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WVU – CED Grand Rounds Webinar –

The Role of Functional Impairment in Depression and Suicidal Behavior among Older Adults

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>> DR. COTTRELL: I want to ask everyone to make sure your line is muted to avoid background noise.

And what we normally do is we'll open it up to Dr. Fiske's presentation.

We'll save questions and answers to the last few minutes of the hour.

But feel free to use the chat function within Zoom if have you questions or you want to include comments.

And we'll be sure to facilitate that discussion, as well.

With that, let me introduce Dr. Fiske.

Dr. Fiske received her Bachelor of Arts from Stanford, and her doctoral degree in clinical psychology with a focus on aging from the University of Southern California.

She completed an internship at the veterans affairs Palo Alta healthcare system.

She completed post-doctoral work at the University of Southern California and joined the faculty in the department of

psychology at WCU in 2005.

She was promoted to associate professor in 2011, and currently serves as department as director of clinical training and coordinator of the clinical psychology program area.

So I'm so happy we stole you from the California system, and that you've been able to stay with us.

And with that, let me turn it over to you for your talk today.

DR. FISKE: Great.

Thank you, Dr. Cottrell.

I appreciate that, and I'm excited to be here at the center for excellence and disabilities, at least virtually to talk about this.

Because when Dr. Cottrell spoke to me about the possibility of doing this talk, it helped me really see an important role disability has played in my research program.

So this has been fun for me to go back and really look at this in a way. So,

thank you for having me today.

What we're going to be doing today is I'll basically give you the conceptual framework that my, part of my research program has been based on.

And it's really looking at functional disability -- functional impairment and either depressive symptoms or suicidology in older adults.

And I'll give you the conceptual framework that comes out of a life spent in developmental theory.

And then we'll talk about some of the things that might explain why functional impairments are related to suicidal outcomes in older adults.

And some of these include attitudes about autonomy, coping strategies, cognitive flexibility, and even actually engaging in events.

There's things that my lab has looked at with respect to depression and suicidology.

So first, I just want to mention a

little bit about depression.

Most people are pretty aware how common depression is.

And in lifetime depression, about 19 percent of people in the United States will get depressed at some time during their life.

And the 2-month prevalence is of course a little bit lower.

But the interesting thing is, as you can see from those age groups, that old age is actually the time when people are least likely to be depressed.

I ask you to think for yourself: What you would have expected?

I think most people think of old age as pretty depressing.

But that's not actually the case.

It is true, however, that older adults are more likely to have, or at least as likely to have lower-level depressive symptoms that don't meet criteria for a depressive disorder, but could be clinically significant.

And then in addition to that, any depression is -- puts a person at risk for some pretty negative outcomes.

One of those negative outcomes is suicidal behavior.

About a million people every year die around the globe of suicide.

And in the United States in the most recent year for which we have complete data, which was 2018, almost 50,000 people died by suicide.

Sadly, those rates have been increasing recently. Now it is ranking as tenth leading cause of death among anyone in the United States.

And as you can see, the suicide rate per 100,000 for the general population, 14.8 is actually, well, an interesting point is it's actually much higher than the rate for homicide.

You know, we hear about homicide a whole lot more.

But the rate actually goes up in late life.

17.4 in people 65 and older; high energy people 58 and older.

And most of those suicides in late life are older men, for which the suicide rate drops off in old age.

But for men, it climbs.

So one of the questions that's been driving me in my career is what might be the reasons that older people might be more suicidal, given the fact that we know as a group that they're less likely to be depressed.

And depression is one of the main risk facts for suicide.

Here are some of the other risk factors for suicide.

There are certain stresses.

Life events, for example, in a study I did, the most prominent stressful life event for older adults was loss of financial status.

So, people -- people's income dropping.

And surprisingly, that was in Sweden

where it is a socialist country and probably there's more income protection than a lot of other places.

But still, that was an issue for older adults.

But the one I want to talk about today is physical illness and disability. Because that really stood out to me as one of the challenges that occurs more frequently in late life, and could potentially explain why more older adults might be turning to suicide.

