

WHEN HOPE GROWS WEARY: TREATING HOPELESSNESS IN OLDER ADULTS

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ABSTRACT

Hopelessness is associated with suicidal ideation and completion, poor physical health, and poor quality of life, and is an important and little-discussed dimension of the experience of older adults. However, hopelessness is not an inevitable part of the aging process. The present paper analyzes the construct of hopelessness specifically in the context of the aging population, discusses measuring and treating hopelessness, and makes recommendations, based on existing models of care, for how targeted services can be created to address this problem.

INTRODUCTION

“This whole town does look like whatever hope becomes after it begins to weary a little, then weary a little more.”

-Robinson, *Gilead*

The septuagenarian pastor, John Ames, at the center of Marilynne Robinson’s *Gilead* (2004) reflects on a long life soon to be cut too short. Like the fictional town of Gilead, he embodies a gentle and genteel despairing. Ames concludes his narration by saying “hope deferred is still hope...I think sometimes of going into the ground here as a last wild gesture of love - I too will smolder away the time until the great and general incandescence” (Robinson, 2004, p. 247). The aging process poses many threats to the mental and physical health and psychosocial functioning of those aging. And hopelessness, as we will discuss in detail, is one of the most insidious.

In the face of transition to any new phase of life, physiological, pathological and psychological changes arise. For the aging population, disconnection from social and professional roles can occur and lead to, or be precipitated by, the experience of negative emotions—such as, hopelessness. This paper will consider the role of hopelessness in the experience of older adults, often concurrent with general feelings of depression or low mood, because of the pivotal role hopelessness plays in poor psychosocial functioning and the need for new, targeted interventions to address its prevalence in older adults.¹

Many scholars have observed that study of the psychosocial challenges of older adults—from mental health issues to abuse—is about fifteen years

¹A substantial literature already documents the feelings of hopelessness and helplessness among caregivers of older adults (see for example, Rzeszut, 2011; Lin, 2018; Jorgensen, 1992; Duxbury, Higgins, & Smart, 2011). But in this paper, we are interested in the other half of the care dyad—the cared for.

behind the study of parallel challenges in children and adults (Settersen, 2005; Bardach & Rowles, 2012; Pedrick-Cornell & Geddes, 1982; Beach et al., 2016; Barber, 2008). The study of interventions for hopelessness in seniors seems to be similarly limited in scope and rigor. Geriatrics and gerontology suffer a tendency to get bogged down in the weeds of semantic issues of what exactly constitutes old: We especially see this in industrialized countries where the mortality rate seems to be ever-increasing, as well as in life stages for which there seem to be no neat demarcations (the antithesis of which is the end of puberty and medical transition into adulthood).

Even when scholars concur on what defines old, a tension exists between the idea that on the one hand, older adults have unique medical and psychological needs in which practitioners need to be well-versed, and that on the other hand, older adults may benefit from the same attention paid to nominally younger adults with similar challenges. There is even a significant scholarly debate over what objectives interventions intending to serve older adults should have. Some favor the notion of “healthy aging,” others prefer “productive aging” or “dynamic aging” (Martinson & Berridge, 2015). In our opinion, the terminology is neither here nor there—because no definition of the best possible aging experience should include the cognitive and emotional experience of hopelessness.

This paper aims to transcend some of the conceptual and semantic challenges surrounding aging by 1) rejecting the false dichotomy of respect for unique aging processes and respect for the essential humanity of the older adult and 2) focusing on extant case studies and potential new approaches for intervention. Ultimately, age (relative, absolute, chronological, medical, or other) should only be relevant to the treatment of hopelessness insofar as it can usefully inform our understanding of why hopelessness arises, the consequences of hopelessness, and clinical treatment. Just as the popular and academic imagination have slowly come to understand memory loss as an abnormality in the aging process, we hope that practitioners and researchers will come to understand hopelessness as treatable rather than intractable.

