Suicidal Ideation, Hardiness, and Successful Aging with HIV
Considerations for Nursing

ABSTRACT
Several predictors of suicidal ideation found in older adults and adults with HIV are the same; synergistically, those aging with HIV may be at risk for suicidal ideation. Focusing on the concept of hardiness provides insight into mitigating suicidal ideation and accentuating successful aging with HIV. Some individuals may have hardy characteristics that counteract the detrimental effects of aging with HIV; others may require greater guidance to cope with the effects that lead to suicidal ideation. As these connections are examined, the concept of hardiness is examined in relation to aging with HIV. Implications for nursing are posited.

Highly active antiretroviral therapy (HAART) has been effective in maintaining the number of copies of HIV in the body at low levels, abating the progression to AIDS (Perez & Moore, 2003). As a consequence, many people infected with HIV are aging with this disease. In 2003, the Centers for Disease Control and Prevention (CDC) announced that more than 191,000 adults age 45 and older have been diagnosed with AIDS. In addition, the number of adults with HIV who are age 50 and older has increased from 65,655 in 2001 to 104,260 in 2004; this represents an increase of 59% in 3 years (CDC, 2006). The number of adults aging with HIV is expected to rise further.

Given the rapid growth of this clinical population, researchers are beginning to hypothesize about the challenges older adults will face as they attempt to age successfully with HIV. The existing literature in gerontology and HIV indicates that a particular challenge to successful aging in this group is suicidal ideation. Moreover, the factors that contribute to these mood disturbances may be compounded by the interaction of aging and HIV (Vance & Robinson, 2004). Hardiness represents a resource that may be considered a means for both examining this problem and helping adults with HIV age successfully.

This article provides a unique contribution by briefly synthesizing the literature on aging and HIV in relation to hardiness and suicidal ideation, which has not been done.
previously. Articles were selected on the basis of their relevance to the conceptual definitions of depressive symptomatology, suicidal ideation, hardiness, and successful aging in this clinical population. Depressive symptomatology is defined as negative affect expressed as sadness and hopelessness (Vance, Moneyham, Fordham, & Struzejzick, 2008). Suicidal ideation is defined as repeated contemplation about actively or passively ending one’s life to escape feelings of sadness and hopelessness (Vance, Moneyham, et al., 2008). Hardiness is defined as psychological resilience that facilitates emotional equilibrium (Vance, Struzejzick, & Masten, 2008). Successful aging is defined as being satisfied with one’s quality of life while growing older (Vance & Robinson, 2004). Older adults with HIV are defined as being age 50 and older; this is the convention currently being used by the National Institutes of Health (Stoff, 2004).

Because suicidal ideation is recognized as a barrier to successful aging, factors that contribute to these mood disturbances are examined in aging, HIV, and aging with HIV. Hardiness is examined as a resource that may mitigate negative affect, reduce suicidal ideation, and promote successful aging in this population. Because nurses have direct contact with these patients, implications are suggested.

**AGING AND SUICIDAL IDEATION**

The expression of suicidal ideation acts as a precursor to attempted and completed suicide (Conwell & Duberstein, 2001). Rates of suicidal ideation vary in the older population and range from 1% to 8% (Callahan, Hendrie, Nienaber, & Tierney, 1996; Hirsch, Duberstein, Chapman, & Lyness, 2007). In 2002, 1,812 U.S. adults age 65 and older were hospitalized for attempted suicide (Cran dall et al., 2007). Collectively, in 2003, 31,484 adults committed suicide (CDC, 2009).

The rates are higher for men and increase with age. In men ages 65 to 69, the suicide rate is 21 per 100,000. This rate continues to rise to 32 per 100,000 for men ages 75 to 79 and to 48 per 100,000 for men age 85 and older (Kochanek, Murphy, Anderson, & Scott, 2004). This figure is more than twice the rate for men ages 16 to 65. Likewise, adults age 65 and older represent 13% of the population in the United States; however, they account for 18% of all suicide deaths (Kochanek et al., 2004).