So, to explain this, I turned to a theory of life span development called the motivational theory of life span development by Heckhausen, Wrosch and Schultz.

They said that successful aging is a matter of how you manage control, how much control you want, and how much control you have. And they break down control in two different ways.

Primary control is if you are actually operating on the environment.

You're doing something to reach your goals through your own steam; basically, that's primary control.

Secondary control in this theory is conceptualized as a way of altering yourself so that you can enhance your motivational resources to pursue primary control.

Okay?

So primary control is really viewed as the most important thing in this theory.

And you have to ask yourself: Does that make sense to you?

I mean, certainly I think most people would agree that, given a choice, you'd like to get things done yourself.

We're kind of it a do-it-yourself species.

So, this schematic gives us an idea of what premises this theory is based on.

One is that we all like to have control.

And if you look at the primary control striving line at the top that goes steadily

across the life span, and a trajectory for that is proposed to be just steady because they would argue that everyone likes to have control no matter how old you or how young you are.

So, striving for control is a constant in this theory.

What does change, however, is our capacity for control.

So, those who work with kids know that most kids probably don't have a lot of control and probably feel like they don't have a lot of control.

But that does increase as they gain competencies and gain age.

However, in the latter part of life, things happen that lead us to have less capacity for reaching our own goals, just using our own independent efforts.

So, as you can see on this schematic, the primary control capacity drops off in the latter half of life.

And that's the challenge; how do you meet your goals when your ability to do

that under your own efforts is declining?

And one thing they're seeing in this schematic is you can enhance your motivation, secondary control striving and other secondary strategies.

I'll explain in a minute.

The other elements that Heckhausen, Wrosch and Schultz includes is selection and compensation.

You'll recognize that as coming from the Baltes and Baltes compensation model.

And the notion is these are things we have to do. These are challenges that we need to meet in order to age successfully.

Selection involves just the fact that we can't do everything we want to do.

So we do have to pick and choose, right?

So, selection is just figuring out where to invest your resources.

And that's something we do throughout the life span.

Compensation is something that you have to do, because into everybody's life a

little bit of rain's going to fall.

Sometimes you don't see success.

And so how do you deal with losses, and how do you deal with failure?

The answer is -- they would refer to that as compensation, whatever you do to adjust for that.

So, those control strategies that Heckhausen, Wrosch and Schultz talk about include -- can also be classified according to these regulatory mechanisms of selection and compensation.

As so, they would say selection is investing in a goal.

And compensation includes responding to loss and failure, either by amping up your action plans; in other words, changing what you do, or protecting your motivational resources.

And maybe none of you recognize this, but some people do, for example say, well, I didn't really care about that goal after all.

Or, I know I didn't make that goal,

but it really wasn't my fault, okay.

So whatever we have to do to protect ourselves would go into the compensation category.

So, if you cross both the primary and secondary rubric with the selective compensatory rubric, you get this list of control strategies.

And in this theory, they would argue that all of these are adaptive.

What makes a difference in what is adaptive in a given situation is what the opportunities are.

So, these first three goals -- so, these first three control strategies involve engaging with your goals.

So, again, selective primary control is you're out there trying to change the environment.

You're doing something to meet your goal.

If you don't have any groceries for dinner and your goal is to cook for dinner, then you're going to get in the car and

you're going to go out there and drive and get your groceries and come back.

That's selective primary control.

Selective secondary control is arranging your motivation, you know, preserving your motivation so that you can basically do your primary control striving.

So, it is organizing your time in such a way that you might have time to go out to do the grocery shopping; avoiding distractions.

You don't sit and watch TV. You actually go to the store and get your groceries.

Compensatory primary control is, how do you adapt if you can't meet your own goals through your own efforts?

And you might do one of two main things.

One is seeking out help; and two is you might find a different way to reach your goals.

So, possibility is asking your neighbor to drive to the store to get the

groceries.

