# 1

# Mental Health and Aging
## *An Introduction*

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Consider the following case description:

> Grace, director of a Senior Center in your area, calls you about Mr. Tucker. Although Mr. Tucker used to come to the center three or four times a week, he hasn't come at all since the death of his good friend, Ed, four months ago. Grace had called Mr. Tucker 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. Tucker 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 abruptly hung up. Grace was worried that Mr. Tucker 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. Tucker and set up an appointment.

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

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

Mr. Tucker's current functioning raises a basic question: Is his behavior simply part of normal aging or does it represent a problem that requires professional attention?

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Our answer represents implicit and explicit assumptions regarding the continuum of functioning that runs from outstanding functioning 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*, the multidisciplinary study of normal aging, and *geriatrics*, the study of the medical aspects of old age and the prevention and treatment of the diseases of aging. In Mr. Tucker's case, we want to know if his reaction is a part of a normal grieving process or an indication of an underlying mental health disorder (e.g., a mood disorder, such as 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 aging, optimal or successful aging, and pathological aging. Baltes and Baltes (1990) provided classic definitions of normal and optimal aging:

> Normal aging refers to aging without biological or mental pathology. It thus concerns the aging process that is dominant within a society for persons who are not suffering from a manifest illness. Optimal aging refers to a kind of utopia, namely, aging under development-enhancing and age-friendly environmental conditions. Finally, sick or pathological aging characterizes an aging process determined by medical etiology and syndromes of illness. A classical example is dementia of the Alzheimer type. (pp. 7–8)

Schaie (2016) provides a somewhat different conceptual perspective of the possible trajectories of aging, distinguishing four major patterns. *Normal aging* is the most common pattern, characterized by individuals maintaining a plateau of psychological functioning through their late 50s and early 60s and then showing modest declines in cognitive functioning through their early 80s, with more dramatic deterioration in the years before death. In contrast, *successful agers* are characterized by being genetically and socioeconomically advantaged, and maintaining overall cognitive vitality until right before their death. As described by Schaie, "These are the fortunate individuals whose active life expectancy comes very close to their actual life expectancy" (p. 5). The third pattern includes *those who develop mild cognitive impairment*. Individuals in this group experience declines in cognitive functioning that are more severe than is typical. Some, but not all, in this group progress to having more substantial cognitive problems. Finally, the fourth pattern is *those who develop dementia*, in which individuals experience severe,

dramatic, and diagnosable forms of cognitive impairments. (We fully discuss the dementias and neurocognitive disorders in Chapter 8).

## A statistical definition

*Distinguishing* between normal aging and optimal aging requires us to sort out statistical fact from theoretically desirable conditions. For example, the Baltes and Baltes definition suggests that normal aging does not include "manifest illness." However, in the United States today, chronic disease is typical of the experience of aging: More than 25% of all adults and 66% of older Americans have *multiple* chronic conditions. This is an expensive issue: More than two-thirds of all health care costs in the US are for treating chronic illnesses. For older adults specifically, 95% of health care costs are for chronic diseases (Centers for Disease Control and Prevention, 2013).

Let's look at a specific condition: arthritis. Current estimates indicate that 22.7% of adults in the US reported having doctor-diagnosed arthritis, including 49.7% of people 65 years old and older (Barbour et al., 2013). Moreover, among the oldest old groups (75+ or 85+) there are substantially higher rates. Thus, from a statistical perspective, arthritis is certainly modal, and may be considered a part of normal aging. We will return to this theme in Chapter 2.

## A functional definition

Another approach to defining normal aging arises from defining "manifest illness." By focusing not on presence or absence of a chronic disease, such as arthritis, but on the *impact* of that disease, we may get another depiction of "normal aging." Here, again, though, the definition of terms can affect our conclusions regarding normal aging.