A variety of factors that contribute to depression-related suicidal ideation and suicide has been examined. Obviously, age-related losses in health, social support, and productivity are considered (Steffens, 2007). Other, more telling indicators have been uncovered. Fairweather, Anstey, Rodgers, Jorm, and Christensen (2007) found that older adults in their 60s who were seeking work were almost seven times more likely to have considered suicide within the past year. In addition, having a ruminate personality style, as defined by perseverating on the same negative thought or emotion, was also associated with a consistently elevated odds ratio of suicidal ideation across all age groups.

After controlling for age, gender, depression, illness burden, activity, sociability, cognitive functioning, negative affect, and physical functioning, Hirsch et al. (2007) found that of 465 adults age 65 and older, those who exhibited a trait for positive-affect (i.e., a tendency for optimism) were less likely to exhibit suicidal ideation. This finding suggests that positive traits, such as hardiness, may also be important in buffering the factors that cause suicidal ideation.

**HIV AND SUICIDAL IDEATION**

Not surprisingly, because of the stigmatizing nature and the complex social and physical issues surrounding HIV, those who are infected, regardless of age, have higher levels of depression, suicidal ideation, and suicide rates than those who are not infected (Jin et al., 2006). Hopelessness is a unique risk factor of suicidal ideation and suicide (Brown, Beck, Steer, & Grisham, 2000). For many diagnosed with HIV, feelings of hopelessness and fear of the loss of one’s future self are devastating. These feelings may manifest as suicidal ideation.

Before HAART, the suicide rate for gay men infected with HIV who were living in New York City was 35 times that of the normal population (Joseph et al., 1990). It is now believed that with the introduction of HAART, the hope of living a more normal life with HIV has reduced the magnitude of suicidal ideation. Nonetheless, HIV is a difficult disease, fraught with stigma and guilt, disfiguring lipodystrophy, disclosure issues, and intimacy concerns. These problems still exert considerable influence that exacerbates suicidal ideation.

Other factors associated with HIV contribute to suicidal ideation, such as changes in appearance, stigmatization, declines in productivity, and changes in lifestyle patterns (Vance & Robinson, 2004). Suicidal ideation often occurs when one is initially diagnosed and later when one experiences medical setbacks or problems related to HIV status. For example, Cooperman and Simoni (2005) found that of 207 HIV-positive women in New York City, 26% had attempted suicide since their diagnosis; of those, 27% acted within the first week and 42% acted within the first month. Likewise, Kalichman, Difonzo, Austin, Luke, and Rompa (2002) found that medical side effects of HAART, very low CD4+ lymphocyte count, and a detectable viral load were related to suicidal ideation in people with HIV.

Furthermore, it is hypothesized that when someone is diagnosed with HIV, fear and all of the other emotions accompanying this disease (e.g., anger, regret, despair) engulf
existing coping mechanisms and may even cause posttraumatic stress disorder (PTSD) and the corresponding situational suicidal ideation. In an HIV-positive adult with PTSD caused by difficulty adjusting to the diagnosis, confrontation with another stressful life event, such as rejection from a lover/partner, may result in the return of suicidal ideation as a symptom of PTSD (Vance & Robinson, 2004).

The lifetime and current incidence of suicidal ideation can vary dramatically in adults with HIV. Robertson, Parsons, Van Der Horst, and Hall (2006) found that, in a sample of 246 adults with HIV but without psychiatric diagnoses, nearly two thirds experienced suicidal ideation at some point. However, Carrico et al. (2007) examined the correlates of suicidal ideation in nearly 3,000 adults with HIV. They found that nearly one fifth (19%) of the sample indicated they had had thoughts of suicide within the past week. Risk factors for suicidal ideation included being homosexual, bisexual, or transgendered; rating medication side effects and HIV-related symptoms as severe; experiencing elevated depressive symptomatology; reporting more habitual use of marijuana; not identifying as being Hispanic/Latino; not being in a primary romantic relationship; and reporting lower self-efficacy for coping.