This paper will be divided into four parts. The first part will analyze the cognitive construct of hopelessness. The second will address the implications of hopelessness, including suicidal ideation, depression, vulnerability to abuse, and higher rates of physical illness. The third will address existing instruments and methods for measuring hopelessness. And finally, the fourth part will present case studies for how hopelessness can be addressed in the settings in which older adults most commonly come into contact with psychosocial services. In short, we argue that hopelessness is not incorporated as a key target in the treatment of older adults—but it should be—and that existing programs to promote older adult well-being could and should incorporate reducing hopelessness as an outcome.

PART ONE: WHAT IS HOPELESSNESS?

Hope and hopelessness can be slippery concepts (Hernandez & Overholser, 2020). Scholars have generally shied away from questions of whether “hope and hopelessness are polar opposites or separate constructs, so that conclusions of low hopelessness cannot be readily generalized to high hope” (Hernandez & Overholser, 2020, pp. 28-29). Cognitive theory defines hopelessness as having negative expectancies towards the future (Beck et al., 1974). Along with suicidal ideation, hopelessness is positioned as a product of distortions in thinking including but not exclusive to catastrophizing, dichotomous thinking, and/or overgeneralization (Uncapher et al., 1998). In depression, these distortions form part of a cognitive triad of negative thoughts of the self, the world, and the future (Uncapher et al, 1998). Hopelessness fits into this triad as a “determinant and a component of the depressive condition” (Beck, Steer, Kovacs & Garrison, 1985). That is, hopelessness is a construct that may be an antecedent to depression, and can be either acute (in response to a situation or event) or chronic (Uncapher et al., 1998).

When hopelessness is chronic, it can exist as a cognitive schema that directs how a person navigates the world and interprets information. A hopelessness schema may be activated by life stress, reflect a conclusion that one’s situation cannot be changed, and/or lead to suicidal ideation (Wenzel & Beck, 2008). Those with a hopelessness schema or acute hopelessness may perceive no end to their suffering. Therefore, hopelessness is both theoretically and empirically associated with suicidal ideation even in the absence of depression or other psychiatric illness, with death seen as a solution to the absence of hope about existence or an end to intolerable distress (Uncapher et al., 1998; Wenzel & Beck, 2008).

In older adults at the end of their life, the cognitive theory of hopelessness should supplement an understanding of transient and situation-related hopelessness (that is, state, as opposed to trait hopelessness). According to Sullivan (2003), some people facing the end of their life suffer a transient hopelessness which is better characterized as a type of complicated grief. This characterization has important implications for the treatment of this hopelessness, which may be more supportive or focus on the restoration of meaning and creation of connections to family, friends, religion and community if there is no underlying depressive etiology.

That said, hopelessness at the end of life is relatively well-studied. The literature on this topic may yet inform studies of treating and addressing hopelessness in seniors. Though we should acknowledge that aging or being old is not the same as dying or being close to death, key similarities would appear to exist between treating hopelessness at end-of-life, including the role of acceptance rather than denial of circumstances (cf. Hernandez & Overholser, 2020; Sullivan, 2003). Notwithstanding his focus on end-of-life care, Sullivan (2003) presents a broadly applicable conceptualization of hopelessness. He writes:

“In medicine, hope is often reduced to the issue of prognosis or chance for survival. In psychiatry, hopelessness is often reduced to a symptom of major depression. Yet hope and hopelessness at the end of life are not simply medical or psychiatric problems. They encompass nearly all that human culture and spirituality have to offer.” (Sullivan, 2003, p. 393)

Hopelessness, especially for the aging population, encompasses more than a situational response or a component of Major Depressive Disorder (MDD).