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

> When you get to Mr. Tucker's house, you find an apathetic, listless, very thin man of 81. He seems to be 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. Tucker functionally disabled? If so, is this normal for someone of his age? According to the US Census Bureau, most persons aged 75 years old and older have a disability: 54% of those 75–79 years old had any type of disability with 38% having a "severe disability" (Brault, 2012). In contrast, Manton, Gu, and Lamb (2006) reported that 78% of the 75–84 age group was "non-disabled." How could such differing pictures of older adults emerge?

The answer lies in the definition of disability. The Census Bureau focuses on difficulty with functional activity for its specific definition of disability. The range of functional activities is somewhat broader than traditional definitions: lifting and carrying a weight as heavy as 10 pounds, walking three city blocks, seeing the words and letters in ordinary newsprint, hearing what is said in normal conversation with another person, having one's speech understood, and climbing a flight of stairs. In contrast, Manton et al. (2006) focused on *activities of daily living* (ADLs; e.g., taking care of basic hygiene, eating, getting dressed, using a toilet) and *instrumental activities of daily living* (IADLs; e.g., managing money, doing the laundry; preparing meals; shopping for groceries).

Not surprisingly, these different definitions of disability produce different depictions of functioning and normal aging. The metric we use in assessing functional ability is important for two reasons: The specific activities may be important in and of themselves; and one's ability to complete activities (such as ADLs and IADLs) acts as a proxy for underlying physical, cognitive, emotional, and social abilities. Thus, depending upon the range of functioning we wish to assess, we may conclude that Mr. Tucker is either disabled or not and that such a pattern of functioning is either normal or unusual aging!

## What Is Abnormal or Unhealthy Aging?

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

> You notice that Mr. Tucker doesn't mention being in any terrible pain—that is until you mention his friend Ed. When you do, Mr. Tucker 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. Tucker 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. Tucker 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, the presentation and responses of Mr. Tucker challenge us. Does he have a mental disorder? The answer depends upon resolving other issues: How will we define mental health among older adults? Conversely, how will we define mental disorder among older adults? In Part III of this book, we will discuss assessment and treatment approaches for many specific mental disorders. Here, however, we start at the beginning: definitions of mental health and mental disorder.

## Mental Health and Mental Disorder

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

> The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Because mental health is essential to overall health and well-being, it must be recognized and treated in all Americans, including older adults, with the same urgency as physical health.

Indeed, in the past two decades mental health has become more integrated into the larger public health mission. As an example, the mental health of older Americans was identified as a priority by the Healthy People 2020 objectives (US Department of Health and Human Services, 2010) and more recently by the 2015 White House Conference on Aging (US Department of Health and Human Services, 2015).

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

## Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

In contrast to definitions of mental health, there is greater agreement on definitions of *mental disorder* (for all age groups, including older adults). For both clinical and research purposes, operational definitions of mental disorder usually follow the guidelines in the *Diagnostic and Statistical Manual of Mental Disorders*, now in its fifth edition (DSM-5; American Psychiatric Association, 2013). The DSM-5 is the standard classification of mental disorders used by mental health professionals in the United States. The DSM-5 defines several hundred distinct mental disorders and lists the specific diagnostic criteria for each disorder, as well as other information such as the impact of gender, culture, and aging on the expression of the disorders. Thus, mental disorder in older adults is operationally defined by patterns of disorders in the DSM-5.

A notable feature of the DSM system is that it uses a *categorical approach* to the classification of mental disorders. In other words, mental disorders are conceptualized as either being present (the diagnostic threshold is reached for an individual) or absent (the threshold was not reached). This follows the prominent model in medicine in which one either has a disorder (e.g., cancer) or one does not. In actuality, it is clear that mental disorders are best represented using a *dimensional approach* in which

the severity of any specific disorder can be rated along a continuum from absent or mild to the most severe expression. This is the approach we endorse, to think dimensionally about mental disorders rather than categorically.