AGING WITH HIV AND SUICIDAL IDEATION

Vance, Moneyham, et al. (2008) proposed that stressors from ageism and HIV-related stigma, loneliness and a decrease in social support, neurological changes, declining health, fatigue, changes in appearance, and financial distress may be compounded for adults aging with HIV, causing them to be more vulnerable to suicidal ideation. For example, in their study of synergistic effects of loneliness and social support in a sample of 160 adults age 50 and older with HIV, Shippy and Karpiak (2005) found that 71% lived alone and only 47% indicated being in a committed relationship. This finding suggests that many are living without the traditional informal supports of family members and partners who could provide physical and emotional care.

Loneliness appears to increase with age (Hawley & Cacioppo, 2007); thus, many people aging with HIV may be at particular risk for social isolation. Shippy and Karpiak (2005) also reported that the primary source of support came from friends who were also HIV positive; therefore, those on whom people with HIV primarily depend are vulnerable themselves. Although dependence on others with HIV would seem to provide a level of camaraderie and understanding through shared interests and experiences, 57% reported that their emotional needs remained unmet. Hence, the lives of older adults with HIV appear to be marked by a fragile social network that is unfulfilling.

Social isolation, unmet emotional needs, and physical declines caused by aging and the co-occurrence of HIV can tax one's coping mechanisms and can result in increased depressive symptomatology and suicidal ideation. Shippy and Karpiak (2005) found that 58% of their participants reported depression. Depressive thoughts and behaviors can lead to suicidal ideation. In a sample of 113 older adults with HIV, Kalichman, Heckman, Kochman, Sikkema, and Bergholte (2000) found that 27% reported having considered taking their life within the past week. Being Caucasian and self-identified gay were associated with such suicidal ideation. Surprisingly, these older adults who revealed their serostatus to friends and families were the ones most likely to experience suicidal ideation. As the results of Shippy and Karpiak’s (2005) study indicated, those who disclosed their serostatus may continue to have unmet emotional needs. These findings suggest that although extending the health and life of those infected with HIV is improving, ameliorating the quality of that life remains a challenge for many individuals. Thus, ways to bolster mental health in this population must be considered.

SUICIDAL IDEATION AND HARDINESS

Hardiness was first examined in the stress-illness relationship in the overall population to explain why among people faced with overwhelming stressors and obstacles, some seem to be more resilient, both mentally and physically, than others (Florian, Mikulincer, & Hirschberger, 2001; Kobasa, 1979). Hardiness is defined as thoughts and behaviors that facilitate coping to internal and external tasks that are interpreted as stressful (Folkman & Moskowitz, 2004). The defining components of hardiness are control, commitment, and challenge (Lambert & Lambert, 1999). People who are considered hardy believe they can exert control over the circumstances in their lives, maintain a commitment to their lives even if the accompanying feelings are not there, and consider stressful events as challenges and opportunities to grow (Dolan & Adler, 2006). Thus, hardy people use problem-focused coping strategies to parlay such challenges into growth-producing experiences, whereas nonhardy people gravitate toward distancing-type coping strategies (e.g., avoidance) that do not solve problems and that, depending on the avoidance strategy (e.g., substance use), may aggravate the problem (Florian et al., 2001).

In their examination of women age 85 and older who were identified by peers as being hardy, Laferriere and Hamel-Bissell (1994) found that a hallmark of successful aging in these women was not that they did not experience difficulties, but that they purposefully dealt with the hard times. People who successfully age still experience losses that can tax their ability to cope, possibly re-
sulting in suicidal ideation. However, if their internal and external resources to be hardy can eventually compensate for such losses, their ability to manage the ensuing depressive symptomatology and suicidal ideation can diminish, thereby facilitating their ability to age successfully.

