AGING AND MENTAL HEALTH

SECOND EDITION

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Daniel L. Segal: To Cindy and Shaynie

Sara H. Qualls: To Mark, Morgan, Lea, and Marcus

Michael A. Smyer: To Piper, Brendan, and Kyle

Preface

> What is important in knowledge is not quantity, but quality. It is important to know wh knowledge is significant, what is less so, and what is trivial.
>
> *(Leo Tolsto*

In this book we have tried to take Tolstoy's maxim to heart, sorting out the significant from th trivial in the domain of aging and mental health. As we did so, we had two audiences in mind: today clinicians and the clinicians of the future. The first group includes clinicians who are already practice settings but who want to know more about the intricacies of working with older adults. Th second group encompasses students in the professions that work with older adults (e.g., psycholog social work, nursing, psychiatry).

Both groups must face the issues of aging summarized by Michel Philibert, a French philosophe "Of aging, what can we know? With aging, what must we do?" (Philibert, 1979, p. 384). These are als issues that older adults and their family members must face. In a way, they are variations on th questions that often arise in clinical settings. Consider the following example:

> Betty was worried about Alex. His memory seemed to be failing him more often. He'd get to the store and forget half of the things she'd sent him there for. He seemed more tired than usual, with less energy for his hobbies at the end of the day or on weekends. He didn't want to go out with friends to the movies or to dinner. Alex didn't notice anything different in his behavior. Betty called to ask your advice: "Should I get him tested at the local Alzheimer's Center?"

How would you answer Betty? What would you need to know? Which portion of her story significant in forming your answer? Which less so?

In answering these questions, you are implicitly answering Philibert's queries as well. You ar implicitly making a differential diagnosis of Alex's situation: Is this a part of normal aging? Is this pathological pattern? Is it a combination of the two? (Of aging, what can we know?)

You may also be linking your answer to an implicit action plan. Betty certainly is: Diagnose th problem and then decide what kind of treatment is most appropriate. (With aging, what must we do?)

To fully answer Betty's question requires much more information about aging in general, abou patterns of mental health and mental disorder in particular, about Alex's distinctive history an pattern of functioning, and about the contexts in which she and Alex live and receive services. Th book is designed to provide you with frameworks for considering each element.

Part I is an overview of basic gerontology, the study of the aging process. This backgroun information forms a context for answering the simple question often posed by clients and the relatives: Should I be worried about this pattern of behavior (e.g., Alex's apparent memor problems)? To answer this deceptively simple question requires that we sort out the influences physical illness, basic processes of aging, and the intersection of historical and social trends as the affect older adults' functioning. In Part I we outline the basic parameters of mental health in later lif providing the foundation upon which later chapters build.

In Part II we consider basic models of mental disorders. Each model provides a set of assumptio about mental health and the development of mental health problems, their assessment, and the treatment. These assumptions direct the clinician's attention to specific aspects of older adults an their functioning. For example, assume for the moment that Alex's memory problems are no organically caused. The behavioral perspective might highlight the context of the older adult behavior. Several important models of mental health and mental disorder are outlined in the chapte

of Part II. In each chapter we focus on an important question for older adults and those who work wi
them: How is this approach relevant to older adults and the problems they encounter in later life?

The third and final part focuses attention on the most commonly occurring mental health problem
and disorders in later life: cognitive impairment, depression, serious mental disorders (e.g
schizophrenia), anxiety, substance use, personality disorders, and other common disorders. In eac
chapter we outline the prevalence of the disorders, the most appropriate assessment approaches f
older adults, and the most effective treatment strategies for older adults. We were fortunate to be abl
to call upon Stephen J. Bartels for his expertise in the diagnosis and treatment of chronic ment
disorders (Chapter 9). Part III concludes with a capstone chapter on the contexts and settings
geriatric mental health practice. One physical setting is particularly important in geriatric ment
health care: nursing homes. Although they were not designed for it, they are a major treatment settin
for mentally ill older adults. Of course, other contexts (e.g., health care settings, social servic
settings, legal issues) affect how, where, and why mentally ill older adults are diagnosed and treate
We discuss these contexts in this final chapter.

Colleagues and friends in several settings have helped us write this book: colleagues in th
Department of Psychology, the CU Aging Center, and the Gerontology Center of the University o
Colorado at Colorado Springs, and the faculty, students, and staff in the Center on Aging & Work a
Boston College and in the Provost's office at Bucknell University. Early in the development of th
first edition we benefited from the guidance and advice of Jim Birren and two anonymous reviewer
The process of revision was supported by input and advice from our academic and communi
services colleagues as well as a new set of anonymous reviewers. We eagerly acknowledge our debt t
each, while also admitting that any remaining flaws are ours. We also express our deepe
appreciation to our friend and editor at Wiley-Blackwell, Constance Adler, whose patience an
diligence ensured that this second edition came to fruition. Finally, we remain grateful to our famil
members for their ongoing love, encouragement, and support.