Earlier editions of the DSM (the first edition was published in 1952) used Roman numerals to identify new editions (e.g., DSM-II, DSM-III, and DSM-IV). However, with publication of DSM-5, the switch was made to Arabic numerals. This change is a true reflection of the current digital age in which we now live. The premise is that minor updates to the DSM can be disseminated more regularly, using sequential annotations of DSM-5.1, DSM-5.2, and so on until a full new edition is eventually published (to be called DSM-6). Although the DSM-5 is arguably the most comprehensive and sophisticated version yet developed, it is still a human-made system that is limited by our current scientific understanding of mental disorders. In our opinion, the DSM-5 is best viewed as a *tool* to be used by clinicians and researchers, not as a definitive manifesto that is above reproach and without criticism (for a discussion of some criticisms and limitations of the DSM; see Segal, Marty, & Coolidge, 2017).

The DSM-5 is often used in conjunction with the *International Statistical Classification of Diseases and Related Health Problems* (ICD, now in its 10th edition), produced by the World Health Organization (WHO). The ICD is a more broad and comprehensive manual that includes physical health as well as mental health disorders, and it is more widely used than the DSM-5 in Europe and other parts of the world. However, regarding mental disorders, the two manuals are highly compatible due to recent and ongoing efforts in the revision process of both systems to harmonize one with the other. In fact, with the passage of the Patient Protection and Affordable Care Act of 2010 in the US, as of October 2015, ICD-10 codes for mental disorders were required for all coding and billing purposes to insurance companies. Fortunately the DSM-5 provides a table that gives ICD-10 codes for all DSM-5 disorders to assist with this transition. For organizational purposes of this book, we will use the DSM-5 categorization of mental disorders throughout because the DSM-5 is still the prominent diagnostic system in the US. It helps to know that the DSM is highly aligned with the ICD.

Now that we have defined mental health and mental disorder, let's take a look at how these play out among older adults in the US. The Centers for Disease Control's Behavioral Risk Factor Surveillance System (BRFSS) is a large interview project that assesses general mental health status in the US. Respondents are asked to report how many of the previous 30 days their mental health was not good because of stress, depression, or problems with emotions. Frequent mental distress is defined as having 14 or more mentally unhealthy days in the previous 30 days. In 2010, only 7.4% of adults aged 65–74 reported frequent mental distress and the percentage was slightly lower (6.3%) for the 75 years or older group (CDC, 2010). Older adults clearly had the lowest rates of frequent mental distress compared to the younger age groups (see Figure 1.1).

A similar pattern emerges when the focus is on diagnosed mental disorders. The National Comorbidity Survey Replication (NCS-R, 2007) includes interviews about mental disorders from a large, nationally representative sample in the US. Again, older adults had lower levels of diagnosable anxiety disorders, mood disorders, impulse control disorders, and substance use disorders compared to younger adult groups (see Figure 1.2).

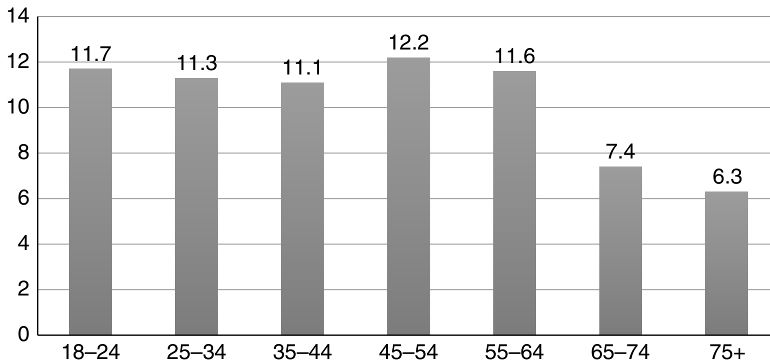


**Figure 1.1** Frequent mental distress by age group in 2010 (% of respondents).
*Source*: Adapted from the Centers for Disease Control (2010).

