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Mental Health and Aging: What Are the Epidemiological Myths, Realities and Policy Implications?

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Based on a lecture presented at the Brookdale Institute, while the author was a Visiting Scholar.

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ABSTRACT

The author reviewed the U.S. literature from 1950, up to and including the 1980-81 Central New Jersey mental health study of older adults. In order to investigate some common beliefs and myths, she:

* Compared the mental impairment rates of older adults with prevalence rates among younger age cohorts
* Sought to determine whether a positive relationship exists between increasing age and existence of mental disorders within the elderly population
* Examined potential barriers to the utilization of mental health services by older adults

The review related only to functional disorders, such as anxiety and depression, and not to such organic disorders as retardation and the senile dementias, and included the most recent studies based on the latest state-of-the-art measurements.

Prevalence of mental distress among community-based elderly: The author reveals that in none of the categories of impairment that she analyzed were the older adults reported to be more impaired than younger age cohorts. The New Jersey study reported on two sub-groups: elderly with no recent stressful life event and recently widowed individuals. Those with no recent stressful event exhibited comparably lower levels of symptomatology than all adults. However, the bereaved respondents reported higher levels of distress than the

normative groups, primarily on the depression and somatization scales.

Increase of distress within the older adult population: Feinson reports that increasing age is slightly associated with increasing distress for elders living in the community, but age is not a factor related to the distress of the bereaved. It may be that the risk factors for the elderly are similar to those of younger individuals: increased risk for the bereaved and those acutely ill.

Barriers to utilization of mental health services: The author reports that location of mental health clinics and availability of convenient transportation appear to be the greatest barriers.

Though there are clear implications for development of public policy and planning future services in this first critical analysis of the "aging and mental health" myth, Feinson recommends further studies involving larger numbers of elderly to reinforce her conclusions.

Introduction

Epidemiologists, sociologists, planners, and policymakers have long been interested in the prevalence and sociodemographic correlates of mental health problems or psychological impairment[1]. These issues are particularly salient considering the rapid demographic changes in the U.S. population. One of the most dramatic changes involves the population aged 65 and over. In 1900, 4% of the population (3.1 million) were 65 and over compared to 11% (25.5 million) in 1980. By 2030, demographers expect one out of five persons, or 20% of the total population, to be 65 and over (U.S. Bureau of the Census, 1983). This rapid expansion of the older age cohorts makes an assessment of the distribution of psychological distress by age particularly important.

Moreover, older adults are commonly portrayed as growing older and more distressed simultaneously. Indeed, psychological distress is often considered an integral part of the aging process. Consider, for example, the position of the President's Commission of Mental Health, "...depression escalates decade by decade" (Mental Health and the Elderly, 1978). Or the official statement from the Commission's Report

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[1]The terms 'psychological impairment' and 'mental health problems' are often used interchangeably with psychological distress, mental disorders, emotional disorders or distress and mental illness. These are all broad terms which refer to a variety of psychological symptoms such as depression, anxiety, and phobia. As used here, psychological impairment and the other terms refer to mild or moderate functional disorders characterized by general states of unpleasant arousal of emotion (e.g. anxiety, depression, etc.). Consequently, the terms do not refer to Alzheimer's Disease, any of the senile dementias, or mental retardation, which are organic rather than functional disorders.

to the President (1978:7): "The prevalence of mental illness and emotional distress is higher among those over 65 than in the general population. Up to 25% of older persons have been estimated to have significant mental health problems".

Similarly, the former Director of the Center for the Study of Mental Health and Aging at the National Institute of Mental Health stated: "...mental illness is more prevalent with the elderly than with younger adults" (1980:972). An official at the National Center for Health Statistics also said: "I have been told that depression is very prevalent among the elderly. I do not know how to evaluate that statement but I am prepared to accept it" (Kovar, 1980:322-2).