Our goal throughout this book is to provide information and a set of frameworks that will be usef
in working with older adults and their families. In the end, we hope that you will conclude that there
much to hope for in aging, and much that we can do about mental health and mental disorders later
life.

Part I: Introduction

1 Mental Health and Aging

An Introduction

Consider the following case description:

> Grace, director of a Senior Center in your area, calls you about Mr. Tinker. Although Mr. Tinker used to come to the center three or four times a week, he hasn't come at all since the death of his friend, Ed, four months ago. Grace had called Mr. Tinker at home to say how much he'd been missed. When she asked if he wasn't coming because he was still upset over Ed's death, he denied it. Instead, Mr. Tinker said that he wanted to return to the center, but he was in terrible pain. In fact, he was in so much pain that he really couldn't talk on the phone and he hung up. Grace was worried that Mr. Tinker might not be getting the medical attention that he really needed. She asked you to make a home visit, which you agreed to do. You call Mr. Tinker and set up an appointment.

As you prepare to visit Mr. Tinker, what are the basic questions you might ask about him and h situation? Which factors do you think are important to explore with Mr. Tinker? How would yo assess Mr. Tinker's functioning?

Your answer to these simple inquiries reflects your implicit model of mental health and aging. I this book, especially in Part II, we will illustrate several different conceptual models of ment disorders and aging. In doing so, we will emphasize the links between starting assumptions an subsequent strategies for assessment and intervention. You will come to see that your philosophica assumptions about mental health, mental disorder, and aging shape the interpretive process of workin with older adults and their families.

Mr. Tinker's current functioning raises a basic question: Is his behavior just a part of normal agin or does it represent a problem that requires professional attention? Our answer represents implicit an explicit assumptions regarding the continuum of functioning that runs from outstanding functionin through usual aging to pathological patterns of behavior.

What is Normal Aging?

The starting point for mental health and aging must be a general understanding of *gerontology*, th study of normal aging, and *geriatrics*, the study of the medical aspects of old age and the preventio and treatment of the diseases of aging. In Mr. Tinker's case, we want to know if his reaction is a pa of a normal grieving process or an indication of a disease process (e.g., a mood disorder, such a major depressive disorder). To answer this requires a starting definition of normal aging.

A conceptual definition

Discussions of this issue focus attention on three different patterns of aging: normal or usual agin optimal or successful aging; and pathological aging (e.g., Rowe & Kahn, 1998). Baltes and Balt (1990a) provide definitions of normal and optimal aging:

Normal aging refers to aging without biological or mental pathology. It thus concerns the agi process that is dominant within a society for persons who are not suffering from a manifest illnes Optimal aging refers to a kind of utopia, namely, aging under development-enhancing and ag friendly environmental conditions. Finally, sick or pathological aging characterizes an agi process determined by medical etiology and syndromes of illness. A classical example is dement of the Alzheimer type.

(pp. 7–

A statistical definition

Distinguishing between normal aging and optimal aging requires us to sort out statistical fact fro theoretically desirable conditions. For example, the Baltes and Baltes definition suggests that norm aging does not include "manifest illness." However, in the United States today, chronic disease typical of the experience of aging: More than 80 percent of those 65 years old and older have at lea one chronic medical disease, and 50 percent have at least two chronic medical diseases (Centers f Disease Control and Prevention and The Merck Company Foundation, 2007).

For example, half of those over age 65 report having arthritis (Hootman, Bolen, Helmick, Langmaid, 2006). By 2030, 54 percent of adults with arthritis are expected to be over age 6 (Hootman & Helmick, 2006). Moreover, among the oldest old groups (75+ or 85+) there a substantially higher rates. Thus, from a statistical perspective, arthritis is certainly modal, and may b considered a part of normal aging. We will return to this in Chapter 2.

A functional definition

Another approach to defining normal aging arises from defining "manifest illness." By focusing n on presence or absence of a chronic disease, such as arthritis, but on the *impact* of that disease, w may get another depiction of "normal aging." Here, again, though, the definition of terms can affe our conclusion regarding normal aging.