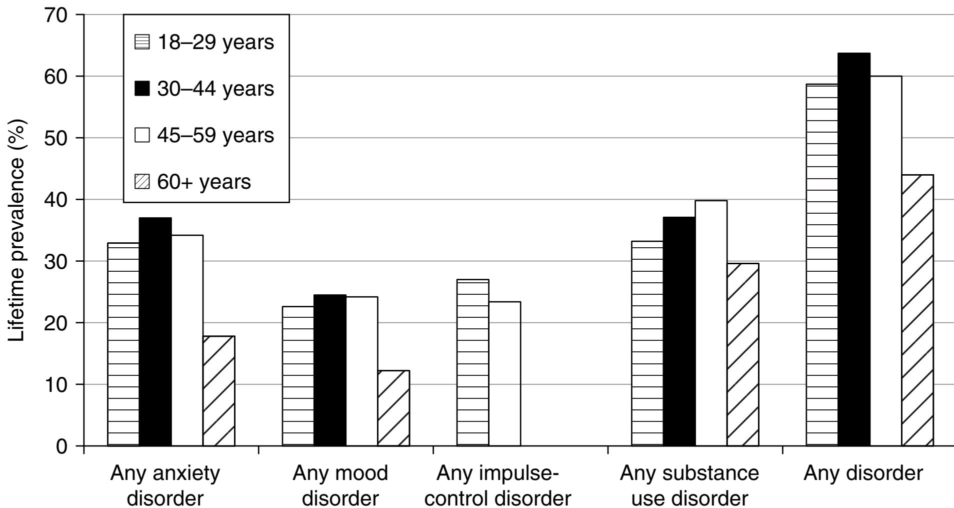


**Figure 1.2** Lifetime prevalence of DSM-IV/World Mental Health Survey disorders by age group in the United States from the National Comorbidity Survey Replication sample.
*Source*: Adapted from the National Comorbidity Survey Replication (2007).

Depression is clearly not a part of normal aging. And, in the vast majority of cases, depression is a treatable condition, with several effective biological and psychotherapeutic approaches (Fiske, Wetherell, & Gatz, 2009). However, geriatric depression reflects the difficulty of discerning "normal aging" from pathological aging. Depression in later life appears in several guises. Depression can easily be confused with medical problems, cognitive impairment, variations in the grief process, and the normal ups and downs of later life. Only around 5.0% of adults aged 65 years or older currently have depression and 10.5% have had a lifetime diagnosis of depression (Centers for Disease Control and Prevention and the National Association of Chronic Disease Directors, 2008). However, the prevalence of depressive *symptoms* among older adults is much higher. (See Chapter 9 for a full discussion of the epidemiology of depression.)

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

Another challenge is that rates of mental disorders vary by setting. For example, older adults in institutional settings present a very different picture. Grabowski, Aschbrenner, Feng, and Mor (2009) analyzed data from Minimum Data Set assessments and found that 27% of newly admitted nursing home residents were diagnosed with schizophrenia, bipolar disorder, depression, or an anxiety disorder. These researchers summarized the impact of these patterns: "Nursing homes have become the de facto mental health care institution as a result of the dramatic downsizing and closure of state psychiatric hospitals, spurred on by the deinstitutionalization movement" (p. 689). Sadly, this situation does not appear to be getting better, and recent data suggest that as the proportion of nursing home residents with serious mental disorders increases, the quality of care for all residents decreases (Rahman, Grabowski, Intrator, Cai, & Mor, 2013).

A final relevant issue is not simply the rates of mental disorder in older adults, but rather the pattern of the *age of onset* of mental disorders (e.g., the average age at which people tend to first experience the disorder). Informative data from the NCS-R indicate that the median age of onset was much earlier for anxiety disorders (11 years old) and impulse-control disorders (11 years old) than for substance use disorders (20 years old) and mood disorders (30 years old). For all of the mental disorders included in this large study, 50% of all lifetime cases start by age 14, 75% of all lifetime cases start by age 24, and 90% of all lifetime cases start by age 42 (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). Thus, the first onset of most mental disorders is in childhood or adolescence and a much smaller percentage of disorders have an onset in later life. Among older adults with a mental disorder, it is clinically relevant to determine when the disorder began. For example, an older adult who has suffered from lifelong depression will likely have a lengthier and more complicated treatment than an older adult who experienced depression for the first time in later life. The issue of age of onset is further explored in many of the chapters on specific mental disorders in Part III of this book.