As recently as this year (1987), two books on depression were published, both containing similar themes. In a book by psychiatrist Nathan Billig, entitled To Be Old and Sad: Understanding Depression in the Elderly, he writes: "Because depression is more prevalent in the elderly than in any other age group, it represents a major mental health, medical and social problem that may potentially touch us all". (p. 4). Similarly, physician Mark S. Gold, who is Director of Research at a private and highly regarded psychiatric facility in New Jersey, wrote a book called The Good News About Depression: Cures and Treatment in the New Age of Psychiatry. In it he says: "Depression is four times more prevalent among the elderly as among the general population". (p. 290).

These consistent perceptions of significant mental health problems, particularly depression, among older adults have had major implications not only for societal views of the aging process, but for social policies as well. Indeed, I accepted these perceptions as valid

representations of reality until I started to examine the data. Interestingly, most of the quotes have no references to data and none contain footnotes referencing data sources.

Although no one study is definitive, there are a number of studies with relevant data. What is missing, however, is a systematic review of these data. Accordingly, this paper focuses on several issues central to mental health and aging. First, in order to determine whether mental health problems are more prevalent among older than younger adults, I compare the prevalence rates of mental impairment between these population groups (i.e. between older and younger age cohorts). Second, within the older population, that is, looking only at the cohorts age 65 and older, I examine the relationship between mental health and age to determine whether there is a positive relationship between increasing age and disorders. Finally, in view of consistent perceptions of significant mental health problems experienced by elders, I examine potential barriers to the utilization of mental health services by older adults.

A Review of Epidemiological Studies

To examine the prevalence of distress, I begin with a review of previous studies and then present data from a recent mental health survey conducted with older adults living in central New Jersey. First is a review of epidemiological studies.

Beginning with the prevalence of distress among older adults and in order to compare distress across age groups, I have prepared a summary description of all prevalence studies conducted in the United States since 1950. Only those studies containing random probability samples of older adults are included. The 20 epidemiological studies

listed in Table 1 represent the preponderance of data on the prevalence of distress among older adults. (Some studies have been listed twice if they report findings on more than one type of distress). Such community studies exclude the institutionalized, the chronically mentally ill, and non-functional elders with organic mental disorders. In this regard, community samples of older adults are similar to samples of younger adults. Thus, studies focused exclusively on organic mental disorders or on nursing homes or other institutionalized populations are excluded.

As Table 1 reveals, the studies reflect broad variations in when the study was conducted, what type of disorder was being measured (e.g. general distress, depressive symptoms, or clinical depression), the instruments used, and the methods establishing cut-off points. However, based on the available data, I have grouped the studies according to the category of distress and summarized the conclusions in Table 2. Examining the conclusions for each type of impairment reveals some interesting findings, especially when juxtaposed with the prevailing consensus of increased mental health problems with increasing age. In none of the seven categories of impairment or three sub-categories of clinically relevant impairment are older adults reported as more impaired than younger age cohorts. This pertains both to early studies using less refined measures of impairment as well as to the most recent studies based on the latest state-of-the-art measurements (e.g. the DIS). The conclusions to be drawn from these studies (shown in the third column of Table 2), reveal either no clear age trends or more disorders among younger age groups. Thus, existing studies do not provide support for the perception that mental health

problems are especially prevalent among older adults or that such problems accumulate with age.

New Jersey Epidemiological Study

Now we turn to an epidemiological study designed to assess the prevalence of psychological distress within the older adult population. An important contribution of this study concerns the demographic variations in the distribution of distress among those aged 65 and over. This focus differentiates the New Jersey study from the majority of studies listed in Table 1 in which older respondents were included in order to make age comparisons. That is, in general population surveys, the research goals have been primarily to determine whether there are more symptoms reported by older or younger adults. To accomplish this goal of comparing older and younger age cohorts, older respondents (aged 60 or 65 and over) generally are grouped into a single age cohort or into two age cohorts. These global comparisons generally ignore important age variations within the older adult population, an issue which the New Jersey study was designed to address.

