

Health and Ageing: The psychology of ageing and concluding the life span perspective

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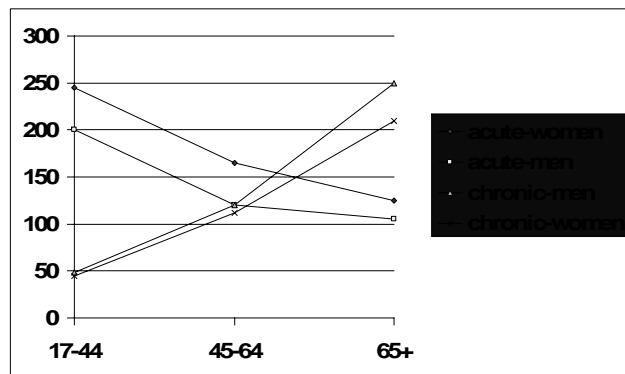
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General Issues for Older Adults

- Loss (status, people, vocation, health, etc.)
- Social isolation, loneliness
- Major financial problems
- Housing changes
- Family concerns
- Time management burden
- Complex medical issues
- Multiple medications
- Sensory deficits
- Reduced mobility
- Cognitive impairments
- Impaired self-care, loss of independence

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Acute v. Chronic Illness



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Acute Illness

- incidence decreases across adulthood
- Becomes more severe with age
 - complicated by
 - normal aging process
 - presence of chronic conditions

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Chronic Illness

- Increases with age
- Gender differences
 - longevity differential
 - type of illness
 - death rates

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Chronic illness after age 65

<u>Men</u>	<u>Women</u>
Hearing impairment	Arthritis
Arthritis	Hypertension
Hypertension	Cataracts, visual
Heart disease	Heart disease
Cataracts, visual	Hearing

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Common Chronic Conditions

- Arthritis
- Osteoporosis
- Diabetes Mellitus
- Incontinence
- Pain

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Risk factors for osteoporosis

- Age
- Female
- White and/or Asian race
- Heredity
- Estrogen deficiency
 - Importance of hormone replacement therapy (HRT)
- Small body frame
- Diet (calcium – vitamin D absorption)

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Leading causes of death (all ages)

- Heart disease
- CVD
- Accidents
- Pneumonia/influenza
- Diabetes
- HIV
- Suicide
- Homicide/legal intervention
- Chronic liver disease
- Kidney disease
- Septicemia
- Prenatal problems

Source: www.statistics.gov

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Causes of death by age-group

65+	85+
heart disease	heart disease
cancer	stroke
cerebrovascular	cancer
pneumonia	pneumonia
atherosclerosis	atherosclerosis
diabetes	accidents
accidents	diabetes
respiratory	respiratory
cirrhosis	kidney
kidney	liver

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Age of Death

	Men	Women
Heart Disease	74.65	81.58
Cancer	72.06	72.69

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Older Adults and Alcohol Problems

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Psychological Difficulties in OA



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Psychological Problems in OA

- Depression
- Suicide
- Bereavement
- PTSD
- Anxiety
- Health anxiety
- Sleep and insomnia
- Personality disorder
- Paranoid psychosis
- Substance misuse

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National Documentation 2000-2001

- **Forget Me Not: Mental Health Service for Older People** (2000) – Involvement of G.P.s' working with Older People. Pushed depression in older adults up the agenda.
- **Car Standards Act** (2000) and updated (2002) – Standards inc are homes, emphasis on well-being.
- **Treatment Choice in Psychological Therapies and Counselling** (2001) – Puts EBP for psychological treatments up the agenda.
- **NSF for Older People** (2001) – Mental health was one of the standards, clinical psychologists actually mentioned as part of teams or core members of teams.
- All emphasise importance of psychological well-being and eliminating age discrimination.

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Psychological & Social Processes of Ageing

Current views:

- Reject unitary model of social and psychological ageing
- Emphasis of lifestyle continuity of lifestyle with age.
- Life story model of identity – we ourselves in a particular way.
- Focus on:
 - Self-esteem
 - Adaptation to change
 - Control
- Adjustment to change is crucial – coping with life events
 - link to stress literature.