And another possibility would be, you might learn how to use a mountain lion.

Go out and get a route map and figure out where you can catch a bus and get your groceries that way.

Then the latter category here at the bottom, disengagement includes the compensatory secondary control.

And that one, basically giving up on a goal and picking a new goal and making yourself -- basically arranging so that your motivation will continue to be high to meet your new goal.

Okay.

So, I like this theory so much that I basically took this and put it into my own model just as a way of organizing my thinking about what I wanted to learn about late life suicide.

So, as you can see, my thought about this is as we get older, physical and cognitive and maybe even financial limitations lead to us no longer being able

to meet our goals in the same ways we used to.

And if that's the case, then it's adaptive to use compensatory strategies that I mentioned, either help-seeking or modifying the way you get to your goals or modifying the goals.

And some people are going to do that.

And those are going to be the people probably who are going to land in the category of successful aging, people who generally have higher well-being.

On the other hand, some people are not engaging these compensatory strategies.

And I would argue that these will be the people who will not meet their goals, because at a certain point, especially with people with functional impairment that might be continuing, if you get to a point where you can no longer drive or you can no longer walk, or there are lots of things you can no longer do perhaps due to a variety of reasons, you will be unable to meet the same goals in the same way.

And if you don't compensate, then I think that's a recipe for hopelessness, which is of course another risk factor for suicidal ideation.

I have a couple of boxes here at the bottom.

And those are things that I speculated might lead into whether or not a person would choose to do the compensatory strategies.

So, those people whose attitude toward independence is -- they're so fiercely independent that they really place a high value on their own autonomy, I would think those people would be less likely to use compensatory strategy; and therefore, more likely to be hopeless, depressed, and suicidal.

And eventually -- that is if their functional impairments get bad enough.

And then people who have an inflexible cognitive style might just not change because, you know, you need to be a little bit flexible to change.

So, they might not take on compensatory strategies not because they don't like those strategies, but just because they have always done it the other way and it's always worked.

So, you set out to test a few of these things.

And the first thing I wanted to test -- I was just fascinated with that testing for autonomy.

I think we have all probably known fiercely independent people.

And I was really interested in seeing what we could learn about that.

But first, we looked at whether physical illness was even associated with depressive symptoms in a large data set.

And I did through my mentor, Dr. Margie Gatz, have access to Swedish twin data. I worked on that when I was in graduate school.

So I have older adults here, a large longitudinal data set.

So we took depressive symptoms using

this CES-D and looked at all of the twins ages 29 to 53, divided up into age 60. Depressive symptoms increased in the group 60 and older but not in the younger group.

And we found there was an association between illness and depressive symptoms.

But it wasn't as clear longitudinally.

There was a baseline in our longitudinal models, but not a change over time that could be attributed to illnesses.

We then set out to do a review of what the literature said about illnesses and suicide risk and found that some illnesses were related to suicide, death by suicide.

And others were not.

It was -- you can kind of see the list here.

And then we look at what some of the commonalities might be.

And one of the things we noticed is some of the studies talked about the death by suicide was more prevalent around the time of diagnosis.

Others said it was more prevalent

later in the stage of the disease.

Cancer, for example, actually has elevated rates of suicide both around diagnosis and also late stage in the disease.

So, we thought that might have different implications as well for functional decline and functional impairment.

And then what about the mediators for this?

It was not clear enough from the literature at that time.

Not a lot of people were really looking at that, but we thought functional impairment was important.

So that led us to do another study where we looked specifically at functional impairment.

In this study it's the share data set, which is available to researchers.

It was other different countries in Europe; it was a large data set.

We looked at all the different medical

conditions that we measured, and we looked at their functional impairments.

I think it was activities of daily living that they measured.

So you can see there the list of all of the diseases that we found were related to passive suicidal ideation in this study.

By the way, passive suicidal ideation is basically a wish to die, a little less explicit than saying you had suicidal thoughts but getting at the same concept.

And we looked at different organ systems as well.

And we found a number of them, as you can see listed.