PART TWO: THE EFFECTS OF HOPELESSNESS

In a general clinical population of adults, hopelessness has proved to be a better predictor of suicidal intention than the severity of depression (Beck et al., 1993). Hopelessness is also a useful construct in evaluating the risk of suicide completion. In a longitudinal study of adult patients hospitalized with suicidal ideation, hopelessness was the only metric that significantly differentiated suicide completers from suicide non-completers (Beck et al., 1985). Completed suicide is also associated with hopelessness in adult outpatients (Beck et al., 1990). These findings support the view, derived from cognitive theory, that hopelessness is not a proxy for mere depressed mood in adult populations (Uncapher et al., 1998).

Numerous studies have also demonstrated the relationship between hopelessness and suicidal ideation in older adults. Dennis et al. (2005) found that life events are not singularly precipitating factors for suicidal actions in older adults: rather hopelessness discriminates between those who commit self harm and those who do not. Dennis et. al’s study also highlights the fact that the self harm group was more likely to have a poor social network, be lonely, and lack supportive services. While no analysis was undertaken to examine the direct correlation between hopelessness and poor social network, loneliness, or lack of supportive services, a connection between these variables may exist, exacerbating the psychosocial stressors for hopeless older adults. Neufeld and O’Rourke’s (2009) study of 117 older adults found that hopelessness was the strongest predictor of suicidal ideation of the variables studied at 83%. Meanwhile, Szanto et al. (1997) found that in a sample of older adults coping with grief, a typical experience of later life, participants who endorsed active or passive suicidal ideation were also more likely to endorse hopelessness.

We should also note that the factors that buffer against hopelessness in adults operate differently in older adult populations. Reasons for living are expectancies that might reduce risk of suicide; these include coping beliefs, responsibility to family, and moral objectives (Britton, Duberstein & Conner, 2008). Britton, Duberstein and Conner (2008) found while ordinarily, individuals with more reasons for living have lower levels of hopelessness, in older adults, responsibility to family may increase the association between hopelessness and suicidal ideation due to perceived burdensomeness. This reveals the need for thorough psychosocial assessment of hopeless, depressed, or potentially suicidal patients since clinicians cannot assume that reasons for living are protective. However, there are other factors unique to older adults that may be protective and contribute to the reduction

of hopelessness and depression severity scores, including but not exclusive to frequent practice of prayer and meditation (but not church attendance) (Cruz et al., 2009).

Findings correlating suicidal ideation and hopelessness in older adults are notable given middle-aged and older adults are at higher risk of suicide than younger adults, and likelier to complete suicide when attempting it (Piscopo, 2017). Table 1 shows suicide completion rates per 100,000—highest among middle-aged and older adults.

<i>Table 1.</i> Suicide rates completion per 100,000, by age group, in 2018 (Data from Suicide Prevention Resource Center [SPRC], 2020)	
Age in Years	Suicides per 100,000
65+	17.5
45 - 64	20
25 - 44	17
15 - 24	14.5

Table 2, meanwhile, shows dimensions of suicidal behavior separate from the completion of suicide. The trend here would seem to be reversed—suicidal thoughts and suicide attempts are less common among middle-aged and older adults. One possible interpretation of these data is that correlates of suicide are likelier to be lethal among middle-aged and older adults.

<i>Table 2.</i> Suicide rates completion per 100,000, by age group, in 2018 (Data from Suicide Prevention Resource Center [SPRC], 2020)		
Age in Years	Suicidal thoughts in the past year, annual averages per 100,000, 2009-2014	Suicide attempts in the past year, annual averages per 100,000, 2009-2014
65+	1.6	0.2
60 - 64	2.5	0.2
55 - 59	3.5	0.4
50 - 54	3.6	0.3
45 - 49	4.2	0.5
40 - 44	3.8	0.5

35 - 39	3.9	0.5
30 - 34	3.9	0.5
26 - 29	4.6	0.5
18 - 25	6.9	1.2

It is worth noting, here, that the data fail to elucidate the variability of risk within age ranges post-65—and significant variability would seem to exist.² A recent study suggested that the risk of suicide and the methods of suicide vary considerably between the age groupings of 65-74, 75-84, and 85+ (Koo, Kolves, & De Leo, 2017). Among adults 65 and older, suicide completion rates were retrospectively observed to progressively increase with age—but men, who have higher suicide rates than women on average in the Western world, drove that trend (Koo, Kolves, & De Leo, 2017).