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Life Events and Adjustment

- Older people experience many life events, therefore **loss is important**
- When other factors are adverse, these may lead to presentation in a mental health setting.

ALWAYS LOOK FOR LOSSES WHEN ASSESSING

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Life Events and Adjustment

- Whether the event is experienced as stressful depends on context, types and perceived demands on psychological resources:
 - If event normative (developmentally) it may be less stressful, e.g. retirement, death of spouse.
 - Depends on support, role models, scripts
 - Personality factors, e.g. locus of control
 - Physical disability is a very common life event for older adults.

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Life Events and Adjustment

Model of adjustment:

- Stigma model – not perceived self as a full person applies to some
- Other patterns of adjustment proposed:
 - Healthy but with a problem
 - Ill but doing the best she can
 - Overwhelmed

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Life Events and Adjustment

Factors which are considered important for adjustment to change:

- Family/friends (someone to confide in)
- Personality
- Social support
- Adaptability to change
- Continuity of environment
- Religion

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Application to Clinical Work

Adjustment vs. Mental Health Problem

- When do changes / life-events present challenges that go beyond an individual's resources for coping and adjustment?
- Important areas to cover are:
 - Life history
 - Previous coping with change (especially adversity)
 - Family scripts for similar life events
 - Knowing about changes associated with ageing is essential for the clinician:
 - Help to normalise experiences
 - Help to look for potential strengths to compensate for weaknesses.

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Specific mental health difficulties

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Depression 1

- Common but frequently not diagnosed: Major depression but also *subsyndromal depression* (APA consensus statement) – have a number of features but not enough features to diagnose depression under DSM-IV.
- Co-morbidity with physical illness (Katona et al, 1997).
- Difference from DSM-III – low mood less prominent
- Prevalence:
 - 16.2% NY; 19.5% London (Gurland et al, 1983)
 - 11.9% Liverpool; 19.5% London (Copeland, 1987)
 - 14.9% Islington study (Katona et al, 1997)
 - More common in women (3:2)
 - Cross cultural issues.

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Depression 2

- Risk factors:
 - Previous history
 - Family history
 - Widowed / lack of close supportive relationship (Murphy)
 - Poverty
 - Living in institutional care
 - Lack of social support
- Precipitants – life events
 - Losses – including of role, income, status
 - Ill health – self or spouse

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Depression 3

Cross cultural issues

- Biological manifestations of depression occur in all cultures
- Descriptions of depression may differ
- Some cultures do not have a word for depression
- Problems of measurement: same or different instruments?
- Some evidence that rates of depression in Black and Asian older people are similar to White population (McCracken, 1997)
- Cross-cultural literature suggests Asian people are:
 - More likely to present emotional problems by reporting somatic symptoms
 - Less likely to be referred to mental health services
 - Lack of evidence for older people – local study

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Depression vs. Dementia 1

- Need to differentiate depression from dementia – “pseudo-dementia” – most frequently asked neuropsychological questions.
- Can be a precursor to dementia, especially late onset depression
- Depression in dementia is frequent
- Depression is common in people in residential care (40%)

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Depression vs. Dementia 2

Area	Dementia	Depression
Awareness of memory problems	Often unaware	Often complains of poor memory
Response to questions requiring thought / concentration	Would confabulate and be unaware that answer is incorrect	Will say "I do not know"
Cognitive testing shows	Consistent, global cognitive impairment	Shows fluctuating ability and uneven ability
Motivation	Has a go	Gives up easily, is uninterested
Performance on complex tasks	Unsuccessful, unaware of errors	Slow but successful, aware of errors

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Suicide 1

- Rates:
 - Men 65-74 19 per 100,000
 - Men 75+ 29 per 100,000
 - Women 65+ 11 per 100,000
 - Therefore men high risk group
- Methods (Cattell, 1988):
 - Drug OD most common (66% of women, 33% of men)
 - Men more likely to use violent means though guns are rare
 - Car exhaust fumes – increasingly used by men

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Suicide 2

- Precipitants – can it be seen as a rational response?
 - Physical illness, especially pain and poor adjustment to stroke
 - Bereavement
 - Loneliness / isolation
 - Hospital discharge
 - Fear of hospitalisation / nursing home admission (reason given in notes)
 - 79% showed depressive symptoms before death
 - Alcohol present – 29% in post-mortem