And we also found that those illnesses were partly mediated by functional impairment and partly mediated by depression.

Okay.

So this gave us kind of a clue that we were on the right track, looking at functional impairment and not just illness.

And then my student Julie Watts, a

wonderful student who just recently graduated, and she looked -- did a critical review look at functional impairment and suicidal ideation specifically, looking at all the studies that were out there at the time, 45 studies looking at that.

And what she found was that there was strong support for the conclusion that functional impairment was related to suicidal ideation.

There was also some suggestion that depression might mediate that relationship, but not enough that the study even tested that to be able to say that that was the case.

So, the next thing we looked at was -- as I said, I was aching to look at people who had fiercely independent attitudes, like autonomy, to see whether that might explain why, you know, that that might explain some of why people were suicidal in late life or depression in late life, as well.

So, what we did is we found a measure

of value placed on autonomy.

Basically it was the same measure we used in the -- or I'm sorry, maybe I'm confused.

So this is a measure that we had used to mail out to people in West Virginia, older adults in West Virginia, as well as the surrounding states. And -- sorry.

And the measure basically -- the autonomy measure had these sub scales on it.

The one I was especially interested in was need for control.

The question for that is, "I resent it when people try to direct my behaviors or activities."

The measure also had other sub scaling objectives, perfectionism and defensive separation.

I was pretty much hypothesizing that need for control is important for older adults because we know that older adults are more likely to have functional impairment.

So the idea is that independence may be more of an issue for them.

And so we look at that.

And as you can see, each of these three sub scales were at least moderately correlated with one another.

But only the need for the control sub scale in the older adults was related to the measure of suicidal behavior, the suicidal behavior questionnaire in this older adult group.

We then went to college students and took the same survey basically, and sent it out to a group of college students and found exactly the opposite.

So, for the younger people, need for control was not related to suicidal behavior, but the other two sub scales were.

So again, that really kind of confirmed for us that control was an important factor when it comes to older adults and suicidal behavior.

So, we did another study where we actually went

out and recruited older adults in the community and then gave them some questionnaires.

Now we wanted to look at again their attitudes about autonomy, and see how that might have been related to suicidal ideation.

What we found from what we see here is that depressive symptoms measured by the CES-D were related to suicidal ideation, as you might expect, and so was autonomy.

But that was also qualified by the fact that there were a couple of interaction terms that were significant.

And so, we interpreted this latter interaction term between depressive symptoms, value placed on autonomy and gender.

And what we found was we interpreted that interaction term. And what you can see here is that higher levels of depressive symptoms are related to higher levels of suicidal ideation.

But that relationship is not at all affected by whether you're high versus low

levels of autonomy, okay?

So in women, I'm saying it was not related at all.

We did look at it in men separately. And lo and behold, it makes a huge difference.

So for men who place a very high value on autonomy and independence, that very much affected the relation between depressive symptoms and suicidal ideation.

That's how we interpreted that.

So this was an interesting area. And we kind of took away from that that how much you value your independence is going to be an important thing when it comes to suicidal ideation, if only because it works through depressive symptoms.

So, the next thing I decided to do is look a little more directly at some of these control strategies, because if somebody places a high value on their own independence, then this is the kind of person as I keep saying who's fiercely independent.

This is probably not somebody who's going to want to ask for help, right?

And that was one of those two strategies that I mentioned in the compensatory control -- primary control strategy category.

So one way in which you can compensate is you can ask for help.

Another way is you can just modify your method of reaching your goal.

But we think that people with high levels of autonomy might not want to ask for help.

And so, I decided to do a little bit of research, specifically about compensatory primary control.

So, what we did was we went into a primary care center and arranged to be able to interview some of the older adults who came in as patients in their waiting room.

And we did that.

So we ended up with -- we also then pulled out groups that had impairments due to their health.

And we did that using those two questions that I have listed.

Either they had endorsed some kind of limitation in their activities of daily living, or they answered yes to the question: Does your health keep you from doing things you'd like to do.