## Linking the Physical and Mental in Later Life: Comorbidity

Mr. Tucker'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, physical illness, or combination of both. In a classic paper, gerontologist Gene Cohen (1992) provided a context for understanding comorbidity by outlining four useful paradigms for the interaction of physical and mental well-being among older adults:

- Psychogenic (or psychologically based) stress may lead to health problems.
- Health problems may lead to psychiatric disturbances.
- Coexisting mental and physical health problems 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 seeing evidence of either a physical or mental health problem.

First, psychogenic stress may lead to physical health problems. In Mr. Tucker's case, abdominal pain may be a reaction to his grief over Ed's death. For Mr. Tucker, this physical symptom may be a more socially acceptable way for him to express his emotional pain. More generally, you are likely well aware of the strong connection between the mind and the body. You may have noticed in yourself or others times when stress from the environment affected you physically, for example through headaches, stomach upset, or teeth grinding.

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

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

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

**e ive en e tend to de line wi ene en e**.

This example mimics high-frequency hearing loss among older adults and gives you a sense of how easily such a hearing loss might lead to delusions and confusion among this age group.

A third possibility is that coexisting physical and mental disorders may interact. One category of mental disorders among older adults underscores this interplay: cognitive impairment, including the neurocognitive disorders (formerly called the dementias). Cognitive impairment among older adults is a challenge for interdisciplinary diagnosis and treatment. Distinguishing among age-related cognitive change, mild cognitive impairment (MCI), and Alzheimer's disease or other major neurocognitive disorders can be difficult. (We discuss this important issue fully in Chapter 8.) In addition, differential diagnosis and prompt treatment requires ruling out a myriad of potentially reversible causes of confusional states: drug reactions, mental disorders, metabolic disorders, impaired vision and hearing, nutritional deficiencies, dehydration, brain tumors and traumas, and infections. This requires an interdisciplinary collaboration designed to assess complex patterns of comorbidity, in which distinctions between physical disorder and mental disorder become blurred.

Fourth, and finally, Cohen (1992) suggests that social and psychosocial resources can affect the course of physical and mental disorders. As we discuss in the stress and coping model (see Chapter 6), social support can buffer the negative effects of life stress and help people cope better with a myriad of problems. Even among those with a cognitive disorder, a positive social environment can enhance 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 adults, as a context for working with Mr. Tucker. One question has been implicit in this discussion: How is Mr. Tucker like other older adults of

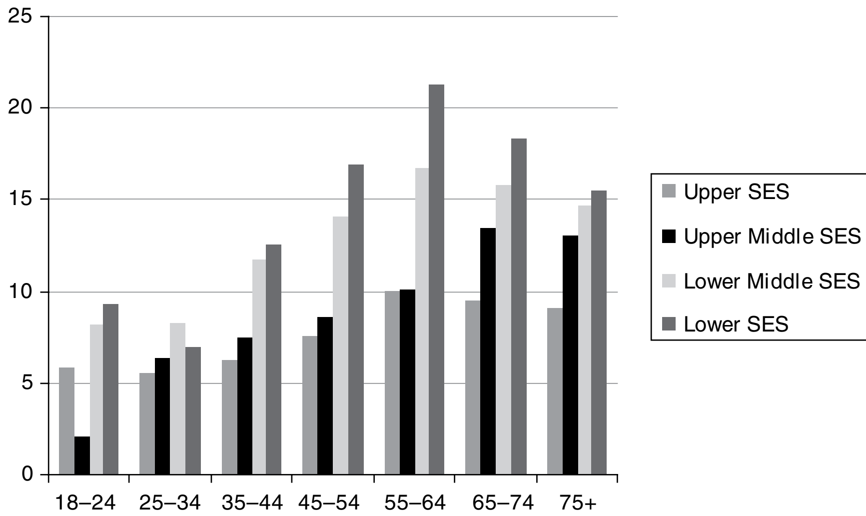


**Figure 1.3** Percentage of respondents reporting that they have a chronic health problem stratified by age and socioeconomic status (SES).
*Source*: Adapted from Centers for Disease Control's Behavior Risk Factor Surveillance System (2007).

his age? In this section, the emphasis shifts to another question: How is Mr. Tucker different from other individuals his age?