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Suicide 3

- **National Confidential Inquiry – Five year report (2001)**
- People in contact with mental health services (25% of all suicides = 1500 p.a.)
- In 65+ age group (12% of total)
 - 50% were male
 - 26% self-poisoning, 25% hanging, 15% drowning, 9% jumping
 - Affective disorders more common than schizophrenia
 - Higher frequency in first year of illness
 - **23% thought to be preventable**
- 47% on enhanced CPA
- 1/3 of all in-patient suicides were on home leave
- 1/3 of all in-patient suicides on non-routine observations
- Risk assessments had been done but difficulties with non-complaint patients – risk training must be updated.

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Bereavement 1

- Differences in older people's response compared with younger people (Wiscock, 1988), therefore **confusing variation**
 - Distress may appear less severe - may just be flattening of affect, query inhibited grief reaction. May lead to a diagnosis of dementia.
 - Complaints of inadequacy, lack of purpose and unwillingness to go on.
 - Exaggerated grief response – apathy, self-isolation, idealisation of person who has died
 - More likely to hallucinate – see/hear the dead person
 - For older person after loss of spouse grief initially less severe but later reaction occurs and recovery time is longer.

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Bereavement 2

- Effect of bereavement on health/well-being
 - Increase in mortality for recently bereaved
 - Findings complicated by people moving to residential care – already an indicator of poor health and a risk factor for mortality.
 - Mixed findings on effect of bereavement on health problems – methodological problems in measuring initial health statuses.
 - Effect of caring for dying relative should not be underestimated: disability, warning of own vulnerability, loss of role/supports of care-giving.
 - Anticipatory grieving of expected deaths often stressful.

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Bereavement 3

- 20 – 30% tend to show depressive symptoms in 1st year.
- Picture shown by people who show complex/extended grief reaction (Lund et al, 1989):
 - intense wish for own death
 - continuous crying
 - no pride in how managing, not trying to keep busy
- Initial and/or prolonged inability to manage may lead to admission to hospital or residential care.
- Loneliness is a major injury problem.
- Coping affected by relationship with person who died, self-esteem, competence in activities of daily living, religious beliefs.
- Protective factors include social networks as much or more than family.

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PTSD

- Distinguish between trauma long ago, e.g. WW2 and more recent trauma
 - Robbins (1994) suggests 16% rate in WW2 veterans
 - Some may have had persistent symptoms throughout their lives
 - For others, PTSD may emerge much later, e.g. in retirement when role changes and more time for reflection / integration of life events
 - Trauma from childhood may not meet criteria for PTSD but distressing e.g. sexual abuse, evacuation, loss/separation
 - Recent trauma e.g. mugging, train crash may lead to PTSD

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Anxiety 1

- Anxiety generally does not get better unless treated
- Prevalence:
 - 12% of 65+ in large urban study (Lindesay et al, 1989) with generalised or phobic anxiety.
 - Low prevalence of panic disorder - ? Avoidance
 - Most of recent onset, but simple phobias with childhood onset (Lindsay, 1991).
 - More frequent in women than men (?unmarried men)
- Precipitants:
 - Illness, esp. myocardial infraction, CVA, fractures.
 - Traumatic event: mugging, fall at home
 - Bereavement

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Anxiety 2

- Common fears:
 - Fear of crime – in fact less crime against older people, out less though consequences more severe
 - Fear of falling >40% of 75+ have a fear of falling, consequences of falling severe.
 - Fear of illness, health, injury – much greater than in younger sample. Fear of dying, related to pain and not being able to breath
- Presentation:
 - Co-morbidity with physical problems, e.g. heart disease, Parkinson's, Alzheimer's, thyroid problems, sensory problems
 - Co-morbidity with depression – 91% of those with GAD and 39% with phobic disorder met criterion for depression (Lindesay et al, 1989).