Data were collected during 1980 and 1981 in two-hour face-to-face interviews with a representative sample of 476 older adults (aged 65 and over) living in central New Jersey. The sample, designed to maximize variability in life experience, consists of two distinct sub-samples: 313 community respondents not included on the basis of any recent major stressful life event; and 163 respondents who recently confronted one of life's most stressful events, the death of a spouse. This strategy was selected in order to compare the two groups with

regard to the distribution and determinants of psychological impairment.

The 313 community respondents were randomly selected using a multi-stage cluster technique (Kish, 1965). The 163 bereaved respondents were also randomly selected from obituary notices appearing in two area newspapers. (For a complete description of the research procedures, response rates, and comparisons of the two samples, see Feinson and Thoits, 1986.) The 65% completion rate for the total sample was lower than desired, but comparable to rates achieved in other surveys. Moreover, the rate is consistent with observations of higher non-response rates among older adults (Srole and Fischer, 1980; Veroff et al., 1981; Cleary and Mechanic, 1983). While the completion rate is acceptable, the findings should be considered suggestive until replicated with other studies.

The two samples of community and bereaved respondents are not significantly different on various sociodemographic characteristics except gender. The bereaved sample has significantly more females than the community sample, as would be expected with a sample of widowed elders. (Almost half of women age 65 and over are widowed - 47% - compared to one out of eight older men - 12%. U.S. Bureau of the Census, 1983.) The community sample is also similar to the total U.S. population age 65 and over on most demographic variables.

A major advantage of this survey, compared with previous studies (except for the ECA studies), concerns the measurement of psychological distress. Two instruments were used: one was a self-report symptom checklist, the Johns Hopkins Symptom Checklist or the SCL-90-R (Derogatis et al., 1973). The SCL-90-R is considered a `notable

example' of the current, clinically relevant research instruments which are multi-dimensional and content-meaningful (Dohrenwend and Dohrenwend, 1982). Its 90 symptoms can be interpreted as nine primary symptom dimensions (such as depression, anxiety, somatization, etc.) or treated as one global measure of overall psychological impairment (GSI). For this analysis, I am retaining the three most reliable symptom dimensions, somatization (alpha of .80), depression (.83) and anxiety (.80) along with the overall measure of distress, the GSI (alpha of .96) as measures of the dependent variable, psychological impairment.

The second instrument used to measure impairment is the General Well-Being Scale used by the Rand Corporation and based on items developed for the U.S. National Health Interview Survey (Brook et al., 1979). The fifteen selected items measure both favorable and unfavorable aspects of general well-being. For example, "How much of the time have you felt cheerful?" "How often did you get rattled or flustered?" This scale is also highly reliable with an alpha coefficient of .90. Because the items have been reversed to correspond with the SCL-90-R, I have renamed this scale General Malaise.

The SCL-90-R and the General Malaise Scale are distinct in the information they elicit. The SCL-90-R asks about <u>specific symptoms</u> during the past seven days, while the General Malaise Scale taps more <u>general feeling states</u> during the past month. The fact that the two instruments are not tapping the same dimensions is reflected in the zero-order correlations between them, .40 for the community sample and .59 for the bereaved sample.

Results

There are a number of ways to examine the issue of aging and distress with these data. One is to make comparisons between samples, that is, between these samples of elderly and other normative samples spanning the full adult age spectrum. A second way is to examine age differences in distress within these two samples. First, comparisons between the elderly samples with two normative samples who were interviewed with the SCL-90-R reveal that community elderly exhibit comparable or lower levels of symptomatology relative to all adults. Only older bereaved respondents report higher levels of distress than these normative groups, primarily on the depression and somatization scales. (See Feinson and Thoits, 1986 for a full description of these comparisons between samples.)