While many correlates with suicide, such as psychiatric disorder, male gender, being White, widowhood, lower socioeconomic status, social isolation, and stressful life events certainly exist in the older adult population (Lynch, Cheavens, Morse, & Rosenthal, 2004), hopelessness is a characteristic that is amenable to change. That said, arguably, questions of hopelessness in older adults have focused too heavily on the dichotomy between life and death, and specifically on suicidal ideation. This positions the purpose of life as survival, and may mean that a person facing the end of their life has little reason for hope since they cannot survive. As Sullivan (2003) notes, there are other bases for hope aside from survival, such as hope for salvation, dignity, or comfort.

In addition, while hopelessness predicts suicidal ideation in the absence of depression, hopelessness is also a better indicator of depression in older adults than depressed mood (Joiner et al., 2007). As hopelessness increases in severity, dysthymia and major depressive disorder (MDD) are more likely and hopelessness is associated with high rates of double depression (dysthymia plus MDD) in older adults (Joiner et al., 2007). There is evidence that hopelessness mediates the relationship between quality of life and emotional distress in older adults (Scogin et al., 2016). Morthland et al. (2016) hypothesized that in a sample of rural adults, hopelessness results in poor motivation and hinders participation in both relationships and activities of daily life.

²The population of American older adults is large and diverse. In 2016, 49.2 million Americans were 65 or over (Roberts, Ogunwole, Blakeslee, & Rabe, 2018). Of those, 28.7 million fell between the ages of 65 and 74 (inclusive), 14.2 million fell between the ages of 75 and 84 (inclusive), and 6.3 million were 85 years or older (Roberts, Ogunwole, Blakeslee, & Rabe, 2018). Various researchers have pointed to the importance of, at minimum, differentiating between the younger old (sometimes listed as 75 to 84) from the oldest old (sometimes listed as 85 and older—see for example, Von Humboldt & Leal (2015).

The literature has further established that hopelessness can be symptomatic of underlying problems. The fields of law, medicine, and social work all treat hopelessness as a symptom or possible indicator of elder abuse and neglect (Bergeron, 2006; Imbody & Vansburger, 2011; Katz, 1979-1980; Nerenberg, 2013).³ And, emerging evidence suggests that hopelessness is positively correlated with severity of medical disease and mortality, particularly in terms of cardiovascular disease (Dunn et al., 2014; Sullivan, 2003). Higher levels of hopelessness have been associated with higher levels of pain (Yildirim et al., 2009) and lower functional status (VanServellen et al., 1996). All of this demonstrates the need to screen for hopelessness in order to avoid negative impacts on quality of life and physical health.

At this point in the discussion, we would also like to note that the findings on hopelessness in older adults are not well studied for ethnic or cultural variations. In a study of the association between depressive symptoms and hopelessness in older adults, Assari & Lankarani (2016) compared White and Black populations of older adults, with race operating as the moderator. The study revealed that the association between depressive symptoms and hopelessness is weaker in Black older adults than in White older adults (Assari & Lankarani, 2016). The authors explain this finding by hypothesizing that despite higher rates of poverty, more severe depression, and less access to healthcare, Black older adults are likely to have higher levels of religious observance and social support, buffering against hopelessness and boosting resilience (Assari & Lankarani, 2016). Importantly, the authors did not measure the moderating effect of religious observance across racial groups, despite religious observance being a proven buffer against hopelessness in older populations. Therefore, it is impossible to generalize about the relative rates of hopelessness in different racial or ethnic groups based on the available data.