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Hypochondriasis 1

- Disproportionate disability more prominent than preoccupation with serious illness in older people – appearing more ill than presentation should be
- Somatic symptoms may be explained by both physical pathology and psychosocial factors

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Hypochondriasis 2

- Co-morbidity with depression and other anxiety disorders
 - 30% of older people in a community population, identified as “neurotic”, exhibited hypochondriasis (Bergmann, 1971)
 - 12% of older people with phobic disorder had unexplained physical symptoms (Lindesay, 1991)
 - 60% of sample of depressed in-patients at admission (Kramer et al, 1989)
- Anxiety about health can result in increased frequency of GP consultation, seeking reassurance from friends and family, withdrawal and isolation from relationships and activities, feeling of helplessness and hopelessness.

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Sleep & Insomnia 1

- Up to 50 percent of people over age of 65 experienced some disruption of sleep (Foley et al, 1995).
- Older people spend more time in bed but sleep less, and are more easily aroused from sleep.
- Increased night-time wakefulness may cause increased daytime fatigue, and daytime napping, and increased likelihood of falling asleep during the day.
- Older women complain of sleep difficulties more often than men.
- Sleep difficulties can be caused by:
 - Sleep in disorder breathing (sleep apnoea)
 - Nocturnal myoclonus (periodic limb movements)
 - Insomnia (inability to initiate or to maintain sleep)

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Sleep & Insomnia 2

- Insomnia is most common sleep complaint recorded by older people.
- Insomnia is often associated with medical, psychological (depression, anxiety) psychosocial (life events) and environmental factors.
- The daytime effects of chronic sleep disturbances include impaired mood, cognition, confusion, slowed psychomotor functioning, and increased risks of injuries due to falls.
- Individuals with chronic insomnia experience more psychological distress, are more preoccupied with somatic complaints, and utilise health care resources more often than good sleepers (Morin, Culbert, & Schwartz, 1994).

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Paranoid Psychosis

- AKA paraphrenia or schizophrenia of late onset.
 - Prevalence:
 - Approximately 19% of older people in psychiatric hospitals.
 - Community 0.1% - 4%
 - On average only 1.5% of those diagnosed with schizophrenia have an onset after the age of 60.
 - Patients with late onset are less likely to have a family history of schizophrenia than early onset patients.
- Paranoid symptoms were significantly more common in the late-onset cases (Jeste et al., 1995). Auditory hallucinations more common than visual ones.
- Alternative problems:
 - Dementia, major effective disorders, medical problems

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Substance Abuse: Alcohol

- Epidemiology
 - Older people tend to consume less alcohol and proportion of people with a drinking problem declines (Ticehurst, 1995)
 - Prevalence of problem drinking in community over 65 – 0.94%
 - 1/5 of regular drinkers consumed more than the recommended limit
 - Women are found to drink less than men
 - Physiological, social, financial factors may account for reduction in drinking

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Prevalence

- Older adults with alcohol use problems are not recognized by many professionals
- Few older adults with alcohol abuse or dependence seek help in specialized addiction treatment settings



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Process

- Precipitants (of late onset problems):
 - Bereavement, and depression, loneliness, anxiety.
 - Chronic pain/physical health problems.
- Presentations:
 - Often indirect - confusion, cognitive impairment, falls, self-neglect, medical problems, social difficulties.
 - Alcohol consumption may be minimised or denied.
 - Older people are often not asked routinely about their alcohol consumption.

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Drinking Guidelines

- The DoH advises that men should not regularly drink more than 3 - 4 units of alcohol per day
- Women should not regularly drink more than 2 - 3 units of alcohol per day.
- After an episode of heavy drinking it is advisable to refrain from drinking for 48 hours to allow your body to recover.
- Limits for older women should be somewhat less than for older men

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Drinking Guidelines

- Recommendations consistent with data on benefits/risks of drinking in this age group
- Lower limits for older adults because:
 - Increased alcohol sensitivity with age
 - Greater use of contraindicated medications
 - Less efficient liver metabolism
 - Less body mass/fat increases circulating levels

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Older Adults and Alcohol Use

- Increased risk of:
 - Stroke (with overuse)
 - Impaired motor skills (e.g., driving) at low level use
 - Injury (falls, accidents)
 - Sleep disorders
 - Suicide
 - Interaction with dementia symptoms