Consider the prevalence of disability among older adults. Functional disability could be considere one indicator of manifest illness among older adults. So far, so good. However, how shall we defi functional disability? The answer may determine our conclusion about what is or is not normal f later life. Again, Mr. Tinker's situation may help us clarify the issues:

> When you get to Mr. Tinker's house, you find an apathetic, listless, very thin man of 81. He seems to be fairly isolated socially, having few friends and even fewer family members in the area. (He never married and he has no living siblings.) Although he seems physically able to cook, he says that he hasn't been eating (or sleeping) regularly for quite a while – and he doesn't care if he never does again.

Is Mr. Tinker functionally disabled? If so, is this normal for someone of his age? According to th US Census Bureau, most persons aged 75 years old and older have a disability: 56 percent of those 75 79 years old had any type of disability with 38 percent having a "severe disability" (Brault, 2008). contrast, Manton, Gu, and Lamb (2006) reported that 78 percent of the 75–84 age group was "no disabled." How could such differing pictures of older adults emerge?

The answer lies in the definition of disability. The Census Bureau focuses on difficulty wi functional activity for its specific definition of disability. The range of functional activities somewhat broader than traditional definitions: lifting and carrying a weight as heavy as 10 pound

walking three city blocks; seeing the words and letters in ordinary newsprint; hearing what is said normal conversation with another person; having one's speech understood; and climbing a flight stairs. In contrast, Manton et al. (2006) focused on activities of daily living (ADL; e.g., eating, gettin in or out of bed, getting around indoors, bathing, dressing, using a toilet) and instrumental activities daily living (IADL, e.g., light housework; doing the laundry; meal preparation; grocery shopping).

Not surprisingly, these different definitions of disability produce different depictions of functionin and normal aging. The metric we use in assessing functional ability is important for two reasons: th specific activities may be important in and of themselves; and the ability to complete activities (suc as ADL and IADL activities) acts as a proxy for underlying physical, cognitive, and social skil (Kemp & Mitchell, 1992). Thus, depending upon the range of functioning we wish to assess, we ma conclude that Mr. Tinker is either disabled or not and that such a pattern of functioning is eithe normal or unusual aging!

What is Abnormal or Unusual Aging?

Thus far, we have considered merely one side of the dilemma: What is normal aging? We have als limited ourselves to *physical* and *functional* definitions, steering clear of similar issues focusing o *mental* health problems or disorders.

> You notice that Mr. Tinker doesn't mention being in any terrible pain – that is until you mention his friend Ed. When you do, Mr. Tinker grabs his side and says how much it hurts to talk. You suggest that he lie down and rest for a minute, which he does.
>
> From the couch, Mr. Tinker begins to talk about Ed. It turns out that the two men were not just "friends" as Grace had implied. They were like brothers (if not closer) and had been since they were boys. "I'm good for two things," Mr. Tinker said, "no good and good for nothing. But Ed was my buddy anyway. Don't know why he bothered with me. I never made much of my life. But I do know that it won't be hunting season without him. Just can't do it alone and nobody in their right mind would want to hunt with an old fool like me."

Again, Mr. Tinker challenges us. Is he mentally ill? The answer depends upon resolving oth issues: How will we define mental health among older adults? Conversely, how will we define ment disorder among older adults? In Part III of this book, we will discuss assessment and treatme approaches for many specific mental disorders. Here, however, we start at the beginning: definitio of mental health and mental disorder.

Mental Health and Mental Disorder

The Centers for Disease Control and Prevention and the National Association of Chronic Disea Directors (2008) summarized the importance of mental health in later life:

> The World Health Organization defines health as "a state of complete physical, mental, and soci well-being and not merely the absence of disease or infirmity" [WHO, 1948] … Because ment health is essential to overall health and well-being, it must be recognized and treated in a Americans, including older adults, with the same urgency as physical health … In fact, the ment health of older Americans has been identified as a priority by the Healthy People of 20 objectives [US Dept. of HHS,

], the 2005 White House Conference on Aging [US Dept. of HHS,

20

], and the 1999 Surgeon General's report on mental health [US Dept. of HHS,

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].