**HARDINESS IN AGING**

Studies of successful aging show that hardiness is perceived as a means of achieving successful aging. In a sample of older women (mean age = 74.5) labeled by peers as aging successfully, Kinsel (2005) found that hardiness was related to being socially connected, being curious about life, making one’s self available to others, and being spiritually grounded. In fact, after experiencing adversity, these hardy women engaged in preservation of self by adopting nontraditional or maverick behavior. Likewise, Nygren et al. (2005) found that in a sample of 125 adults age 85 and older, hardiness was positively associated with a sense of coherence, self-transcendence, purpose in life, and general mental health.

**HARDINESS IN HIV**

Hardiness has also been shown to be related to positive physical and mental health outcomes in adults with HIV. Levy, Cottrell, and Black (1989) found a relationship between a hardiness commitment subscale and CD4+ lymphocyte counts in a sample of adults with HIV. Although hardiness may not cause the immune system to function better, this finding suggests that hardiness buffers the body against stresses.

Similarly, in 200 adults with HIV (mean age = 39, age range = 23 to 71), Farber, Schwartz, Schaper, Moonen, and McDaniel (2000) examined the relationship between hardiness factors (e.g., commitment, control, challenge) and core personal beliefs, quality of life, psychological distress, and adaptation to HIV. These researchers found that adults with high levels of hardiness displayed lower psychological distress and higher quality of life. In particular, one component of hardiness—commitment—appeared to have the most robust relationship to adaptation. Thus, commitment (defined as being resolute in the face of adversity) may be the most important quality associated with hardiness. Facing a diagnosis of HIV requires a great deal of commitment, and hardiness is clearly important for successful aging with HIV.

**HARDINESS IN AGING WITH HIV**

Hardiness has been documented as having several biopsychosocial advantages for people living with chronic conditions such as diabetes, hepatitis, and hypertension (Brooks, 2003). Likewise, we assert that hardiness is a characteristic that can mitigate the negative effects of aging with HIV and promote successful aging. Whether hardiness is viewed as a stable trait or a dynamic process, we posit that hardiness is a characteristic that can mitigate the negative effects of aging and HIV and promote successful aging for those who are infected. Vance, Burrage, Couch, and Raper (2008) proposed that hardiness in aging with HIV can be viewed as both stable and dynamic. As a stable trait, hardiness helps people live longer and age successfully. To clinicians, practitioners, and researchers, this static view does not allow for the development of interventions. When people are considered complex, dynamic, and adaptable, hardiness can be viewed as a process that can be augmented and used to promote wellness.

People who age well with HIV may develop the skills required to adjust, cope, and flourish. Hypothesizing hardiness as dynamic fosters the view that as people age with HIV, they can engage in behaviors that strengthen their resilience to stresses and strains. In fact, elevated distress during the initial diagnosis of HIV declines over time (Cooperman & Simoni, 2005); this finding suggests that coping mechanisms develop and support the overarching concept of hardiness.

Conceivably, it is possible to envision hardiness as a dynamic trait that is mutable and that waxes and wanes within a set parameter unique to each person. Thus, hardiness may increase
in response to factors that bolster the person, such as social support, spirituality, self-efficacy, purpose, and external resources like education. These factors correspond with many of the dispositional and contextual factors found in the Preventive and Corrective Proactivity Model of Successful Aging with HIV (Kahana & Kahana, 2001).

This model was developed to highlight the possible mechanisms with which one may age successfully with HIV. Kahana and Kahana (2001) proposed that HIV/aging-specific stressors such as HIV-related stigma, ageism, and medical and financial burdens diminish quality of life and lead to reduced meaning in life, depressed mood, and interference with the maintenance of prized activities and relationships. Such declines are internal and external resources negatively affect one's ability to cope with stressors. Preventive, health-promoting actions (e.g., medication adherence, exercise) can avert additional losses and protect one from additional stressors. Meanwhile, corrective adaptations, including substituting roles, marshalling support, and using environmental modifications, also compensate for the loss associated with aging with HIV. Motivating these coping mechanisms are the dispositional/internal factors of successful aging (e.g., hopefulness, altruism, self-esteem, life satisfaction). Although hardiness is not explicitly represented in this model, all of the model's dispositional/internal factors of successful aging can be incorporated within the concept of hardiness.