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Older Adults and Use

- Other effects:
 - Higher blood alcohol concentrations (BAC) from dose
 - More impairment from BAC
 - Medication effects:
 - Potential interactions
 - Increased side effects
 - Compromised metabolising (especially psychoactive medications, benzodiazepines, barbiturates, antidepressants, digoxin, warfarin)



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Signs of Potential Alcohol Problems

- Anxiety, depression, excessive mood swings
- Blackouts, dizziness, idiopathic seizures
- Disorientation
- Falls, bruises, burns
- Headaches
- Incontinence
- Memory loss
- Unusual response to medications
- New difficulties in decision making
- Poor hygiene
- Poor nutrition
- Sleep problems
- Family problems
- Financial problems
- Legal difficulties
- Social isolation
- Increased alcohol tolerance

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Special Populations

Barriers to effective identification exist for:

- Women
- Certain minority group members/lack of culturally competent tools and interventions
- Individuals with physical disabilities, comorbidities
- Homebound

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Co-morbid Conditions

Co-morbidity is a serious, common concern among older adults using alcohol:

- Impaired Activities of Daily Living (ADL's)
- Psychiatric symptoms, mental disorders
- Alzheimer's disease
- Sleep disorders

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Screening Instruments

- Health Screening Survey (quantity/frequency and CAGE questions embedded in a general health survey)
- CAGE (Cut down, Annoyed by others, feel Guilty, need Eye opener)

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Quantity/Frequency Screen

1. Do you drink alcohol?
2. On average, how many days a week do you drink?
3. On a day when you drink alcohol, how many drinks do you have?
4. What is the maximum number of drinks you consumed on any given occasion in the past month?

8 or more drinks/week or 2 or more occasions of binge drinking in last month are indicative of alcohol use problems.

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Intervention with Older Adults

1. Preventive education for abstinent, low-risk drinkers
2. Brief, preventive intervention with at-risk and problem drinkers
3. Alcoholism treatment for abusing/dependent drinkers

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Brief Intervention

- Time-limited (5 mins, up to 5 brief sessions)
- Targeted at a specific behaviour
- Goal directed
 - Reducing alcohol consumption, and/or
 - Facilitating entry into formal treatment
- Relies on negotiated goals
- Empirical support with younger drinkers across multiple settings

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Brief Protocols with Older Adults

- Brief intervention/motivational enhancement are effective approaches
- Accepted well by older adults
- Can be conducted at home or in clinic
- Reduces alcohol use
- Reduces alcohol-related harm
- Reduces health care utilization

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Brief Protocols (continued)

Ten components:

1. Identify future goals (health, activities, etc.)
2. Customize feedback
3. Define drinking patterns
4. Discuss pros/cons of drinking (motivation to change)
5. Discuss consequences of heavier drinking

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Brief Protocols (continued)

Ten components:

6. Identify reasons to cut down or quit drinking
7. Setting sensible limits, devising strategies
8. Develop a drinking agreement
9. Anticipate and plan for risky situations
10. Summary of the brief session

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Other Treatment Approaches

- Cognitive-behavioural therapy
- Group-based counselling
- Individual counselling
- Medical/psychiatric approaches
- Marital and family involvement/family therapy
- Case management/community-linked services & outreach
- Formalized substance abuse treatment

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Substance Abuse: Tranquilizers 1

Benzodiazepines

- Used mainly to help with sleep disturbance and anxiety
- Benzo use is falling at a slower rate in older people than compared o younger people.
- Sullivan et al (1988)
 - Community survey – 1000 older people
 - 13% were taking benzo medication
 - At 3 years, 60% of these individuals continued to do so, despite recommendations for their use to be short-term

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Substance Abuse: Tranquilizers 2

- Benzo use has been linked to confusion, memory problems, and falls in older people (Higgitt, 1992).
- Psychological techniques such as anxiety management, "sleep therapy" and support in gradual withdrawal may help older people to stop taking benzodiazepines (e.g. Jones, 1990/91).