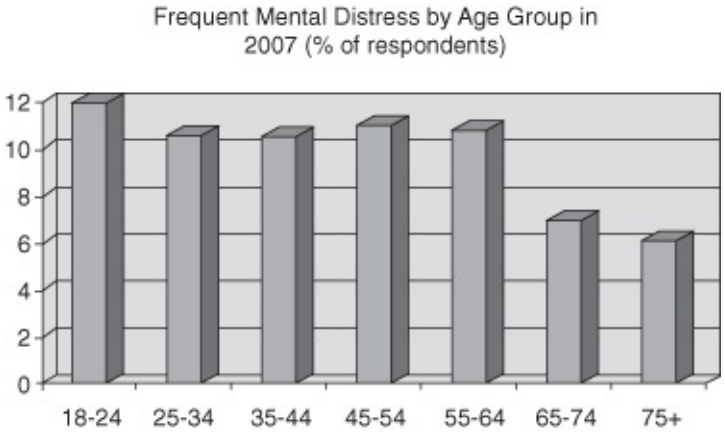
Mental health among older adults is a multifaceted concept that reflects a range of clinical a research activity, rather than a unified theoretical entity (Qualls & Layton, 2010; Qualls & Smye 1995). Definitions of mental health in later life combine several complex elements: statistic normality; the link between individual functioning and group norms; the extent to which specif disorders can be effectively treated or controlled; and ideals of positive functioning (Butler, Lewis, Sunderland, 1998).

In contrast, there is greater agreement on definitions of *mental disorder* among older adults. F both clinical and research purposes, operational definitions of mental disorder usually follow t American Psychiatric Association's guidelines in the *Diagnostic and Statistical Manual of Ment Disorders* (DSM-IV-TR; American Psychiatric Association, 2000). Thus, mental disorder in olde adults is operationally defined by patterns of disorders as outlined in the DSM-IV-TR, which is t prominent classification system for much of the developed world (Segal, 2010). Several hundr mental disorders are defined in the manual, which lists the specific diagnostic criteria for ea disorder.

Data from the Centers for Disease Control's Behavioral Risk Factors Surveillance System (BRFS revealed that in 2007, 6.9 percent of adults aged 65–74 reported frequent mental distress as defined b having 14 or more mentally unhealthy days. The percentage was slightly lower (6.1 percent) for the 7 or older group (CDC, 2007). Older age groups had the lowest prevalence of frequent mental distre compared to all younger age groups (see Figure 1.1).

Figure 1.1 Frequent mental distress by age group in 2007 (% of respondents).

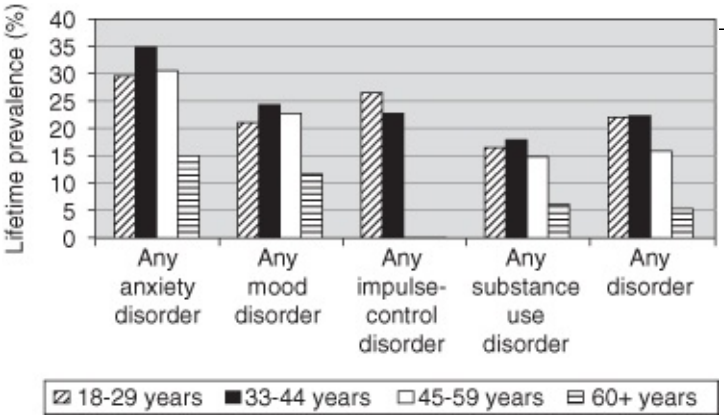
Source: Adapted from CDC (2007).



A similar pattern emerges when the focus is on diagnosed mental disorders. Kessler, Berglun Demler, Jin, and Walters (2005) reported data from the National Comorbidity Study, which include interviews with a nationally representative sample of over 9,000 people. Again, older adults had low levels of diagnosable anxiety disorders, mood disorders, impulse-control disorders, and substance u disorders compared to younger adult groups (see Figure 1.2).

Figure 1.2 Lifetime prevalence of DSM-IV/World Mental Health Survey disorders by age group fro the National Comorbidity Survey Replication sample.

Source: Adapted from Kessler et al. (2005).



Depression is clearly not a part of normal aging. In 80 percent of cases, depression is a treatab condition (Centers for Disease Control and Prevention and the National Association of Chron Disease Directors, 2008). However, geriatric depression reflects the difficulty of discerning "norm aging" from pathological aging. Depression in later life appears in several guises. When using th Beck Depression Inventory, older adults have low rates of moderate depression and anxiety (6 percent lower) in comparison to young adults (Goldberg, Breckenridge, & Sheikh, 2003). Only 5 percent of adults age 65 or older currently have depression and 10.5 percent have had a lifetin diagnosis of depression (Centers for Disease Control and Prevention and the National Association Chronic Disease Directors, 2008). However, the prevalence of depressive *symptoms* among old adults is much higher. (See Chapter 8 for a full discussion of the epidemiology of depression.)

Again, the challenge is distinguishing between normal and pathological aging: Are Mr. Tinker sleep and appetite disturbances a sign of depression, a part of the normal aging process, or combination of the two?