I now turn briefly to the issue of distress and aging within the older adult population, an often neglected area. This issue concerns whether there is an increase in distress associated with increasing age among those 65 and over. Here the results are less consistent (see Table 3, Age column). Among the community respondents, the correlations of age with distress are positive and significant, indicating that for those aged 65 and over, distress increases with age. However, the size of the correlation coefficients (.20 and less) reflects that the relationships are extremely weak. That is, less than 4% of the variance in distress is accounted for by age. For the bereaved, age is not significantly correlated with any measure of distress. The conclusion to be drawn from these findings is that increasing age is only slightly associated with increasing distress for

community elders, but age is not a factor associated with any type of distress for bereaved elders.

Discussion of Prevalence Issues

To summarize the first two prevalence issues, I began with the observation that policy experts (and the public in general) believe that an increase in psychological distress is associated with increasing age. A review of previous studies, however, reveals a lack of epidemiological data to support this perception. In none of the categories of psychological impairment do the preponderance of studies support the notion that older adults are more impaired than younger age cohorts. This conclusion pertains to both the early studies using less refined measures as well as the most recent studies utilizing the latest state-of-the-art instruments.

These findings provide a strong basis for arguing that the extent of mental health problems among older adults may have been exaggerated, an argument which is supported by the New Jersey study of community and bereaved elders. Comparisons of these two elderly samples with normative adult samples reveal equal or fewer symptoms reported by elders than non-elders. Even with the special case of bereaved elders, they were not consistently higher on all measures. Thus, it may be that only certain sub-groups within the older adult population, such as the bereaved or acutely ill, are at higher risk of specific mental health problems than others. In this regard, older high risk groups may not differ from younger people who are experiencing similar major stressful life events. Clearly, however, these findings, combined with the conclusions derived from previous studies, do not support the

consensus that older adults are growing older and more distressed simultaneously.

Utilization of Mental Health Services

The third issue, the utilization of mental health services by older adults, bears an important relationship to the prevalence of distress. The prevailing perception that there are more mental health problems among older than younger adults has been quite consistent, despite the lack of supporting evidence. Moreover, this perception has had a significant impact in the formulation of mental health legislation which mandates services for older adults because of their high risk status (e.g. P.L. 96-398, Mental Health Systems Act). However, despite both federal and state policies targeting services to elders, their utilization of mental health services historically has been low. That is, older adults are seldom seen as out-patients in psychiatric clinics, community mental health centers, or in the offices of private therapists. Moreover, a majority of older adults who become in-patients at state mental hospitals or who are admitted to psychiatric emergency departments generally have no history of prior mental healh care (White House Conference Report, 1981; Waxman, 1982). Not unexpectedly, a number of studies have documented that older adults' utilization is substantially lower than the utilization of younger age groups (e.g. Redick et al., 1973; Kahn, 1975; George et al., 1987).

This paradox of assumed high needs (i.e. high rates of psychological distress) and markedly low out-patient utilization rates raises a number of policy issues. A central policy issue concerns identifying those factors which are implicated in the low utilization

rates. An illumination of those factors which function as barriers to the utilization of services is not only intriguing, but directly related to the design of future social policies and programs.

Social Influences on Utilization

Several explanations have been offered to account for the low utilization rates of elders, especially compared to perceptions of widespread mental health problems. A large number of studies have investigated the attitudes and behaviors of service providers (both primary care providers and mental health professionals) as primary inhibitors of utilization (Butler and Lewis, 1982; Gaitz, 1974; Ford and Sbordone, 1980). This explanation focuses specifically on attitudes of 'agism' among providers, referral patterns, heavy caseloads, inadequate provider training and experience, and stereotypical provider perceptions about patients' resistance to mental health treatment.

A second explanation and area of research assumes that the biased attitudes and resultant behavior of older adults represent the greatest obstacle to mental health utilization (Waxman et al., 1984). That is, older adults do not acknowledge their mental health problems and thus do not seek treatment. The third area examines the negative impact of structural factors including availability, accessibility, and appropriateness of services on low utilization rates. These structural factors include Medicare and insurance reimbursement, geographic location of services, and transportation problems. For this presentation, I focus on the last two categories of explanations - the attitudes of older adults and selected structural conditions - as important barriers to the utilization of services. (This is not to

suggest that the attitudes and behaviors of health and mental health professionals are unimportant factors.)