PART THREE: MEASURING HOPELESSNESS

There are several instruments utilized for the measurement of hopelessness in older adults, most notably the Beck Hopelessness Scale (Beck, Weissman, Lester & Trexler, 1974) and the Geriatric Hopelessness Scale (Fry, 1984). Despite practice guidelines urging the use of assessment measures that are either developed for, or modified for use with older adults (American Psychological Association, 2014), the Beck Hopelessness Scale (BHS), developed for use with adult psychiatric patients, is the most commonly used measurement in studies of late-life hopelessness (Neufeld, O'Rourke, & Donnelly, 2009).

The BHS is a 20-item true/false scale based on affective, motivational and cognitive dimensions. While the BHS is used widely, few studies have measured its measurement invariance (and consequent utility for intergroup comparison) in large community representative samples (Kliem, et al., 2018).

³Hopelessness can also be the result of elder abuse. See Podnieks, 2006.

Hence, the BHS may not capture the dimensions of hopelessness specific to older adults since it was not designed for use with this population. Kliem et al. (2018) conducted the only investigation of the psychometric properties of the BHS in a large representative Western community sample, and concluded that its psychometric properties were mostly sound, with a need for further research in variance between ethnic and cultural groups. They did not, however, report findings on the utility of the BHS according to age-based classifications. The BHS was only recently validated for use with a sample of older Spanish adults in a study by Satorres et al., (2018). It also demonstrated strong psychometric properties for use with older adults in studies conducted by Fraser, Burnell & Salter (2014), Duberstein et al. (2001) and Szanto et al. (1998), respectively.

Conversely, psychometric research has generally indicated acceptable internal consistency and construct validity for the Geriatric Hopelessness Scale (Heisel & Flett, 2005), yet the instrument has low predictive validity for suicidal ideation or behavior (Trenteseau et al., 1989).⁴ Notably, the GHS performed poorly in a sample of community residing adults, although these findings did not specifically focus on the construct validity of hopelessness (Hayslip et al., 1991). Heisel & Flett (2005) partially supported Hayslip et al. (1991)'s findings that the GHS is better suited to institutionalized seniors as it does not distinguish well between mental health patients and non-mental health patients. However, the GHS performed well in reliability and construct validity (Heisel & Flett, 2005).

Further important questions remain surrounding the utility of standard measures of hopelessness such as the BHS and GHS specifically in the very elderly population, who may be cognitively impaired (Neufeld, O'Rourke, & Donnelly, 2009). Perhaps even more importantly, older adults are less likely to self-report emotional distress, with those who see physicians more likely to focus on somatic symptoms unless specifically asked about factors such as suicide ideation (Neufeld & O'Rourke, 2009). This demonstrates the need for direct and specific questioning about hopelessness in this population by social workers and other service providers who come into contact with older adults, in addition to the use of psychometric instruments.

PART FOUR: MODELS FOR HOPELESSNESS TREATMENT?

Often, wrongly, hopelessness is seen as inevitable, natural, or untreatable in older adults (Uncapher et al., 1998; Kjøseth, Ekeberg, & Steihaug, 2010). However, many modalities have shown promise, including goal-focused group psychotherapy (see for example, Klausner et al., 2000); life review therapy (Serrano et al., Latorre, Gatz, & Montanes, 2004); problem-solving therapy (Choi, Marti, & Conwell, 2016); and various cognitive and behavioral approaches (Brown et al., Brown, Bhar, & Beck, 2008; Lynch Morse,

⁴Note that an association between GHS scores and suicidal ideation in older men receiving health care was reported by Uncapher et al. (1998)

Mendelson, & Robins, 2003). Hernandez and Overholser (2020), meanwhile, single out a few therapies as relatively ineffective for the treatment of hopelessness, including dignity therapy, physical exercise, and educational programming.

Even so, “[c]ontrolled trials with hope/hopelessness as a primary objective are needed to more clearly demonstrate effectiveness” (Hernandez & Overholser, 2020, p. 1). Much research on interventions relevant to hopelessness has treated hopelessness as a secondary objective of the research and has been performed without a control group (Hernandez & Overholser, 2020).