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From Adult to Older Adult: Managing the Transition

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General Issues for Older Adults

- Loss (status, people, vocation, health, etc.)
- Social isolation, loneliness
- Major financial problems
- Housing changes
- Family concerns
- Time management burden
- Complex medical issues
- Multiple medications
- Sensory deficits
- Reduced mobility
- Cognitive impairments
- Impaired self-care, loss of independence

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Issues for Transitional Adults

Health

- Declining health and mental acuity; fear of dementia, heart attacks, increased pain, medical disabilities, etc.
- There is a parallel process for physical health and mental health
- When individuals age within a system, the adjustment to new staff such as; doctor, nurse, case manager, clinicians, may be difficult.....this adjustment is with the individual as well as staff.
- Depression and higher risk for suicide

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Issues for Transitional Adults

Abuse

- Substance use and abuse issues; increased need for medications along with side effects
- Elder abuse



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Issues for Transitional Adults

Spirituality and Feelings

- Search for meaning and purpose in one's life (past and future)
- Spiritual issues
- Unresolved guilt and grief
- Unfinished Emotional Business

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Issues for Transitional Adults

Family

- Older adults who are also parents to grandchildren, nephews and nieces etc.
- Fear of becoming dependent on someone else
- Relationship issues with children & spouse, including former partners
- Fear of abandonment
- Living alone – family concerns

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Issues for Transitional Adults

Aging Process

- Fear of dying
- Anger/fear at being marginalized because of age
- Fear of becoming ugly and/or unattractive in various ways
- Ageism
- Managing physiological/emotional changes of aging



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Issues for Transitional Adults

Retirement

- Fear of being useless (loss of job and earner role)
- What to do with that free time?

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Issues for Transitional Adults

Financial and Housing

- Financial issues, especially as they relate to healthcare
- Living options – relocate or stay
- Affordable Housing

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Issues for Transitional Adults

- Loss of friends and relatives through death and disability
- Realistic/Unrealistic Expectations
- Crises – How to Cope



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Death & Bereavement

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What is death?

■ Brain Death

- No spontaneous movement
- No spontaneous respiration/1 hour
- Total lack of responsiveness
- No eye movement (blinking/pupil)
- No postural activity – swallowing, yawning, vocalizing
- No motor reflexes
- Flat EEG - 10 minutes
- No change in any of these if tested again in 24 hours

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When and how do people die?

- 80% deaths occur after age 60 in the U.K.
- Median age of death is 77 years.
- Among survivors to age 65, median age at death is 84 for women, and 80 for men.
- Women live an average of 7 years longer than men in the U.K. and in other countries
- There are ethnic differences
 - Female born in 1998 – 80 years life expectancy
 - Male born in 1998 – 74.5 years life expectancy

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What causes death?

- | | |
|----------------------------|----------------------|
| ■ <u>Early: Ages 25-44</u> | ■ <u>Late: 45-64</u> |
| ■ Accidents | ■ Cancer |
| ■ Cancer | ■ Heart Disease |
| ■ Heart Disease | ■ Accidents |
| ■ Suicide | ■ Strokes |
| ■ HIV | ■ Lung Disease |
| ■ Homicide | ■ Diabetes |

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Where do people die? 1

- Hospitals – place relatively little emphasis on the care of terminally ill – known as palliative care (without regard to terminal state)
 - There are other problems, especially the expense
- Nursing homes / long-term care facilities – may offer palliative care but usually don't
 - There are other problems, little help with the dying process

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Where do people die? 2

- Hospice care
 - Dying person decide what they need
 - De-emphasized prolonging life
 - Pain control emphasized
 - Normal setting (if possible)
 - Bereavement counseling for entire family
 - Research shows positive outcomes
- Home
 - Advantages are several
 - Disadvantages are: quality of medical care, ability of care givers to provide care – increase level of stress, help may be available from hospice

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Bereavement

- Bereavement
 - State of being deprived of something. Doesn't have to refer to death but usually does.
- Grief: the reaction to bereavement. Many dimensions. A normal and healthy reaction.
 - Feelings, Cognitions (preoccupation, disbelief)
 - Physical sensations
 - Behaviors (sleep, eating disturbances)
 - Social difficulties
 - Increased risk of illness?
 - Spiritual searching
- Issues of death trajectory: lingering v. quick