What do we know about Mr. Tucker that would differentiate him from other 81-year-olds? What are the categories of information we would use in sorting older adults? Socioeconomic status (SES) dramatically affects the experience of aging. Consider the relationships among age, having a chronic health problem, and SES (see Figure 1.3). Data from the Behavioral Risk Factors Surveillance System (CDC, 2010) showed that individuals in the lower SES categories have the highest rates of chronic conditions throughout adulthood.

Moreover, by early mid-life (ages 35-44), those in the lower SES group already have chronic health 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, however. There are similar patterns of variability in risk of mental disorders. Consider the risk for suicide. We resume our conversation with Mr. Tucker:

> … "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 Mr. Tucker's will to live and his plans for the future. Should you ask him about these elements, about his potential for self-harm or suicide?

Psychiatric epidemiological data can be helpful in tracing patterns of suicide risk across the lifespan in the US (see Figure 1.4). Overall, a total of 42,773 people died

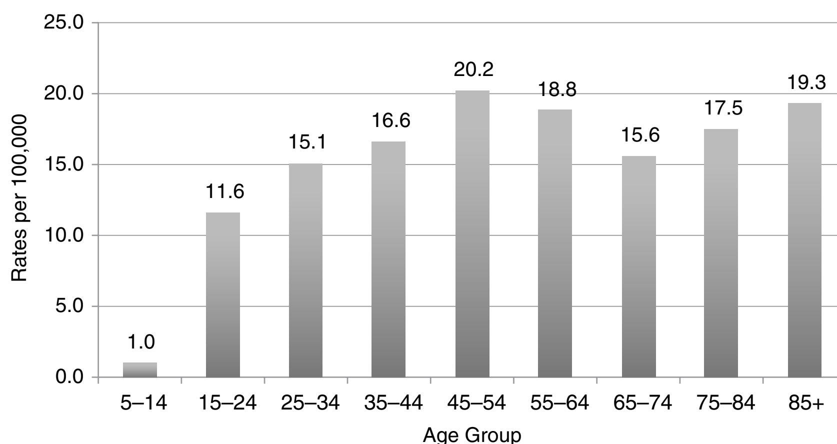


**Figure 1.4** Suicide death rates per 100,000 people, ages 5 to 85+ for 2014 in the US.
*Source*: Adapted from Drapeau & McIntosh (for the American Association of Suicidology; 2015).

by suicide in 2014. Suicide death rates climb from early adulthood and then peak in both the 45–54 year old group and the 85+ year old group. Aggregated across later-life (65+), the threat of completed suicide is substantial, with older adults having a higher suicide death rate (16.6 per 100,000 people) than for the general population (13.4 per 100,00 people; Drapeau & McIntosh, 2015). Across the lifespan, men are much more likely to die by suicide than women, with 3.4 male deaths by suicide for each female death by suicide. White men are at especially elevated risk (24.1 per 100,000 people) with older White men at the absolute greatest risk of any group.

Armed with this knowledge of differential risk—particularly for white men over 80—you ask Mr. Tucker about his current plans and perspectives:

> "It sounds like you're feeling pretty blue. Have you ever thought about hurting yourself in any way?"
>
> "I may be down, but I'm not crazy!"

Mr. Tucker quickly gives you a sense of his own perspective on his problems, allowing you to follow 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 hurting yourself in any way?"
>
> "Every now and then I get that feeling."
>
> "I'm sorry to hear you are in so much pain. Have you thought about how you would 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, and seemingly little concern about the consequences.