Another challenge is that rates of mental disorders vary by setting. For example, older adults institutional settings present a very different picture: In a sample of older medical inpatients, 4 percent had mild depressive symptoms and 27 percent had severe depressive symptoms (Link Bartkó, Agárdi, & Kemény, 2000). Similarly, a recent study analyzed data from Minimum Data Se assessments and found that 27 percent of newly admitted nursing home residents were diagnosed wi schizophrenia, bipolar disorder, depression, or anxiety disorder (Grabowski, Aschbrenner, Feng, & Mor, 2009). Grabowski and his colleagues (2009) summarized the impact of these patterns: "Nursin homes have become the de facto mental health care institution as a result of the dramatic downsizin and closure of state psychiatric hospitals, spurred on by the deinstitutionalization movement" (p. 689

A final relevant issue is not simply the rates of mental disorder in older adults, but rather the patte of the *age of onset* of mental disorders (e.g., the average age at which people tend to first experien the disorder). Informative data from Kessler et al. (2005) indicated that the median age of onset w much earlier for anxiety disorders (11 years old) and impulse-control disorders (11 years old) than fo substance use disorders (20 years old) and mood disorders (30 years old). For all of the ment disorders included in this large study, 50 percent of all lifetime cases start by age 14, 75 percent of a lifetime cases start by age 24, and 90 percent of all lifetime cases start by age 42. Thus, the first ons of most mental disorders is in childhood or adolescence and a much smaller percentage of disorde have an onset in later life. Among older adults with a mental disorder, it is clinically relevant t determine when the disorder began. For example, an older adult who has suffered from lifelon depression will likely have a lengthier and more complicated treatment than an older adult wh experienced depression for the first time in later life. The issue of age of onset is further explored

many of the chapters on specific mental disorders in Part III of this book.

Linking the Physical and Mental in Later Life: Comorbidity

Mr. Tinker's pattern of symptoms – his lethargy, social withdrawal, and his reported physical pain remind us of the importance of *comorbidity*: combinations of more than one mental disorder, physic illness, or combination of both. Cohen (1992) provides a context for understanding comorbidity b outlining four useful paradigms for the interaction of physical and mental well-being among old adults:

- Psychogenic (or psychologically based) stress may lead to health problems.
- Health problems may lead to psychiatric disturbances.
- Coexisting mental and physical health challenges may interact.
- Social and psychosocial resources may affect the course of physical or mental disorders.

Indeed, one's initial concern about a client or patient may be raised by either a physical or ment health problem.

First, psychogenic stress may lead to physical health problems: In Mr. Tinker's case, abdomin pain may be a reaction to his grief over Ed's death. For Mr. Tinker, this physical symptom may be more socially acceptable way for him to express pain.

Second, the direction of causality may be reversed, however, with a physical disorder leading psychiatric disturbance. Consider the following sentence:

> **The five senses tend to decline with senescence**.

Remove the f's, s's, and th's. Now try to make sense of what's left:

> **e ive en tend to decline wi ene e.**

This example mimics high frequency hearing loss among older adults (Butler et al., 1998) and giv you a sense of how easily such a hearing loss might lead to delusions and confusion among old adults.

A third possibility is that coexisting physical and mental disorders may interact. One category mental disorders among older adults underscores this interplay: cognitive impairment, including th dementias. Cognitive impairment among older adults is a challenge for interdisciplinary diagnosis an treatment. Distinguishing among age-related cognitive change, mild cognitive impairment (MCI), an Alzheimer's disease or other dementias can be difficult (Buracchio & Kaye, 2009; Green, 200 Peterson, 2004). In addition, differential diagnosis and prompt treatment requires ruling out a myria of potentially reversible causes of confusional states: drug reactions; emotional disorders; metabol disorders; impaired vision and hearing; nutritional deficiencies; dehydration; brain tumors an traumas; infections. This requires an interdisciplinary collaboration designed to assess comple patterns of comorbidity (see Chapter 7).

Currently, resources are being invested in research on the biological bases of Alzheimer's diseas and related disorders (e.g., Anderson, Litvack, & Kaye, 2005; Bertram, McQueen, Mullin, Blacker, Tanzi, 2007; Brouwers, Sleegers, & Van Broeckhoven, 2008), the social impact of these diseases (e.g

Kim, Knight, & Longmire, 2007; Montgomery & Kosloski, 2009), and the potential for preventi interventions aimed at avoiding the personal and economic devastation that accompany dement (e.g., CDC & Alzheimer's Association, 2007; Day, McGuire, & Anderson, 2009; Teri, Logsdon, & McCurry, 2008; Willis et al., 2006).