Attitudes and Behaviors of Older Adults

One explanation for older adults not requesting or utilizing mental health services is the stigma associated with mental health problems. That is, individuals are often reluctant to acknowledge the existence of a problem requiring mental health assistance (Gaitz, 1974). Specifically, it has been suggested that "the birth cohort to which the elderly group belongs fosters attitudes that constrain the use of specialty mental health services". (Golstrom et al., 1987; Butler and Lewis, 1982).

Clearly, a reluctance to acknowledge the existence of a mental health problem represents an important influence on help-seeking behaviors (Mechanic, 1983). Several studies have shown that most symptoms are not reported to health professionals but rather to friends and relatives. Waxman et al. (1984) found that only one-third of an older adult sample would tell a health professional about symptoms of depression; the remaining two-thirds said they would tell a friend or family members (42%), or would not tell anyone (21%). In sharp contrast to this reluctance to disclose mental health symptoms, 72% of Waxman's respondents said they would tell a health professional about cardiovascular symptoms. Finally, when asked whom they would seek help from for psychiatric symptoms, 88% of the respondents selected a general physician. In addition, 80% said they thought a general physician would be the most effective. Mental health professionals were not rated highly, with less than 10% of the sample selecting them for help or expecting them to be effective.

These findings are generally consistent with other studies showing that many individuals, including older adults, tend to confide their symptoms, both physical and psychological, to primary care physicians (Brody and Kleban, 1981; Shapiro et al., 1984; Orleans et al., 1985). Because of older adults' attitudes and preferences, mental health problems are often taken to the medical sector rather than the mental health sector.(Regier et al., 1978, 1982; Orleans et al., 1985). And medical doctors report dealing with these problems themselves, even when mental health services are readily available (Hankin et al., 1982), while referring only those patients with more severe disorders. (Regier et al., 1982).

Other reasons inhibiting the use of mental health services by older adults include a lack of information, denial of problems, and stigmatizing attitudes about psychological distress as a natural accompaniment to the aging process. Thus, in spite of legislative mandates to provide mental health services to older adults, certain social factors undoubtedly impede the provision of these services.

Structural Influences on Utilization Patterns

The third explanation to account for low utilization focuses specifically on structural conditions. These structural conditions may be historical, may have evolved from the planning and policy process, or may be a function of the bureaucracy itself. For example, community mental health center policy was designed to make services more accessible to various underserved groups by locating services in the community and having them operate 24 hours a day. However, in many communities, access is still hindered by a lack of available public transportation, upon which many older adults rely (Cohen, 1976).

Other structural barriers may include more logistical problems such as long waits for appointments, financial difficulties, and lack of information about mental health services. These barriers may be exacerbated by primary care physicians' reluctance to refer patients for mental health services. And certainly federal regulations limiting Medicare reimbursement to $250 in addition to other limited insurance coverage impose significant obstacles to utilization.

Utilization Data from the New Jersey Study

In order to focus more sharply on which factors potentially affect the utilization of mental health services, I now examine additional data from the New Jersey study described previously. In this study of mental health needs, a hypothetical question was included in an attempt to understand what factors are perceived by older adults to affect their utilization of mental health services. (Obviously, there is a big gap between responses to a hypothetical question asked in a survey and the reality, a problem faced by survey research in general.)