These two resolutions to the inquiry highlight the theme of variability among and between older adults. This variability is a hallmark of aging: As we grow older, we become increasingly distinct from our age-mates. This diversity among older adults (often called *inter-individual differences*) is the result of the 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 and the history of the individual. In the case of Mr. Tucker's suicide potential, for example, we will want to know something about his previous experience with suicidal ideation: Has he been suicidal for many years and now grown older? Or, has he grown older and now become suicidal? These two divergent paths both arrive at suicidal risk in later life, but they offer very different suggestions for treatment attempts, the availability of social and emotional resources, and the likelihood of successful intervention.

In summary, we will want to know more about several key elements of Mr. Tucker's history: his social and economic resources, his current and past physical health, his current and past mental health, and his functional abilities. Approaches to these issues 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. Tucker and we have gathered information about his current functioning, his previous history, and his future ability to continue to cope on his own. What will we do next?

Our approach to Mr. Tucker is a function of several, interrelated elements: our sense of his strengths and weaknesses (e.g., how acute is his crisis; is he a threat to himself or others; how has he handled personal challenges in the past; etc.); our assessment of his capacity to be involved in health care decision-making as an active participant in developing the treatment plan; and the service settings and contexts in which we work. These issues are discussed in detail in Chapter 17.

The context of mental health services for older adults has changed substantially since the 1970s. As part of a larger public policy of deinstitutionalization, there were increases in *both* institutional and outpatient services. In the institutional sector, inpatient services were shifted from state mental hospitals to private psychiatric hospitals, psychiatric units in general hospitals, and "swing beds" in general hospitals. As pointed out earlier, one other setting became increasingly important as a receiving site for mentally disordered older adults: nursing homes (Rahman et al., 2013).

Access to mental health services is another important issue. According to Karel, Gatz, and Smyer (2012), older adults significantly underutilize mental health services. And when older adults do receive services, they are less likely to receive care from a mental health specialist compared to younger and middle aged adults. As noted earlier, older adults represent the vast majority of the mentally disordered population in nursing homes (Rahman et al., 2013) representing an overreliance on nursing homes as a treatment setting for older adults with mental disorders. Pepin, Segal, and Coolidge (2009) examined the kinds of barriers that prevent younger and older adults

from accessing mental health services, finding that stigma was at the bottom of the ranked list of barriers for younger and older adults alike. Instead, more practical issues such as concerns about paying for treatment, difficulty with transportation, and difficulty finding an appropriate mental health service provider were perceived as greater barriers. The shortage of specialists trained in geriatric mental health continues to be a problem plaguing the US mental health workforce (Institute of Medicine, 2012). This current and projected shortage can easily be deemed a crisis for the field.

These patterns of care—with a substantial bias toward inpatient, medically oriented services—are only one of two major elements that shape the availability of and access to mental health care for older adults. The second is the combined priorities of major funding sources for geriatric mental health: Medicare, Medicaid, and private insurance plans. We discuss these programs and their impacts in Chapters 14 and 15. These contextual factors—institutional patterns of service provision, insurance coverage, fee structures—affect the choices for services for Mr. Tucker. To work effectively with him, you will need to understand the coverage of mental health services that he has, the availability of services in your local community, and the range of services for which you can be reimbursed. These issues will be further discussed in Chapters 14 and 15.

## The Biopsychosocial Model

We wish to round out this introduction to core issues in aging and mental health by introducing the *biopsychosocial model of mental disorders.* This popular and broad model represents current philosophical thinking about the etiology (or underlying causes) of mental disorders. In essence, the biopsychosocial model posits that the etiology of the vast majority of mental disorders is due to various intricate combinations of biological factors, psychological factors, and social factors (hence the name bio-psycho-social) (see Figure 1.5). Biopsychosocial factors are also thought to impact the manifestation and outcome of mental disorders.

