillance and treatment activities, and can lead to additional treatment challenges (Coon et al., 1999; Gaw, 1993; Purnell & Paulanka, 1998). Therapists need to be aware that individual histories are likely to be shaped through multiple layers of powerful sociocultural influences including the elder's immediate family, community, cultural or ethnic background and country of origin that incorporate years of family and peer pressures, social class standing and expectations, and gender, racial and ethnic identifications. All of these layers of powerful influence can ultimately shape the signs and symptoms of depression and suicidal ideation or intent, leading some elders to view their distress as a somatic, cognitive or spiritual problem, rather than as a psychological one. Thus, sociocultural influences and personal histories can also significantly influence the overall health and mental health beliefs and values of elders, including their views about self, others, and the environment as well as their thoughts and feelings, and ideas about suicide as a viable option. In many countries, including the United States and Britain, non-majority ethnic and racial groups as well as other disadvantaged groups (e.g. the physically challenged, the poor, gay men and lesbians) face obstacles that create new challenges for mental health professionals. These barriers frequently include insensitive service providers, language barriers and financial constraints that block help-seeking behavior and treatment engagement and adherence (e.g. Miranda & Valdes-Dwyer, 1993; Organista, Valdes-Dwyer, & Azocar, 1993; Iwamasa, 1993). Fortunately, CBT's collaborative empiricism provides a compatible conceptual and clinical backdrop to effectively tailor assessment processes and intervention strategies to meet the needs of a variety of depressed elders.

Adaptations for chronically ill and frail elderly. Approximately 80–85% of the present cohort of older adults have some type of chronic illness, such as arthritis, diabetes, hypertension, respiratory problems, or cardiac problems that cannot be cured and that cause at least mild levels of disability (Cavanaugh, 1990; Knight, 1996). Risk for suicidal ideation and behavior in the elderly increases with the severity of the illness or functional disability (e.g. Frierson, 1991; Zautra, Maxwell, & Reich, 1989). Thus, adaptations of the strategies presented so far are needed to assist clients facing these challenging situations.

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The clinical literature provides a variety of recommendations for adapting CBT for suicidal elders with frailty or chronic illnesses (Coon et al., 1999; Grant & Casey, 1995; Rybarczyk, Gallagher-Thompson, Rodman, Zeiss, & Yesavage, 1992). First, collaborate with patients and their support system to resolve any practical barriers to participation (e.g. use large print material, resolve transportation concerns, adjust office lighting). Next, adjust the goals and pace of therapy, beginning with modest goals to foster success and modifying the pace of therapy to match patient progress. Third, hold shorter, more frequent sessions. Fourth, evaluate "excess disability" (i.e., the amount of disability not attributable to the elder's physical impairment), and then address related issues immediately. Fifth, educate the elder that depression and suicidal ideation and intention can be reversible problems that are separate from their physical challenges. Sixth, work collaboratively to challenge the elder's perception of self as only "a burden" to others.

Finally, Haley (1996) advises therapists to become more sensitive to the medical context of psychotherapy with older adults, urging them to increase their knowledge of common illnesses and functional impairments. Treatment of frail or chronically ill suicidal elders also demands not only more frequent contact with the physician, but also more teamwork among all the professional care providers. Similarly, successful psychotherapeutic outcomes will require the identification of support network members to assist therapists with implementation of CBT interventions. Key elements of adapting CBT for medically ill or disabled elders could also include making home visits, gaining permission to speak with other professionals and family members, and expanding the range of acceptable session locations and meeting times.

Adaptations for depressed and suicidal elders with cognitive impairment. As the world's population ages, elders with cognitive impairments are becoming an escalating group. Given the enormous value placed on memory and reason in many societies, therapists must be ready to assist depressed patients struggling with the psychological distress often associated with a dementia diagnosis. The risk of suicide may be particularly high in the early stages when the patient can still grasp the nature and implications of the diagnosis. Although no empirical studies document the effectiveness of CBT for depressed or suicidal individuals with mild cognitive impairments, Teri and Gallagher-Thompson (1991) make several useful recommendations: use shorter, more frequent sessions, especially in the early phases of therapy; limit the number of concepts presented, and then consistently reinforce their use; provide audio-tapes of therapy sessions for clients to review at home; develop activity schedules that incorporate simple daily pleasant activities collaboratively with patients; and create a simple, highly structured notebook and/or calendar to hold all this material and the schedule of therapy sessions. Finally, a randomized clinical trial showed that behaviorally oriented interventions that increased pleasant activities and decreased unpleasant situations were effective in improving depressed mood in both outpatient dementia patients and their family caregivers, providing promising steps toward the development of more effective treatments for dementia patients with suicidal ideation and behavior.

Case study

The following example illustrates the use of CBT treatment approaches in working with suicidal elders. While this is only one example, it provides a framework for understanding the CBT model presented in this article.