Again, national data reflect the individual and societal importance of this work: Estimates are th as many as 5.3 million Americans currently have Alzheimer's disease and related dementias (ADRD with 70 percent of these patients aged 71 or older suffering from Alzheimer's disease (AD (Alzheimer's Association, 2009a). Estimates suggest that the number of ADRD patients will increas to more than 11.8 million by the year 2040 (National Academy on an Aging Society, 2000).

Similarly, recent work (Plassman et al., 2008) indicates that, for older adults age 71 years and olde two estimates of disorders are important to assess: those with already-diagnosed Alzheimer's disea (approximately 3.4 million people) and those who have cognitive impairment without dement (approximately 5 million people). Taken together, these two categories produce a prevalence rate 22 percent for those 71 and older (Lichtenberg, 2009).

A global estimate of the prevalence of dementia suggests that there are currently 24 million peop worldwide with dementia (Ferri et al., 2005). This number is projected to double every 20 years to 4 million by 2020 and to 81 million by 2040 (Ferri et al., 2005). Perhaps surprisingly, 60 percent those with dementia are estimated to live in developing countries, a rate projected to rise to 71 perce by 2040 (Ferri et al., 2005).

Fourth, and finally, Cohen (1992) suggests that social and psychosocial resources can affect th course of physical and mental disorders. As we discuss in the stress and coping model (see Chapter 5 social support can buffer the negative effects of life stress and help people cope better with a myria of problems. Even among those with a dementing disorder, a positive social environment can enhanc the person's dignity and quality of life.

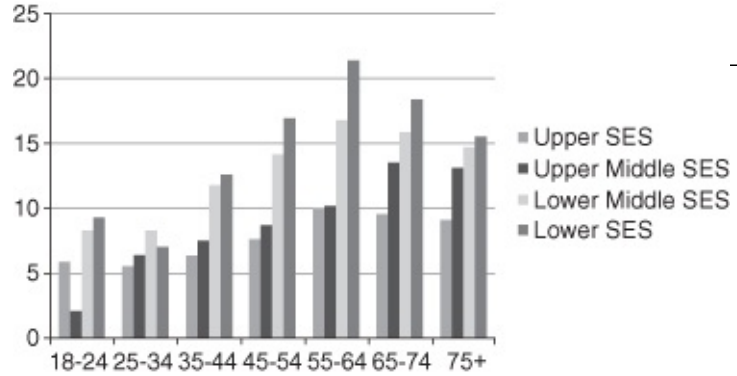
Individual Differences and Assessment of Risk

Thus far, we have sketched general patterns of mental health and mental disorder among older adult as a context for working with Mr. Tinker. One question has been implicit in this discussion: How Mr. Tinker like other older adults of his age? In this section, the emphasis shifts to another questio How is Mr. Tinker different from other individuals his age?

What do we know about Mr. Tinker that would differentiate him from other 81-year-olds? What ar the categories of information we would use in sorting older adults? Socioeconomic status (SE dramatically affects the experience of aging. Consider the relationships among age, having a chron health problem, and SES (see Figure 1.3). Data from the Behavioral Risk Factors Surveillance Syste (CDC, 2007) showed that individuals in the lower SES categories have the highest rates of chron conditions throughout adulthood.

Figure 1.3 Percentage of respondents reporting that they have a chronic health problem stratified by age and SES.

Source: Adapted from CDC (2007).



Moreover, by early mid-life (ages 35–44), those in the lower SES group already have chronic heal problems at higher rates than those in the highest SES group at ages 55–64, 65–74, and 75 Variability in risk among older adults is not limited to the physical or functional domains, howeve There are similar patterns of variability in risk of mental disorders. Consider the risk for suicide. W resume our conversation with Mr. Tinker:

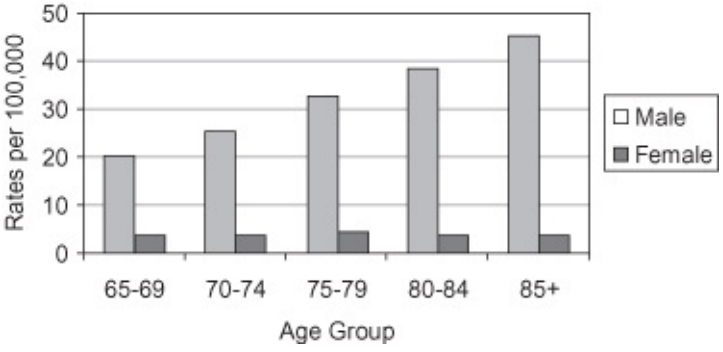
> "I never made much of my life. But I do know that it won't be hunting season without Ed. Just can't do it alone, and nobody in their right mind would want to hunt with an old fool like me."