So we had 50 people in this sample aged 65 to 94.

And you can kind of see what some of the health problems -- those were the main health problems that they endorsed.

It was -- these are the demographics of the sample .and it's probably not terribly surprising for this age group and in this town.

Actually ,a very high level of education, as you can see, which is not unlikely for Morgantown.

Their depressive symptoms in this sample were below the cutoff on average.

But they were not negligent.

And the geriatric suicide ideation scale did also have a mean of 12 with a

cutoff of 19.

So they were not ,on average not in the clinical range.

But it shows there was enough variability that we did get a bit of depression and suicidal ideation in this sample.

So, if you looked at both for depressive symptoms and suicidal ideation, we wanted to know how these control strategies predicted those affected outcomes.

And what you can see is it, for the -- for compensatory -- I did this, there's two ways.

For compensatory primary control, we looked at that as that scale directly.

But we also looked at the two sub scales within that, one for help-seeking and one for modifying the goal.

And what you can see is help-seeking is where the action is, right?

So, those people who endorsed that they did ask others for advice or help were

less likely to report depressive symptoms.

They were also slightly less likely to report suicide ideation.

However, that was not significant in the sample.

When we just looked at compensatory primary control in the CPC scale altogether instead of breaking it into sub scales, it was significant for suicidal ideation.

If you look at those secondary control strategies ,that compensatory secondary control, which is giving up on your goal, finding a new goal, maybe helping yourself feel better about that, you can see that's also significant.

But that is significant in the wrong direction.

So those people who did that were more likely to be depressed.

And those who engaged in selective secondary control, trying to amp up your motivation, were more likely to be suicidal.

And the only explanation I can say for

that is that these are cross-sectional data.

So it may be the case that those who were more depressed or those who were more suicidal were trying harder to -- to work on themselves and get their motivation in place to be able to do better.

So we wanted to look at that in a little bit more detail.

So, and we also had found that that selective primary control, which is persisting in trying to meet the goal with your own efforts ,was also significant I think at least for depression.

So we looked at the interaction between the two.

And what we found I'm pleased to say is exactly what we would think might happen.

And that is, those people who were doing the best are people who were either high in selective primary control, which is persistence, or high in compensatory primary control, help-seeking specifically.

Okay?

And so, these are -- if you had -- and this makes sense.

Why does this make sense?

Because if you are able to reach your goals by persisting, you wouldn't need to be compensating.

And if you were compensating, you wouldn't need to be persisting.

You really just need to have one or the other.

And that makes a lot of sense to me.

So, that gave us cross-sectional evidence that there was a relationship between control strategies and suicidal ideation and depressive symptoms.

But what we then wanted to do, what I needed to do next is find out, is there a prospective relationship between these things.

So I did a little pilot study.

It didn't feel little while I was doing it, because I drove all around West Virginia to meet with people in their own

homes at least for the baseline interviews; and then did telephone interviews after that.

And it was a longitudinal study for a year.

As you can see, we collected data both at baseline and six weeks to kind of capture change happening immediately after the baseline; three months, six months, nine months and a year.

And I basically went to the cardiology department and got referrals from them of people who had had a recent, meaning within the last six months, heart attack or congestive heart failure.

And the idea between -- for getting a sample of that kind was my thought that this would be a way of getting people with -- who are going to be vulnerable for functional impairments, if they didn't have them already.

So I was expecting some decline over time in their functioning and potentially decline in their affective outcomes as

well.

And the question was going to be: Do compensatory primary control strategies predict that decline?

well, what I found was -- I did run some cross-sectional results. And I found compensatory primary control was significantly associated with virtually everything I was interested in: Depressive symptoms, hopelessness and suicidal ideation.

And that was significant, even in a sample with ten people.

So ,it was a pilot study.

I was kind of impressed by that.

Selective primary control was not as consistently related.

But the trends were all in the right direction, as well, for selective primary control in these cross-sectional results.