The research targeting reduction of hopelessness as a primary outcome is limited enough that we must turn to treatment programs targeting other problems of older adulthood as possible models of care. We have already discussed end-of-life care as a model for aging care in Part One (see again Sullivan, 2003) and we suggest that a key similarity between end-of-life care and aging care is setting. Notwithstanding cultural shifts and advocacy around minimizing the amount of time that end-of-life patients and aging clients spend in medical institutions, these two populations spend a great deal of time in hospitals. Likelier than not, this is where older adults may be most linked to mental health professionals as well as other health care (emergency department visits are the only time that many seniors leave their homes—see Rosen et al., 2016). This holds especially true for low-income or otherwise marginalized seniors without other forms of access to healthcare (Bazargan, Bazargan, & Baker, 1998; Fan et al., 2011; Counsell et al., 2007; O’Mahony et al., 2008). Hospitals are therefore a crucial site for prevention and intervention.

Hospital-based elder abuse prevention units, although technically specific in scope, offer a useful model for prevention, intervention, and provision of services for seniors in medical settings, and, we argue, should be extended to include reduction of hopelessness as an intervention target. New York City has long been a leader in developing social services for older adults (Netherland, Finkelstein, & Gardner, 2011; Morken, 2012; see also for example, Vogel, Ransom, Wai, & Luisi, 2007)⁵ and Weill-Cornell Medical Center’s Vulnerable Elder Protection Team (VEPT) is one of the jewels in the crown. Following the interdisciplinary team model of care (already well-established in hospice settings and in the treatment of severe refractory depression—see Oliver & Peck, 2006; Unützer & Park, 2012), VEPT includes doctors and social workers, and collaborates with attorneys and other professionals (Rosen et al., 2018). VEPT works similarly to many hospital child protection teams; elders coming through the emergency department (ED) with any signs of abuse (identified by other hospital professionals trained in identifying such signs) are immediately referred to VEPT for

⁵The NYC Department for the Aging is the largest of its type in the country (“Organization Profile,” n.d.), and Brooklyn District Attorney’s Office has a unique-in-the-nation elder abuse prosecution unit (Hynes, 2010).

wrap-around services and referrals (Rosen et al., 2018). The group meets regularly for case conferences, with a rotating cast of professionals involved in a given patient's care (Rosen et al., 2018). Hospital-based senior health units can operate with similar principles of quick screening and referral and wrap-around care, and incorporate new services targeting hopelessness.

VEPT is a useful model for senior care targeting hopelessness for three additional reasons. First, hopelessness, like elder abuse, is typically comorbid with other conditions and challenges and treating comorbid mental health conditions concurrently can offer a better chance of success than targeting one condition in isolation (e.g. Stambaugh et al., 2007; Pringle et al., 2002; Furman & Jackson, 2002). Second, the model may actually be easier to implement for hopelessness than it is for abuse. As noted beforehand, hopelessness is relatively simple to test through a short question inventory or direct questioning, and may not entail the same level of extreme stigma associated with elder abuse (abused older adults are uniquely reluctant to report abuse—see Dyer, Connolly, & McFeeley, 2003; Lachs et al., 1998; Mosqueda & Dong, 2011). By the same token, hopelessness may be less intimidating for professionals to report or identify as well, because professionals who notice signs of abuse may hesitate to report because of fear of involvement with the legal system (Rosen et al., 2019)—a concern that should not be present with hopelessness.

Third, VEPT is a crucial model for treating older adults who are marginalized and underserved for reasons other than their age—a lacuna in treatment programs and a limitation of many other treatment programs.⁶ VEPT serves an elderly population that is multiply disadvantaged. Not only are ED-dependent patients likelier to be lower-income in general, the New York Presbyterian Hospital (NYPH) system serves an especially large group of socioeconomically marginalized New Yorkers. NYPH has the third most Medicaid discharges of any hospital in New York State (New York–Presbyterian Hospital [NYPH], 2016). Sixty percent of NYPH inpatients are on public insurance (Medicaid or Medicare) (NYPH, 2016). In this way, VEPT succeeds in offering services to a normally underserved population.