Respondents were asked to imagine a situation where, for a period of eight months, they had been very unhappy with their lives, unable to sleep at night, had gotten into lots of arguments, and were unable to pursue their daily activities. The respondents were asked whether a particular factor would make them more willing, less willing, or would not affect their decision to seek professional mental health help. Eighteen items were included, representing various factors assumed to have an impact, either positive or negative, on utilization. Structural factors included the location of the agency, type of sponsoring agency (e.g. religious or governmental), office hours, travel time, services delivered at home, costs on a sliding fee scale,

name of agency, sex and ethnic background of professionals. (It should be noted that many of these factors have been included in legislation and regulations.) Another set of factors focused on attitudinal influences on older adults including recommendations from family members, friends, clergy, family physicians, and community leaders. For each factor the respondent indicated whether it would make him/her more willing to seek mental health services, less willing, or would have no effect on the decision.

The responses to this hypothetical question were intriguing, especially in view of previous explanations for older adults' low utilization rates. Comparisons were made between the responses of the bereaved and community samples for each of the factors. Due to the minimal differences in the response patterns between the two samples, they were combined for the following analysis.

To begin with, there were a number of factors that were perceived to have little or no effect on an older person's decision to utilize services. These included the sponsoring agency and its name, the sex and ethnic background of the professional, the hours of service, and friends' or neighbors' discovering their problem.

Only one factor was acknowledged to have the potential to impede utilization, the location of services. About one-third of the respondents (34%) indicated a decreased willingness to seek services if it took more than 30 minutes to get there. While this was not unexpected, it is important to observe that traveling more than one-half hour was not perceived as a deterrent to utilization for two-thirds of the respondents.

Finally, six factors stood out as being potentially influential in stimulating mental health service utilization for a majority of the respondents. The most important factor was the recommendation of the family doctor. Almost three-quarters of the respondents (72%) indicated that they would be more willing to utilize mental health health services if their family doctors recommended it. Of slightly less importance than the family doctor's recommendation were recommendations from family or relatives (59%) and from the clergy (58%). A similar percentage said they would be more willing to use services if they could be delivered at home or if the agency were located in the neighborhood. Finally, a majority of 54% said they would be more inclined to use services if the fees were charged on a sliding fee scale.

Thus, six factors emerged as being influential with regard to utilization of mental health services for about one-half to three-quarters of the respondents. Interestingly, the factors neatly divide into two categories: social factors, including recommendations from the members of the formal and informal network; and structural factors, such as the location and costs of services.

While the findings provided thus far are primarily descriptive, some statistical analyses were performed to determine whether there were gender and age differences for the six factors. Beginning with gender, there were no significant differences and no patterns by gender in the data. Thus, the factors were similar in importance for both females and males.

With regard to age, only one factor reflected significant age differences: "Your family doctor said it was a good place to go for

help" (chi-square=9.282, $p \leq .05$). The youngest cohort (65-74) indicated being the most willing to utilize mental health services based on a physician's recommendation. The middle cohort (75-84) was the next most likely to follow the recommendation with the oldest cohort (85+) the least likely to be influenced by such a recommendation. There were no age differences for the other five factors.

Discussion of Utilization Data

Clearly, these data are preliminary and cannot be used to estimate a demand for services (Blazer and Maddox, 1982) or as projections of utilization patterns. But they are intriguing and do provide some new information with a number of policy implications. The discussion of findings is structured as follows: first, the most important policy finding to emerge from the utilization data; and second, a return to the data on the prevalence of distress with a more general discussion of the role of age versus need in the formulation of mental health policy.

Beginning with the utilization issue, the most important policy finding to emerge from these data concerns the critical role played by the family doctor vis-a-vis older adults' utilization of mental health services. While this is intuitively reasonable, these data clearly document older adults' reliance on the family doctor not only for physiological symptoms, but for advice with mental health problems. In contrast to the studies which indicate a reluctance to acknowledge mental health problems to professionals, these data imply that this might not always be the case. Moreover, these findings do not support the perceptions of primary care providers that their older patients are resistant to mental health treatment. Such views are undoubtedly

related to the reluctance of providers to refer their older patients for mental health services. In one study, physicians reported treating most of their patients' mental health problems themselves with a combination of psychotropic medication and verbal therapy (verbal therapy was described as consisting "almost exclusively of reassurance, advice, and support given in the context of medical visits"). While treating most of the problems themselves, almost three-quarters of the physicians interviewed said they had too little time to treat such problems effectively (Orleans, et al., 1985). Clearly, both these scenarios (verbal therapy or lack of time) suggest that primary care physicians should be making more referrals to mental health professionals.