When we looked at this longitudinally, and what you should see -- I think you should focus on where it says affect size over one year, you can see there's at least

a signal to moderate affect size for depressive symptoms, the CESDR and suicidal ideation, the GSIS.

So this gave us for CESDR .0, close to significant.

But what this gave us is a signal showing that compensatory primary control at baseline did appear to be predicting changes in the expected directions in CESDR -- sorry, in depressive symptoms and in suicidal ideation.

And so this kind of led me to believe the most important thing next is to do a larger study with a larger sample to be able to see if these findings are borne out.

One of the other things we looked at in this study was cognitive flexibility.

So, while I was driving around to people's homes in West Virginia, which was by the way really a fun thing to do and one of the things that kept me here from California, because I have to say I've really, really enjoyed meeting and being

around people in West Virginia, and the natural beauty was great, as well.

So I really enjoyed the driving.

But one of the things I did is the reason I had to do this in person is because I like to do tests.

And I wanted to look at flexibility because there is some evidence showing that, personality-wise, people who have openness to experience to a greater degree are less likely to die by suicide in older age.

And I thought, aha, that kind of lines up with this idea, doesn't it?

Maybe if they're open, they're flexible to changing what they do.

So, I wanted to look at that.

And I did and did not find any results unfortunately with that personality measure.

But I did also add the Wisconsin compensatory test, which as you may know is a test that basically has a game you're playing with the participant, who then --

and then the rules of the game change in the middle of this sort of card game.

And the test is trying to see whether they will catch up, whether they realize there's been a change ,and whether they make a change in response to the changing roles.

And for people who do not change during this test, basically those are referred to as preservative, continuing what they were doing, even though it's not working.

And so my thought was maybe this is a measure of cognitive flexibility that can help us see whether somebody might be, you know, it might lead to whether or not somebody is suicidal in old age, as they have functional limitations to deal with.

And what we did find is that if you look at these different control strategies, selective primary control, compensatory primary control and then the secondary controls as well, the only one with significant correlation is the compensatory

primary control.

So that suggests that it takes a little bit of cognitive flexibility in order to shift over to the compensatory strategies.

We did find that those higher levels of perseverative errors were related to change in moment helplessness with a moderate affect size.

They didn't predict suicidal ideation or depressive symptoms but again this, is only ten people.

So that's probably the reason for that of then another one of my students in my lab came one an idea, Patty Veramonte, who is now at VA in Boston, and she came up with this great idea of looking at, taking people selected for functional impairment, and figuring out whether engaging in pleasant events could explain why these people either did or did not have some affective outcomes, again depressive symptoms, as well as positive affect and meaning in life, which is highly correlated

with suicidal behavior.

So, she recruited these people in the community, again, an older sample.

And mediation analysis found that physical disability was associated with greater symptoms, lower positive affect and lower meaning in life.

And this was indirectly through, in other words, mediated by the extent to which they engaged in pleasant activities.

And this is good news for those of you who may know a little bit about something called behavioral activation.

It's a therapy that we use to treat depression.

And one would assume that that would be a good therapy to use. And it's certainly imperially supported in all other groups as well.

But the question is: Is this a treatment that would actually work with people who have a disability, functional impairments?

And the answer is this research really

suggests that it is.

It's also true that for somebody with impairment, it might be important however to help the individual figure out how they're going to engage in pleasant events, again it's a new impairment.

They might not be able to do what they used to be able to do to engage in pleasant events.

So, going back to this original model, I would say I think we do have at least a little bit of the evidence that engaging in compensatory strategies is associated with hopelessness, suicidal ideation and depression in late life.

And we do know that cross-sectionally, we had a little signal of that in terms of prospective research.

We need a little bit more prospective research in that area.

We do volume evidence that high value placed on autonomy is related also to hopelessness and suicidal ideation.

But we'd need to know -- an

interesting question might be: Does that actually relate to people not engaging in compensatory control strategies?

Don't quite know that yet.

And we know a little bit about inflexible cognitive style being related to compensatory control strategies and also suicidal ideation.

So future directions?