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Mr X is a 72-year-old widowed Caucasian male whose wife died of heart disease within the past year. He was not psychologically prepared for her death, nor did he feel that he could make the necessary adjustments to live alone. He had little experience with such household management tasks as cooking and cleaning and was not used to setting up the social calendar. These things had been done by his wife and now that she was gone, his life was quite empty and, to him, meaningless. Although he had two grown children in the area, with whom he had good relationships, he did not feel that it was appropriate to turn to them often in his time of grief. Rather, he waited for them to visit him and to talk about their absent mother. He found it difficult to cry or to be demonstrative in the expression of any of his feelings regarding the loss of his wife.

He had recently been diagnosed with Parkinson's disease and worried that he would develop dementia. He feared becoming totally dependent on his daughters. About one month before coming for treatment, Mr X was forced to move out of the apartment in which he and his wife had lived for more than 40 years due to the demolition of the building for new construction. This seemed to him to be "the last straw" and sent him into a very deep depression. In addition to acknowledging being depressed, Mr X also talked about feeling hopeless with regard to the future. His declining health, although it was not precipitous, made him very fearful of the future. By the time one of his daughters brought him for therapy, he was talking about "ending it all" and seemed to be taking steps to put his affairs in order, as if he were planning to commit suicide in the relatively near future. He acknowledged that he had developed a concrete plan for committing suicide and kept a gun in the apartment. He stated that the only deterrent was the shame that this would bring on his daughters.

Following the initial assessment the patient's primary care physician was contacted, and the patient agreed to a voluntary psychiatric hospitalization. He was treated with cognitive-behavioral therapy during a 2-week stay in the hospital. During this time his psychiatrist prescribed a low dosage of fluoxetine (Prozac). Some of his cognitive distortions included the belief that suicide would bring an end to his suffering and that it would be a way to be reunited with his deceased wife. Mr X was asked to keep Daily Thought Records so that he could become more aware of his dysfunctional thoughts. He began to identify negative automatic thoughts and to learn how to challenge them. Specifically, the Thought Record helped to point out that he was not as alone as he thought he was (his daughters were very supportive) and that he did not have dementia (only the fear that someday he would develop it). He was asked to read information about Parkinson's disease so that he could see for himself that dementia was not an inevitable consequence of the disease.

By challenging his all-or-nothing thinking, he realized that even though he felt overwhelmed, there were some positive things going on in his life. For example, he acknowledged that his former apartment was actually quite large and difficult to maintain. Moving into a smaller unit would make the practical housekeeping chores easier for him. Also, he had previously played golf and had several male friends with whom he used to have lunch on a fairly regular basis. He was encouraged to contact these men again to let them know of his situation and to see what kind of support they would be willing to provide. This behavioral assignment resulted in a very surprising (to him) outpouring of support from his friends and helped to challenge the thought that suicide was the only solution to his current problems.

Finally, considerable time was spent examining the consequences of possible suicidal action. He acknowledged the strong negative impact that it would have on his daughters and other family members and that he would think of himself as "a quitter" if this really were the path that

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he chose. He also identified many of his prior success experiences in life and acknowledged that he had coped with previous difficult situations in an adaptive manner. Throughout the course of treatment, he was given a great deal of emotional support, as he clearly felt overwhelmed by the number of negative life circumstances to which he had to adjust.

Following his discharge from the inpatient unit, he was seen once a week for outpatient therapy with the same CBT therapist for approximately one year, rather than the more typical 16 to 20 sessions, in order to be sure that he was integrated into the community before terminating therapy. Across treatment, the emphasis shifted to encouraging reengagement in pleasant activities and development of age-appropriate friendships. Follow-up 2 years later indicated that he continued to maintain himself well in his new apartment, was glad to be alive, and had found new purpose in life, saying he was ready to live out the remainder of his days and to die when his Creator called him.

Concluding comments and future directions

Clearly, the perspective taken in this article has been that suicide is not a rational response to aging, and that suicide as an outcome is to be prevented. Although clinical reports suggest CBT is effective with suicidal elders, substantially more controlled research needs to be initiated on the effectiveness of various CBT approaches across a variety of geriatric patient populations including those from different cultural contexts. Additional research is needed to better understand the links between cognition and suicide among older adults where initial research suggests that in contrast to younger adults, the relationship between hopelessness and suicidal ideation may be dependent on level of depression (Ellis, 1998; Uncapher, Gallagher-Thompson, Osgood, & Bongar, 1998). Research exploring "success stories" to help us answer the following questions is also needed: What are the characteristics of elders who effectively weather the storms of life while others experience suicidal ideation and intention? What are their successful coping strategies and how do resilient elders derive their sense of self-efficacy to carry on? How can therapists incorporate what we learn from these "success stories" to assist their neighbors who suffer from clinical depression and suicidal thoughts, desires and actions?

In summary, the purpose of this article was to provide an introduction to the characteristics associated with suicidal elders and to review a model of CBT therapy used successfully with depressed and suicidal older adults on an outpatient basis. It also discussed ways to extend these techniques and strategies out of a "one-size-fits-all" therapeutic approach to modifications which may be necessary to meet the needs of diverse groups of elders. It is hoped that the cognitive-behavioral strategies described in this article will be useful to clinicians as they in intervene with this at-risk group of older adults.

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