These words have a haunting finality to them. As you hear them, you begin to wonder about M Tinker's will to live and his plans for the future. Should you ask him about these elements, about h potential for suicide?

Psychiatric epidemiological data can be helpful in tracing overall patterns of suicide risk amon older adults, as well as differential patterns of risk (see Figure 1.4). The threat of completed suicide substantial in later life, with the highest rates appearing among those 65 years or older (14.7/100,00 vs. 11.0/100,000 for the general population; Centers for Disease Control and Prevention and th National Association of Chronic Disease Directors, 2008). Older adults are more likely to comple suicide than any other adult age group, due to more lethal methods of suicide attempt. Suicide amon older adults is associated with diagnosable psychopathology (most often affective disorder especially depression) in approximately 90 percent of cases (World Health Organization, 2005).

Figure 1.4 Suicide rates for ages 60 to 85+.

Source: American Association of Suicidology based on raw data from CDC. Retrieved from http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-158.pdf.



When gender and ethnicity are included, the group at highest risk for death by suicide is White me over the age of 85, with a rate of suicide two and a half times higher than the nation's rate for me (American Association of Suicidology, 2008). Sadly, the majority of older suicide victims had see their primary care physician within the month prior to suicide (Caine, Lyness, & Conwell, 1996 Thus, there is a serious need for better preparation of physicians for screening and treatment geriatric depression, and for screening and prevention of older adults at risk for suicide (NI

Consensus Panel on Assessment and NIH Consensus Panel on Depression in Late Life, 1992).

Armed with this knowledge of differential risk – particularly for White men over 80 – you ask M Tinker about his current plans and perspectives:

> "It sounds like you're feeling pretty blue. Have you ever thought about ending things?"
>
> "I may be down, but I'm not crazy!"

Mr. Tinker quickly gives you a sense of his own perspective on his problems, allowing you to follo up with specific questions regarding intent. The conversation could have gone in a different direction

> "It sounds like you're feeling pretty blue. Have you ever thought about ending things?"
>
> "Every now and then I get that feeling."
>
> "How would you do it?"
>
> "Well, I'd use that shotgun that I keep loaded next to the door – just head out to the barn, clear out the cows, and pull the trigger …"

This conversation confirms your fears – he has motivation, a way to achieve that purpose, a seemingly very little concern about the consequences.

These two resolutions to the inquiry highlight the theme of variability among and between old adults. This variability is a hallmark of aging: As we get older, we get more distinct from our ag mates. This diversity among older adults (often called inter-individual differences) is the result of t complex patterns of both biological and biographical functioning across the life span.

The biographical elements may play a key role in two different ways: the history of the disorder a the history of the individual. In the case of Mr. Tinker's suicide potential, for example, we will wa to know something about his previous experience with suicidal ideation: Has he been suicidal f many years and now grown older? Has he grown older and now become suicidal? These two diverge paths both arrive at suicide in later life, but they offer very different suggestions for treatme attempts, the availability of social and emotional resources, and the likelihood of successf intervention.

In summary, we will want to know more about several key elements of Mr. Tinker's history: h social and economic resources, his current and past physical health, his current and past mental healt and his functional abilities (NIH Consensus Panel on Assessment, 1988). Approaches to these issu will be presented in Part II of this book.

The Context of Clinicians and Clients: Now What Do We Do?

Thus far, we have had one conversation with Mr. Tinker and we have gathered information about h current functioning, his previous history, and his future ability to continue to cope on his own. Wh will we do next?

Our approach to Mr. Tinker is a function of several, inter-related elements: our sense of h strengths and weaknesses (e.g., how acute is his crisis; is he a threat to himself or others; how has h handled personal challenges in the past; etc.); our assessment of his capacity to be involved in heal care decision-making as an active participant in developing the treatment plan; and the service setti and context that we work within. These issues are discussed in Chapter 12.

The context of mental health services for older adults has changed substantially during the last thr decades. As part of a larger public policy of deinstitutionalization, there were increases in bo institutional and outpatient services. In the institutional sector, inpatient services were shifted fro state mental hospitals to private psychiatric hospitals, psychiatric units in general hospitals, a "swing beds" in general hospitals. As pointed out earlier, one other setting became increasing important as a receiving site for mentally disordered older adults: nursing homes (Gatz & Smye 1992; Grabowski et al., 2009).