Boy like to test -- as you can see, what I've done in my research so far is to try and select for samples that have or should have some form of functional impairment, and then see whether these relationships hold in that sample.

I'd like to take a larger sample that will has people who do and people who do not have functional impairments and see whether we can test directorially for level of functional impairment and see if that then predicts these outcomes, and whether it's positive rated by coping strategies. Another thing we need do is we need to take into account cross-sectional findings and test

them in a larger prospective data set.

Then I think we need to maybe develop some interventions to help people learn to ask for help, for example, and feel better about it.

Or to help people come up with flexible ways of meeting their goals and test those out, whether those alter our affect active -- if we do intervention studies with those methods, see this that alters affective outcomes.

And also, I'd love to just know whether autonomy is related to people doing compensatory control strategies or not. So, I think we've gone over these conclusions already.

I think there is some evidence that functional impairment is a huge challenge for older adults., and is definitely related to depressive symptoms, hopelessness and suicidal ideation.

And I think we've got to start on finding some ways to look at those and maybe explain what those relations might

be.

So, again, I very much appreciate being asked to be here to talk.

I also would like to acknowledge some grant funding that I got that helped with some of that research.

One of my colleagues out in California that I'm still in touch with who helps me a lot with my statistical work as well, and at students past and current in the mental health and aging lab, who work with me, I really appreciate them, as well.

So, I am open for any questions people might have.

Is it okay if I go ahead and stop my sharing at the moment?

>> DR. COTTRELL: Absolutely, that sounds great.

And I see we already have one question in the chat.

And then as people have question, people remember to unmute.

The first question S.

So how has COVID-19 and increased

isolation impacting suicide ideation in older adults and suggest strategies?

DR. FISKE: Ah.

Well, suicidal ideation is increasing during COVID-19.

You might have heard that already and that's true I believe in older adults as well as in other age groups.

And one of the things that I've been really interested in recently is social -- how social factors have something -- might have something to do with the control strategies people use.

Because help-seeking not going to do you any good if you have nobody to ask for help, right?

So, we're -- I'm just seeing this among people that I know, that people are sometimes having some difficulty finding anybody to help them out.

So, I think that's a big issue.

But that was one of the directions actually I wanted to head in a future study to, figure out whether those compensatory

control strategies are actually facilitated literally just by the presence of another person.

Great question.

>> DR. COTTRELL: Next question, are there differences found in compensatory strategies of individuals who have chronic life-long disabilities and these require -- so depending on when.

DR. FISKE: Yeah.

That's a great question.

I'm going to write that down.

[Laughter]

DR. FISKE: I would love to study that and have not actually -- I have no data pertaining to that right now.

I've been especially really interested in people who develop functional impairment late in life.

And the reason for that is that there is a little bit of research on it heck and as a result's theory as it pertains to -- heck did research on people with age-related macular degeneration; and found

that as that got worse and people lost their eyesight in both eyes you could actually see people shifting from the persisting to meet their goal, that's that selective strategy to a compensatory strategy.

And I thought that would be kind of an interesting way of watching that happen in realtime.

But it would be great to just compare those two groups.

I think that would be interesting.

>> DR. COTTRELL: And Grace says: What can society do to improve the accessibility so that if and when people ask for help, it will be given to them in an effective way.

Is there evidence of co-morbid events earlier in life that may contribute to these issues?

DR. FISKE: Again, really good questions.

There are a number of -- a number of ways in which I think communities really do a nice job of helping older adults who

might be -- might not want to ask for help.

One of the experiences I had when I first came to West Virginia that really stuck with me, I went over and met with some folks over at Scotts Run in the senior center there.

And I was fascinating with this whole idea of help-seeking and how people view autonomy.

And I was asking them some questions about that.

And I said would you -- because I was meeting with these older people -- I said would you ask for help if you had a problem you couldn't solve on your own.

And they said, oh, no.

And I thought, ah, that fits into my stereotype of West Virginians being fiercely independent, right?