**IMPLICATIONS FOR NURSING**

As intermediaries between health care systems and patients, nurses are in a good position to observe individuals’ responses to stressors and to identify patients who are experiencing depressive symptomatology and suicidal ideation and intervene (Table). During the process of getting to know patients, nurses can also notice when patients voice a need for additional communication; exhibit an inability to manage previous activities; miss medical appointments; and appear agitated, despondent, or depressed. To promote early identification of those who are at risk for suicide, nurses can directly screen for depression or indirectly by inquiring about depression or sadness, either through the patients or their caregivers, as a way of determining an individual's degree of vulnerability to stressors. If a patient is considered vulnerable to suicidal ideation, he or she can be encouraged to see an appropriate health care professional (e.g., clinical social worker, psychologist, psychiatrist, clergy); providing an option of professionals from which the patient may choose can help the patient perceive such a referral as supportive. For example, a patient may prefer to talk with a minister rather than a psychologist.

Nurses may recognize certain hardy characteristics in individuals and focus on helping the patient promote hardiness through the acquisition of resources that bolster this trait. For example, research indicates a direct relationship between perceived social support and hardiness (Nicholas & Webster, 1993). Thus, a patient who seems to be exhibiting low levels of hardiness can be encouraged to develop social supports by participating in support groups, volunteer activities, and religious organizations. In fact, nurses often have ready access to a variety of support groups and agencies in their communities to which they can refer their patients.

Other external resources may also bolster hardiness. For example, a patient's need for emergency financial assistance or even food can often be met by charitable organizations. Nurses, along with social workers, can act as liaisons between their patients and these agencies. As a result, hardiness may be increased, and the intensity of depressive symptomatology and suicidal ideation may be decreased.

Nurses can refer patients to established programs, such as individual or group therapy, to facilitate development of hardiness. After reviewing the hardiness literature, Vance,

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**KEYPOINTS**

**SUICIDAL IDEATION, HARDINESS, AND SUCCESSFUL AGING WITH HIV**


1. Older adults with HIV may be more vulnerable to depression and suicidal ideation.

2. Older adults with HIV may experience several stressors that contribute to depression and suicidal ideation, including ageism and HIV-related stigma, loneliness and a decrease in social support, neurological changes, declining health, fatigue, changes in appearance, and financial distress.

3. Hardiness may be a dynamic concept that is not only depleted, but restored, which can help mitigate some of the stressors that contribute to depression and suicidal ideation in adults aging with HIV.
Struzick, et al. (2008) developed an individually focused treatment plan designed to increase hardiness in older adults with HIV to promote successful aging in this clinical population. Basically, participants engage in cognitive-behavioral activities throughout the day. These activities must be identified by the patient as being purposeful and valued life activities that mirror his or her definition of hardiness. For example, the individual may start the day by reciting a personally meaningful mantra, such as “I’m going to do my best today, no matter what.” During the course of the day, other activities reflecting hardiness as a malleable characteristic are undertaken. For example, the participant may watch one life-affirming television program showing people persevering despite adversity. Although these suggestions may seem simplistic, their use and practicality parallel cognitive-behavioral therapy and are important for changing thinking and, therefore, changing behavior.

CONCLUSION
Depressive symptomatology and suicidal ideation are associated with aging and HIV. Those aging with HIV may be more at risk for experiencing such negative effects. However, because hardiness has been shown to be associated with good quality of life in both aging and HIV, focusing on hardiness may be a way to promote successful aging in this emerging population. The dearth of information in this area is inopportune, given that promoting hardiness in adults aging with HIV may improve their everyday functioning, affect, and quality of life.

Because nurses provide direct care to adults aging with HIV, they may be able to recognize those who are experiencing depressive symptomatology and suicidal ideation. (For more information on detecting suicidal ideation in patients, see Pfaff and Almeida, 2005.) In addition, they may be able to assess patients for hardy characteristics and direct those needing assistance to interventions that promote hardiness and abate negative effects.

REFERENCES


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