Outside of the hospital, a “public health” approach may be worthwhile in the prevention and treatment of elder hopelessness. Analogously to the implementation of interdisciplinary teams in hospitals, the Centers for Disease Control and Prevention has been funding programs that weave together health advocacy led by physicians and mental health initiatives led by psychologists, including in geriatric mental health care (Aldrich & Benson, 2013). The CDC-appointed Community Preventive Services Task Force has in the past recommended home- or clinic-based “depression care management” (DCM) for depression in seniors (Community Preventive

⁶Literature in psychology and social work has documented a lack of services for multiply marginalized older adults (for elder abuse issues specifically, see Walsh et al., 2011; for other issues of intersectionality in aging, see Finkenauer, Sherratt, Marlow, & Brodey, 2012; Espinoza, 2011; Brotman et al., 2015; Choi & Kimbell, 2008; Goins et al., 2006).

Services Task Force [CPSTF], 2014 [2008]). In DCM, an elderly patient receives services, psychoeducation, and treatment (often, CBT) from a “care manager”—typically, a nurse practitioner or social worker—supervised by a psychiatrist (Aldrich & Benson, 2013; CPSTF, 2013 [2008]). Programs following this model have been studied through the Baylor University School of Medicine and the University of Washington (Aldrich & Benson, 2013). Both sets of programs proved effective in reducing MDD, at least in the short term (Casado et al., 2008; Quijano et al., 2007; Unützer et al., 2002; Unützer et al., 2008).

The challenge that such community-based programs face is stigma and recruitment (Kobau et al., 2010; Snowden, Steinman, & Frederick, 2008). We would speculate that integrating a DCM program with a hospital team consultation and referral model akin to VEPT would address the stigma and recruitment issue while providing another venue for continued follow-up (which is sometimes absent in hospital-based interventions) with a patient experiencing hopelessness.

CONCLUSION

Supposedly, the root of any solution lies in recognizing the problem. We suggest that this holds for older adult hopelessness and its sequelae (most concerningly, suicide). As scholars, we hope that the research community continues to study new treatment modalities specifically for the impact on elder hopelessness. Too few treatment trials performed with older adults consider hopelessness as a primary outcome measure and only a few more studies include it as a secondary measure (again see Hernandez & Overholser, 2020). When clinicians recognize hopelessness as a needless correlate of the aging process, they can redress it as such. This, along with public funding and policy interventions, will lay the groundwork for a successful response to hopelessness in an aging world.

Older adults are likely to be in a uniquely marginalized position, carrying with them some of the challenges that they had when younger and taking on the new struggles of growing old. Issues of concern to them deserve greater scholarly and clinical attention. In some sense, treating this single, albeit crucial aspect of their mental well-being is the least that (the broadly defined) we can do.

To steal a phrase from twentieth-century German psychologist Erich Fromm, “rational despair” coexists alongside hopelessness (Fromm, 1973, p. 436). In tackling hopelessness in older adults, we should ask: how fair is it to tell a patient with circumstances that might rationally cause him/her/them to lose hope, that he/she/they must simply feel, think, behave, or “construct reality” differently (Nevid, 2007)? (Criticisms such as these are far from new—see, for example, Kant, 2015; Gilbert, 2009.) But once again, we can attempt to address a seeming paradox by suggesting that doing something to address suffering, beats doing nothing—and that psychological treatment is surely one part of an integrated interventional agenda.

Despite all of the limitations discussed herein—whether conceptual, clinical, or research-related—enough is known about effective therapies for practitioners to begin attempting to treat. And more existing programs on older adult wellbeing (such as the VEPT and Baylor/Washington DCM case studies noted hitherto) could incorporate reduction of hopelessness as a goal or outcome. Aging is inevitable. Aging hopelessly is not.

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