They said ,it's that you would offend the person you asked, because they should have known to offer.

And I thought, oh, my goodness.

This is a place where people who have

lived here a long time maybe have such a norm of helping each other that it's taken for granted that you're going to do if the -- you know, giving help.

You shouldn't even have to ask for it, and I thought that was stunning.

That really touched me.

And so, I have seen, even since I have gotten here and some of my graduate students mentioned, there's a lot of help and giving around here and it really is delightful.

There are non-profit oranges that do provide assistance for people.

And that's also helpful as well.

One area where I've seen there's not a lot of help -- and I keep bringing this up example -- is driving.

And that's another area where I'm really fascinated.

I'm also seeking some funding to do a study on that.

A lot of older adults, especially those I think who are fiercely independent,

have a terrible time with not being able to drive.

And if they had somebody they could ask to drive them there, some people still would not want to do that, but I think a lot of others would come around to doing that, if it were available.

And I think that in our society that's an area where we don't do a really nice job.

If there is better public transportation, it wouldn't be as big a deal.

But the research suggests this is especially in rural areas, obviously we're not going to get the public transportation in all areas.

So I think that's still an issue.

So that would be an issue for act victim, I think, is trying to get some help for people who can't drive.

And I think I missed the second part of this question, I'm sorry.

>> DR. COTTRELL: Co-morbid traumatic

events earlier in life, do you think that would influence your findings in any way?

DR. FISKE: I think that could happen, because we do know traumatic events and PTSD specifically are very related to suicidal behavior.

And often those can be things that happened early in life that are still having an effect late in life.

So I wouldn't be surprised by that at all.

Great question.

And thank you, Dr. Cottrell for reading these for me.

>> DR. COTTRELL: No worries.

There were two things that popped me in my mind during your presentation.

And the phrases would be assistive technology and self-advocacy.

And in the area of disability, we're constantly striving to provide services and support that lead to self-advocacy.

So, the question I think particularly related to what Elizabeth was asking about

whether this is chronic or an acute, the longer they have had the disability, the more time, perhaps, maybe not always be the case that they're associated that way, but have they heard more and they have developed more skills on self-advocacy, which I don't know how that would be associated with compensatory strategies, if that leads to more independent or if that lead them to develop the skill dose ask others to help or maybe both.

Honestly, so I thought of that piece.

And the assistive technology or when they aren't able to complete an activity the way they did prior, that fits into -- so they could complete that activity.

They just need to go at it a different way, usage different tool of some sort offer approach.

And so we have a couple of people from that program.

And I wonder, you know, are we looking at -- the profiles of individuals that you're talking to are those that use

compensatory strategies more likely to approach the assistive technology program, for instance, and seek that change in approach in the first place?

And they work with them from there on to think of it a little differently.

So, yeah.

I think a cup of it areas that we strive f we're doing it right, could influence your results a little bit.

DR. FISKE: Totally.

So much so, yeah.

In fact, I got a change to meet Dr. Ramona at engineering.

And he and his group are doing some really amazing thing and yeah.

It does give you hope.

>> DR. COTTRELL: M'hm, absolutely.

DR. FISKE: Yeah.

I have to find a way to build this into some additional research because you know, yeah, it's hard to predict.

I think people usually assume that older adults are not going to adopt new

technology.

But it if it is designed in way that meets their needs certainly I think some of them will, yeah.

>> Thank you.

Other questions that people might have that aren't in the chat?

All right.

We're not hearing anything.

I think we're coming to a close.

And Dr. Fiske, thank you so much for joining us.

It's really interesting to hear your research and we look forward -- please share future things that you do.

Because I think it does interact with what we're doing out here.

So thank you so much for your time.

And thanks to everyone for spending your hour with us as well, to hear Dr. Fiske's research.

All right.

Everyone, have a nice afternoon.

Absolutely, Dr. Fiske, thank you.

We'll have to bring you back again.

DR. FISKE: Thanks.

>> DR. COTTRELL: Take care.

DR. FISKE: Bye.