Interestingly, although doctor visits increase with age (Wolinsky et al., 1986), and although there is a general perception that older patients have more faith in the doctor, it was the oldest respondents who reported being the least likely to be influenced by the doctor's recommendation. In contrast, those respondents in the youngest cohort (65-74), with traditionally fewer doctor visits, reported being most amenable to a doctor's recommendation. Although this study provides no data on reasons for doctors' recommendations reflecting age variations, it is possible that increased stigma among the oldest cohorts and limited access are some of the factors.

So while mental health problems are not associated with increasing age (as are many physiological problems), the potential utilization of mental health services does reflect age variations. That is, if the doctors' recommendations are the most important stimulant of services, and if they have the least influence on the oldest cohorts (those who

go to the doctors the most often), it may be that different policy strategies are needed to increase utilization for different age cohorts. If additional research substantiates these findings, future health policies should focus on the education of both physicians and patients while encouraging (probably with financial incentives) the intersection of health and mental health services.

With regard to this latter option, a meshing of health and mental health services, it should be noted that a small percentage of older adults (10-11%) use the health care system excessively for symptoms that physicians consider trivial and hard to treat. These patients come back month after month seeking relief while doctors express frustration at not being able to achieve results. This scenario suggests that some emotional problems, which express themselves physiologically, may be at the root of these unproductive physician visits. It also suggests that expensive, excessive, and unnecessary medical care utilization might decrease if such problems were treated in the mental health sector.

Social Policies: Age vs. Need

In conclusion, some comments about policies being based on age or need are in order. The data on the prevalence of psychological distress suggests that distress is not associated with age. These data also show that mental health problems are experienced by highly stressed groups such as the bereaved. This has been shown to be true for all bereaved persons, not merely older bereaved. In fact, for the elderly the death of a spouse is probably more expected - a more 'on-time' event - than a spouse's death occurring among forty year-olds and therefore, may produce less distress for older than younger cohorts. Indeed, while older adults represent a heterogeneous population, those

who live to their 70s and 80s are homogeneous in that they are survivors of a sort. Perhaps they have learned successful coping skills so that stressful life events do not have the same harsh impact on them as on younger adults. All this suggests that, at this time, need rather than age is a more relevant criterion on which to base mental health policies. I am careful to specify 'more relevant' because it is impossible and unwise to disregard age completely. Age must be considered since older adults generally do not use mental health services, but there is evidence that they over-utilize the medical system for psychosomatic problems. Future policies should continue to have an age element, but the emphasis should be primarily on special needs and not on age.

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בריאות נפשית וזיקנה:

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מרג'ורי פיינסון

המכון למדיניות טיפול רפואי והמדרשה החדשה למחקר חברתי

אוניברסיטת רוטג'רס

ג'וינט ישראל
מכון ברוקדייל לגרונטולוגיה
והתפתחות אדם וחברה

גבעת-ג'וינט ת.ד. 13087
ירושלים 91130

פב-16-88

תאריך	תאריך	תאריך

המכון

הוא מכון ארצי [illegible] ה. הוא נוסד ב־1974 [illegible] של יהודי אמריקה), [illegible]

בפעולתו [illegible] לופיים בשירותי הב[illegible] שיתוף הפעולה של [illegible] לה כדי לגשר בין מ[illegible]

סידרה בי[illegible]

המאמרים [illegible] בחו״ל, של אנשי א[illegible] דיונים החורגים [illegible] משגיות ומתודולוגיו[illegible] בחנים בפרספקטיב[illegible]

המימצאים [illegible] את אלה של המ[illegible]

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ירושלים ספטמבר 1988

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