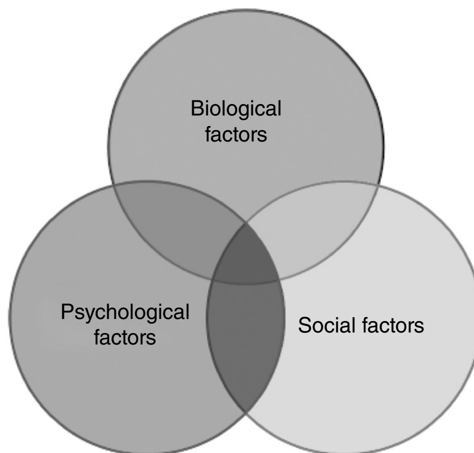


**Figure 1.5** Graphical representation of the biopsychosocial model of mental disorders.

Briefly stated, *biological factors* include genetics, medical disorders, medications and other psychoactive substances, nutrition, hormones, and physical trauma (such as a head injury), whereas *psychological factors* include learned behaviors, faulty or unhelpful ways of thinking, one's coping strategies (whether effective or ineffective), defense mechanisms, self-esteem, and personality traits, all of which affect one's mental health. *Social factors* include culture, race, socioeconomic status, and religion as well as influences in one's environment that impinge on mental health and wellness, for example, adverse childhood experiences, current hassles and stressors, and larger social issues such as racism, discrimination, and political upheaval that affect people in those environments.

Viewing mental disorders through the biopsychosocial lens is especially important to ensure comprehensive assessment of all factors that could possibly play a role in the development and outcome of a mental disorder, and not just factors from one domain that at first blush seem prominent to the client or clinician. This is not to say that there are no mental disorders that do not load primarily on one domain or the other (for example, the neurocognitive disorders are known to have strong biological causes, whereas the eating disorders are known to be strongly affected by social and cultural factors). Rather the core idea is that for most people and for most mental disorders, it is best to view potential causes as having biological, psychological, and social influences, in varying degrees and combinations, as they play out in individual cases. We encourage you to keep this model in mind as we discuss the various mental disorders covered in Section III of this book. You will come to see that, with rare exceptions, biopsychosocial factors are almost always present and contribute to the etiology (and outcome) of psychopathology.

## Summary and Conclusions

In this chapter, we have introduced several themes that will reemerge throughout the book. First, we highlighted the importance of philosophical assumptions regarding normal and abnormal functioning in shaping our assessment strategies, targets for intervention, and definitions of therapeutic success. Next, we emphasized the importance of individual differences in shaping our understanding of the etiology and presentation of mental health problems in later life. We also discussed briefly the fiscal and political context that shapes the availability of mental 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. Finally, we introduced the biopsychosocial model, which is the lens through which we will strive to view the etiology of the mental disorders described in this book. We hope that these themes also reflect the excitement inherent in trying to bring order out of the chaos of needs and services, of trying to both understand the older client and match the client's needs with the services available.

## Critical Thinking / Discussion Questions

1. Articulate some of the historical factors that have shaped your personal views of healthy aging and unhealthy aging, perhaps from your experiences in your family of origin. How might your personal views impact your clinical work with older adults?
2. Think of an older family member or friend who you know well. What are some of the salient biopsychosocial factors that contribute to the person's sense of well-being and/or distress?

## Website Resources

American Psychological Association: Office on Aging
http://www.apa.org/pi/aging/index.aspx
American Psychological Association, Division 12, Section II: Society for Clinical Geropsychology
http://www.geropsychology.org
American Psychological Association, Division 20: Adult Development and Aging
http://www.apadivisions.org/division-20
Diagnostic and Statistical Manual of Mental Disorders (DSM-5)
www.dsm5.org
International Classification of Diseases (ICD)
http://www.who.int/classifications/icd/en
The State of Aging and Health in America (SAHA)
http://www.cdc.gov/aging/help/dph-aging/state-aging-health.html
Psychologists in Long-term Care (PLTC)
http://www.pltcweb.org
2015 White House Conference on Aging
http://www.whitehouseconferenceonaging.gov

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