Access to mental health services is another important issue (Pepin, Segal, & Coolidge, 2009 According to the American Psychological Association (2003), about 63 percent of older adults with mental disorder do not receive the services they need, and overall, only 3 percent of older adults repo seeing a mental or behavioral health professional. In inpatient settings, older adults represent percent of the population receiving inpatient care in specialty institutions and general hospita (Rosenstein, Milazzo-Sayre, & Manderscheid, 1990). However, older adults represent 90 percent the mentally ill population in nursing homes (Lair & Lefkowitz, 1990). This pattern reflects an ove reliance on nursing homes as a treatment setting for mentally ill older adults. Recently, Pepin et a (2009) examined the kinds of barriers that prevent younger and older adults from accessing ment health services, finding that stigma was at the bottom of the ranked list of barriers for younger a older adults alike. Instead, more practical issues such as concerns about paying for treatment a difficulty finding an appropriate mental health service provider were perceived as greater barriers. further understanding of barriers is an important avenue for further research study.

These patterns of care – with a substantial bias toward inpatient, medically oriented services – a only one of two major elements that shape the availability of and access to mental health care f older adults. The second is the combined priorities of major funding sources for geriatric ment health: Medicare, Medicaid, and private insurance plans (Smyer & Shea, 1996).

In 2003, the core costs of health care for mentally ill older adults were $15.1 billion (Mark et a 2008). These costs included the direct costs of care, plus the indirect costs of associated morbidity a mortality. Thus, from an economic perspective, geriatric mental health care is worthy of attention – only to foster cost-containment efforts.

Medicare is a federal health insurance program for older adults. Its eligibility criteria and scope covered services are standardized throughout the United States. Unfortunately, Medicare coverag although improved in recent years, is still somewhat restrictive. For example, in 2010 Medica covered only 55 percent of outpatient mental health services (e.g., psychotherapy) provided b psychologists or other mental health professionals while it covered 80 percent of comparable physic health services provided in an inpatient setting (Centers for Medicare and Medicaid Services [CMS 2010). Recent legislation has addressed this unfair practice but it will take several years for t changes to phase into the program, with full parity for outpatient mental health services (80 perce coverage) completed by 2014.

Medicaid is the US national health insurance program for the indigent. It is funded through combination of state and federal funds and coverage varies from state to state. Medicaid has emerg as the payer of last resort in nursing home care for older adults, covering 6 out of every 10 nursi home residents. Medicaid pays for more than 40 percent of nursing home and long-term care coverag in the United States (Kaiser Family Foundation, 2009). Private insurance plans also provide som assistance for mentally ill older adults. The primary private options available for older adults consi of either supplemental insurance policies, often called "Medigap" policies, that cover the co-payme

portions of original Medicare part B for a monthly premium or privatized "Medicare Advantag Plans" that function more like a health management organization (HMO) and are run by priva insurance companies approved by and under contract with Medicare. These plans provide hospital ar outpatient coverage but can charge different out-of-pocket co-payments for different services as we as the monthly premium.

These contextual factors – institutional patterns of service provision, insurance coverage, fo structures – affect the choices for services for Mr. Tinker. To work effectively with him, you will nee to understand the coverage of mental health services that he has, the availability of services in yo local community, and the range of services for which you can be reimbursed. These issues will b further discussed in Chapter 12 in this book.

Summary and Conclusions

In this chapter, we have introduced several themes that will re-emerge throughout the book. First, w have highlighted the importance of philosophical assumptions regarding normal and abnorm functioning in shaping our assessment strategies, targets for intervention, and definitions therapeutic success. Next, we have emphasized the importance of individual differences in shapi our understanding of the etiology and presentation of mental health problems or disorders in later lif Finally, we have discussed briefly the fiscal and political context that shapes the availability of ment health services for older adults. These themes – ranging from individual functioning to social policy illustrate the complexity of the task of providing mental health services to older adults. We hope th these themes also reflect the excitement inherent in trying to bring order out of the chaos of needs ar services, of trying to both understand the older client and match her needs with the services available

The last point we wish to emphasize in this introduction is that the DSM-IV-TR (America Psychiatric Association, 2000) is an *evolving* classification system. As such, at the time of th writing, the manual is undergoing revisions to the diagnostic categories including many specif mental disorders. These revisions are expected to be substantial for the next edition, which will b called the DSM-5. The interested reader can track progress of these developments at the website f the DSM-5 (http://www.dsm5.org), which is expected to be released in 2013.