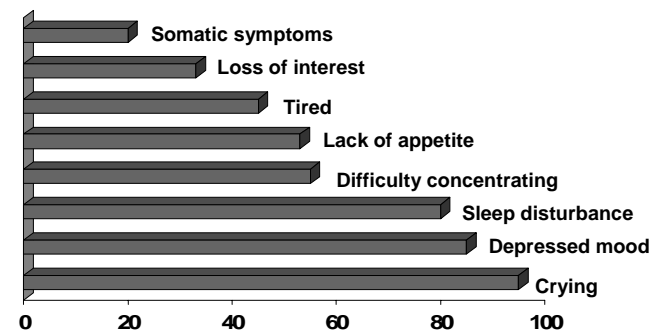
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Mourning

- Process of coping with loss and grief
- Berado (1988) stages
 - Reaction stage: Shock and numbness: usually the initial reaction to loss. Difficulty in taking care of basic needs.
 - Yearning and searching: effort to return to things as they once were.
 - Disorganization/Reorganization: unable to concentrate on challenges. Death has interfered with life.
 - Reorientation and recovery: begin to reshape a new life
- Some person might experience unresolved guilt, especially with quick-trajectory death, like suicide

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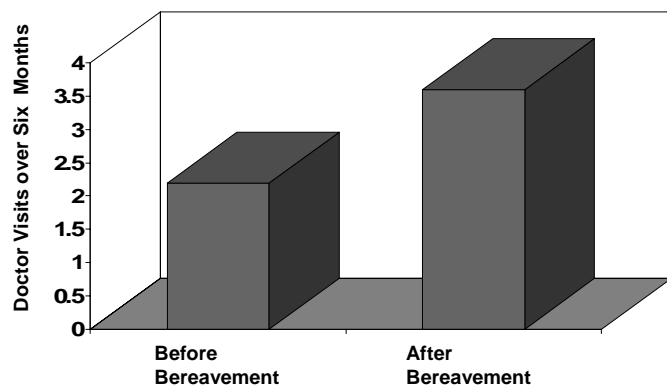
Bereavement and Symptoms



Note: Data from Clayton et al (1971). – percent reported

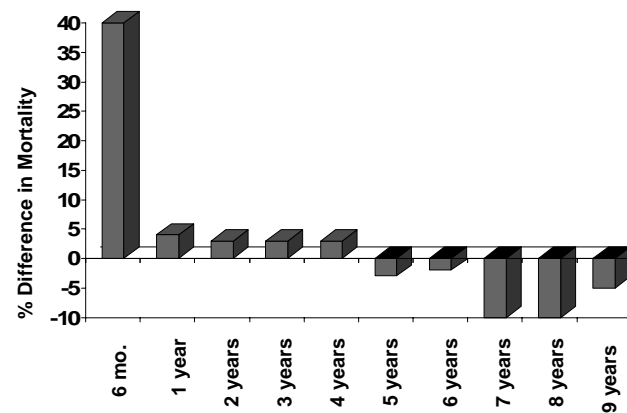
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Bereavement and Illness



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Bereavement and Mortality



Note: Data from Parkes, et al (1969)

Time Since Bereavement

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How do people cope with bereavement?

- Doing “grief work”
- Secure infant attachment related to coping skills
- Low self-esteem related to more difficulty
- Cause of death influences bereavement
- Support system essential
- Additional life stressors detrimental
- Positive outcomes often found

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How do people react to different types of death?

- Death of a spouse
 - Highest value on SRRS to evaluate level of stress – devastating effect
 - Second to the death of a child
 - Gender differences – men more likely to remarry, women outlive their spouses. Women more likely to form new social relationships and there are more support for widows.

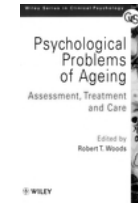
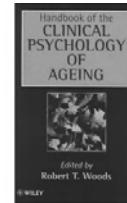
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Discussion topic

- Should people be allowed to choose when to die?
 - http://www.assistedsuicide.org/suicide_laws.html

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Suggested Reading



- Woods, R.T. (1996). *Handbook of the Clinical Psychology of Ageing*. London: John Wiley & Sons.
- Woods, R.T. (1999). *Psychological Problems of Ageing: Assessment, treatment, and care*. London: John Wiley & Sons.

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Practice essay questions

- 'Old age promises nothing but decline'. Discuss.
- What differentiates depression from dementia in older adults? What are the implications for health providers?

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